STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Adams		STREET ADDRESS, CITY, STATE, ZIP CODE 3011 W Adams Ave Temple, TX 76504	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect the resident's(s') right to be free from abuse, neglect, misappropriation of property, and exploitation for 2 of 6 residents (R#1 and R#2). The facility failed to ensure R#1 was not sexually assaulted by R#2 on 12/27/25. An IJ was identified on 12/31/25. The IJ template was provided to the facility on [DATE] at 9:04 p.m. While the IJ was removed on 01/02/26, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk of further abuse, neglect, harm, injury, or death.Findings include:R#1Review of R#1's admission record, dated 12/31/25, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. She had medical diagnoses that included transient cerebral ischemic attack (a temporary blockage of blood flow to the brain, causing stroke-like symptoms that resolve within 24 hours, usually much sooner), noninflammatory vagina disorders (conditions affecting the vagina often due to hormonal changes, anatomical issues or irritation), unsteadiness on feet, gait and mobility abnormalities, need for assistance with personal care, anxiety disorder, pain disorder, major depressive disorder and dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities). Review of R#1's quarterly MDS assessment, dated 11/19/25, reflected the cognitive patterns section showed she had no BIMS score, which indicated she was unable to complete her BIMS interview. Staff assessment for her mental status also showed she had short- and long-term memory problems, was normally able to recall the location of her own room and was moderately impaired when making daily life decisions. The behavior section showed she did not exhibit physical, verbal and other behavioral symptoms and wandering behaviors. The functional abilities section showed she required supervision or touching assistance with lower body dressing, transfers and bed mobility. Review of R#1's care plan, revised on 12/31/25, reflected she had a behavior problem of wandering throughout the secure unit, often into other residents' rooms, and sometimes lying down in other residents' beds. Staff were required to implement interventions, which included administering medications as ordered, anticipating and meeting her needs, intervening as necessary to protect other residents' rights and safety, divert her attention and remove her from a situation and take her to an alternate location as needed. Staff were also required to redirect her to her room or another common area when she was observed wandering into other residents' rooms. Review of R#1's task care record for December 2025 reflected staff documented observing her on 12/27/25 at 3:00 p.m. Review of R#1's change in condition evaluation note created by LVN A on 12/27/25 at 4:04 p.m. reflected, Resident found in bed with another resident; staff intervened and separated both without incident. Resident is non-verbal (BIMS 99) and was calm and cooperative. Full physical and skin assessment completed with no injuries or signs of penetration noted. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Psychosocial assessment showed no acute distress. DON, responsible party, and abuse coordinator notified. Resident remains ongoing monitoring and care plan review. Review of R#1's skin check note created by LVN A on 12/27/25 at 4:09 p.m. reflected, No skin issues noted upon assessment, nurse and staff observed dried feces on resident's pubic hair. Resident's [family member] was present and gave her a shower. Review of R#1's BIMS evaluation note created by the DON on 12/27/25 at 4:46 p.m. reflected, Resident is nonverbal and unable to participate meaningfully in the assessment. When verbalizations occur, resident repeats words spoken by staff (echolalia), laughs inappropriately, and/or begins dancing. Resident is unable to comprehend, respond appropriately, or follow directions required to complete the BIMS assessment due to severe cognitive/mental impairment. Review of R#1's psychosocial note created by LVN B on 12/27/25 at 5:04 p.m. reflected, Resident observed in male resident's room in bed with male on top of her gyrating his hips. Residents immediately separated. Full body assessment completed with no apparent injuries observed. No c/o pain/discomfort. VS obtained and WNL. DON, Admin, family member, and MD all notified and aware. Review of R#1's incident note created by LVN A on 12/27/25 at 5:56 p.m. reflected, The female resident was found in bed with another resident during routine rounds, and staff intervened immediately, separating both residents without incident. The resident's BIMS score is documented as 99 (unable to assess) and she is non-verbal. At the time of assessment, the resident was observed to be calm, with non-verbal cues including facial expressions, body posture, eye contact, or lack thereof, and was cooperative with care. A thorough head-to-toe physical assessment, including a comprehensive skin check, was completed, with no penetration reported or observed and no bruising, bleeding, or signs of injury noted to the genital, groin, or buttocks areas. A psychosocial assessment was conducted using observation of non-verbal behaviors, with no signs of acute distress noted at the time. The Director of Nursing, responsible party, and facility abuse coordinator were notified per facility protocol. The resident remains on 1:1 supervision to ensure safety, with continued monitoring and interdisciplinary review for psychosocial support and care plan updates. Review of R#1's 15 minute check monitoring form, dated 12/27/25, reflected she was monitored as follows:the DON from 12/27/25 at 3:30 p.m. through 12/27/25 at 5:15 p.m. and CNA F from 12/27/25 at 5:30 p.m. through 12/27/25 at 6:30 p.m.Further review revealed there were no other entries. Review of R#1's physician progress note created by the MD on 12/27/25 at 6:21 p.m. reflected, Resident has been on 1:1 supervision for her safety. She is stable at this time and no longer needs to be on 1:1 supervision. Will D/C the 1:1 supervision. Review of R#1's nurse's note created by LVN A on 12/29/25 at 4:33 p.m. reflected, Female resident involved in a recent incident, family requested transfer to the emergency room for further medical assessment. Resident assessed by nursing staff and medical provider, and based on family request, 911 was initiated for hospital transfer. Nurse called report to Emergency Department and provided pertinent resident information. MD and Director of Nursing were notified and are aware of the transfer. Emergency Medical Services are currently in route to the facility. Resident remains under nursing supervision pending EMS arrival. Review of R#1's hospital after visit summary, dated 12/29/25, reflected she arrived at the hospital by EMS on 12/29/25 at 5:12 p.m. Her visit was due to medical clearance for diagnosis regarding possible STI exposure. Her right knee and right femur were x-rayed due to tenderness on exam due to possible recent abuse. The history and physical information reflected, [R#1] presenting for medical clearance. Presents with family for recent history of possible abuse per the family member. She is currently at her neurological baseline, unable to answer questioning or respond to instructions. Family states that 3 days ago a co-resident at her memory care facility was found on top of her in bed. Both the patient and the other individual appeared to be naked, but no known injuries occurred. Since that time, she (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	has not complained of any pain, has been ambulatory, eating and drinking per normal. Final diagnosis as of 12/30/25 at 12:50 a.m. was possible STI exposure. Review of R#1's nurse's note created by LVN C on 12/30/25 at 3:28 a.m. reflected, Res returned from ED with an order for Flagyl 500mg BID x 7 days; order placed in EMAR and placed to pharmacy. Res appears in good spirits. No s/s of pain. Resps even and unlabored. No skin issues noted. Res. smiling at this writer. MD notified and clarified Vaginitis. Review of R#1 nurse's note created by LVN B on 12/30/25 at 11:48 a.m. reflected, After review of AVS from Xrays show no fxs or abnormalities. No STI test results included in AVS. New order for Flagyl 500mg BID X 7 days prophylactically for possible STI exposure. Initial dose to be administered 12/30/25 at HS. R#2Review of R#2's admission record, dated 12/31/25, reflected he was admitted to the facility on [DATE]. He had medical diagnoses that included intermittent angle-closure bilateral glaucoma (temporary, repeated episodes where the eye's drainage angle closes, causing brief pressure spikes and symptoms like headaches, blurry vision or halos), vascular dementia, schizophrenia and auditory and visual hallucinations. He was discharged to the hospital on [DATE]. Review of R#2's quarterly MDS assessment, dated 11/06/25, reflected the cognitive patterns section showed he had a 15/15 BIMS, which indicated he was cognitively intact. The behavior section showed he did not exhibit psychosis, physical, verbal, or other behavioral symptoms and wandering behaviors. The functional abilities section showed he was independent with lower body dressing, transfers and bed mobility. Review of R#2's care plan, dated 10/27/25, reflected he resided in the secure unit due to his wandering and poor safety awareness. Staff were required to implement interventions, which included providing him with activities, assistance where he need to be going, and monitor and report changes in behaviors to the ADM, DON, MD, and RP. Review of R#2's task care record for December 2025 reflected staff documented observing him on 12/27/25 at 2:57 p.m. Review of R#2's change in condition evaluation note created by LVN A on 12/27/25 at 4:23 p.m. reflected, Resident was observed by staff lying in bed next to a female resident when staff intervened. Review of R#2's struck out incident note created by LVN A on 12/27/25 at 5:29 p.m. reflected, The resident was found in bed with a female resident during routine rounds, and staff intervened immediately, separating both residents without incident. The resident has diagnoses of schizophrenia, unspecified, and dementia, unspecified, with a BIMS score of 6, indicating severe cognitive impairment. At the time of redirection, the resident appeared confused and disorganized, demonstrated impaired judgment and poor personal boundaries, and showed limited insight into the inappropriateness of the behavior, consistent with psychiatric and cognitive conditions. The resident was able to follow simple directions with repeated prompting and was escorted back to the room, no injuries were observed. A full head-to-toe physical assessment and psychosocial assessment were completed with no acute issues noted. A 1:1 supervision was initiated for safety. MD and responsible party was notified, and the VA ED was contacted and provided with report. Due to the severity of the incident, 911 was called, and emergency services responded with police presence. The resident is being transferred to the VA Emergency Department for further medical and psychiatric evaluation. Review of R#2's psychosocial note created by LVN A on 12/27/25 at 9:05 p.m. reflected, Resident assessed following aggressive behavior. BIMS score is 6, indicating severe cognitive impairment. Resident observed to be withdrawn with periods of agitation, evidenced by tense body posture, limited eye contact, and restlessness. Verbal interaction was minimal with delayed and inconsistent responses. Affect appeared constricted. No signs of acute distress noted at time of assessment. Resident was redirectable with staff intervention and is currently in his room on one-to-one supervision with every 15-minute checks for safety. Continued monitoring recommended, with interdisciplinary team involvement for behavior management and psychosocial support. Review of R#2's 15 minute check (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitoring form, dated 12/27/25, reflected he was monitored as follows: *the DON from 12/27/25 at 3:15 p.m. through 12/27/25 at 3:45 p.m.*CNA F from 12/27/25 at 4:00 p.m. through 12/27/25 at 5:00 p.m.Further review revealed there were no other entries. Review of R#2's administration note created by the ADM on 12/29/25 at 8:23 a.m. reflected, While passing meds, [MA D] knocked and entered [R#2's] room and found [R#2] in bed with [R#1]. [R#2] found with pants down with genitalia exposed. [R#1] pants down but brief up and intact. [MA D] verbalized, stop. [R#2] rolled to his side and witness observed an nonerect penis and intact brief on [R#1]. [MA D] separated immediately by ushering [R#1] out the room. Administration/Abuse coordinator notified. No penetration noted by witness and no evidence noted on either physical examination of alleged victim or alleged perpetrator. [R#2] immediately placed on 1:1 monitoring and 15 min observation. Physical assessment completed on both individuals. [R#1] noted to have no evidence of penetration but found to have liquid stool in brief. Upon being notified writer/administrator physically went to building to investigate in person. Writer inspected [R#2] genitals and no evidence of penetration or pelvic contact. Unable to interview [R#1], but when [R#2] interviewed, he verbalized incomprehensible speech and shook head and body. Witness statement obtained from [MA D]. Responsible parties notified along with psych NP, MD, EMS and VA. [R#2] subsequently sent out to VA by EMS for psych evaluation. [NAME] notified and onsite officer: PO. Psychosocial assessments completed on both, Safe surveys completed. [R#2] BIMS noted to be 6, and PM noted to be 99. When interviewing witness she state that there appeared to be no struggle. Abuse coordinator interviewed: [MA D], [CNA E], and [LVN A]. In-services being conducted: abuse and neglect, resident to resident, frequent rounding, redirection of resident to assigned room or common area. Additionally, all residents on MCU to have full body assessments and [R#1] placed on 1:1 and 15 min observations until cleared by physician.Review of R#2's administration note created by the ADM on 12/29/25 at 8:51 a.m. reflected, Called [R#2's] RP and rediscussed [R#2] recent incident with another resident. I notified her that [R#2] incident makes himsubject to immediate discharged based up on signed admissions agreement regarding safety and that this notification serves as notice of discharge. Writer on site and investigated event in person. Licensed nurse called report to VA and received acceptance. EMS on site with PD to transport [R#2]. Review of R#2's administration note created by the ADM on 12/29/25 at 8:58 a.m. reflected, Called multiple times by Case managers regarding [R#2]. I repeatedly stated that EMS were instructed to take [R#2] toVA Hospital and that report had been call for acceptance. The VA hospital has resources for [R#2] as PD had no intervention other than EMS escort. I also notified CM, that I personally contacted [R#2's] RP regarding incident and that he is subject to immediatetransfer/discharge and the conversation serves as notification. Review of R#2's nurse's note created by the DON on 12/31/25 at 11:40 a.m. reflected, Responsible parties were notified, including the psychiatric NP, attending MD, EMS, and the VA. Due to ongoing psychiatricconcerns, [R#2] was assessed and subsequently transported by EMS to the VA for further psychiatric evaluation and monitoring. Police Department was notified per protocol, and an onsite officer responded (PO). Comprehensive psychosocial assessments were completed on both involved residents. SAFE surveys were also completed in full. [R#2's] BIMS score was assessed and noted to be 6, indicating cognitive impairment. Due to the need for continued psychiatric follow-up and future evaluation, the resident was sent out to the VA for ongoing psychiatric services. A detailed report was called in to the VA by [LVN A] prior to transport to ensure continuity of care. Review of R#2's MD order, dated 12/27/25 at 11:08 a.m., reflected he was okay to discharge to alternative facility/all male facility. The order was confirmed by the DON. There was no MD signature and signed date indicated. Review of the facility's incident report, from 12/01/25 through 12/31/25, reflected R#1's alleged abuse incident occurred on (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12/27/25 at 4:21 p.m. R#1's alleged abuse incident occurred on 12/27/25 at 3:15 p.m. Review of the facility's discharge report, dated 12/31/25, reflected R#2 was transferred to the hospital on [DATE] at 3:21 p.m. and there was no return. R#1 was also transferred to the hospital on [DATE] at 5:06 p.m. and returned on 12/30/25 at 3:15 a.m. Review of the facility's self-report reflected the incident that occurred on 12/27/25 at 3:15 p.m. The narrative summary of reportable incident reflected it was identical to R#2's administration note created by the ADM on 12/29/25 at 8:23 a.m. Review of MA D's handwritten statement, dated 12/27/25, reflected, On this day I was passing medication at 3:15 and as I entered [R#2's] room I seen [R#2] laying on top of [R#1] and asked him to stop and made sure she was safe and then called for help.There were no other staff statements attached. Review of the facility's resident safety surveys completed by the ADM on unknown dates reflected 6 residents were interviewed. All 6 residents indicated, Yes, when asked did they feel comfortable asking the staff for assistance, did staff treat them with respect and dignity, did they feel safe, did they feel comfortable telling the staff about any concerns and were staff willing to listen and resolve their concerns. All 6 residents indicated, No, when asked if a staff member had physically harmed them, yelled or cursed at them, and if they had any questions for the ADM. Review of the facility's in-services, dated 12/27/25, reflected the DON taught staff about abuse, neglect, resident rights, resident to resident and immediately separating residents to ensure safety, routine checks/frequent rounding, 1:1 observations for safety and supervision of residents, and wandering and redirection. The in-services had attached copies of the abuse, neglect, exploitation and misappropriation prevention program policy, resident rights policy, resident to resident altercations policy, resident checks policy, safety and supervision of residents' policy, and wandering and elopements policy. During an observation of the memory care unit on 12/31/25 at 9:44 a.m., R#1 was sitting in a recliner chair in the living area. The surveyor attempted to interview her, but she was unable to answer any questions. During an interview with CNA G on 12/31/25 at 9:45 a.m., she stated R#1 was nonverbal; she did not verbally communicate. She stated R#1 sometimes showed facial expressions whenever she was in distress or feeling discomfort and whenever she responded in single words, such as No and Stop. She stated R#1 wandered, but she would wander into her own room and no other residents' rooms. She stated R#1 was not on 1:1. She stated R#2 was no longer at the facility, did not know when he was discharged from the facility and did not know why he was discharged from the facility. She stated R#2 was verbal. She stated R#2 did not wander into other residents' rooms. She stated R#1 and R#2 were not cognitively intact. She stated R#1 could not give consent and she was unsure if R#2 could give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she recalled signing off on in-services, but she could not recall what in-services she received and could not recall what she learned. She stated she did not know who the abuse coordinator was. She stated she knew she would separate, notify staff for help, and notify management if there was a resident-to-resident incident. She stated CNAs and nurses checked on residents every less than two hours in the memory care unit. She stated she knew it was important to check on residents and said, Safety. A lot could happen to residents. Any form of accident could happen if they are not frequently rounded (checked) on. During an interview with CNA H on 12/31/25 at 9:47 a.m., she stated R#1 did not verbally communicate. She stated R#1 sometimes showed facial expressions whenever she was in distress or feeling discomfort and whenever she responded in single words, such as No and stop. She stated R#1 wandered into other residents' rooms. She stated R#1 was not on 1:1. She stated R#2 was not at the facility. She stated R#2 was at the facility on 12/26/25. She stated she believed R#2 left the faciity on [DATE]. She did not know why R#2 was discharged (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	from the facility. She stated R#2 was verbal. She stated R#2 did not wander into other residents' rooms. She stated R#1 and R#2 were not cognitively intact. She stated R#1 could not give consent and she was unsure if R#2 could give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she was in-serviced by CNA I, LVN A, and the ADON on abuse, neglect, reporting and resident-to-resident altercation on 12/29/25, 12/30/25 and 12/31/25. She stated she learned to report any abuse and neglect observed, separate residents, and notify the ADM, DON and ADON if there was a resident-to-resident incident. She stated the ADM was the abuse and neglect coordinator. She stated CNAs and nurses checked on residents every less than two hours in the memory care unit. She stated she knew it was important to round on residents and said, Safety. A lot could happen to residents. Any form of accident could happen if they are not frequently rounded on. During an interview with CNA I on 12/31/25 at 10:04 a.m., she stated R#1 communicated in and out. She explained R#1 responded with one words. She stated R#1 will do facial expressions for staff to know how she feels. She stated R#1 did not wander. She stated R#1 was not on 1:1. She stated R#2 was no longer at the facility. She last seen R#2 at the facility on 12/24/25. She did not know why R#2 was discharged from the facility. She stated R#2 was verbal. She stated R#2 did not wander and knew where to go from one place to another place. She stated R#1 and R#2 were not cognitively intact. She stated R#1 and R#2 could not give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she was in-serviced by the DON and ADON on ensuring resident safety, rounding and checking on residents, shift change, abuse and neglect, resident-to-resident, and 1:1 monitoring. She stated she learned she must immediately report abuse and neglect to the ADM and DON because they were both the abuse and neglect coordinators and investigated abuse and neglect, conduct 1:1 to prevent altercations, ensure resident safety, observe residents every 15 minutes, redirecting residents, alternating in between rounds, helping staff with duties and relieving staff of duties. She stated she would separate the residents, yell for help, notify the charge nurse DON and ADM, keep residents apart, and give a statement if there was a resident-to-resident incident. She stated CNAs checked on residents every 30 minutes in the memory care unit. She stated she knew it was important to round on residents and said, To make sure their breathing, alive, no safety issues, clean, not on the floor, know where they are at, ensure they are not in distress. Residents could be at risk of a lot happening if staff are not conducting rounds. We don't want to not round and find any resident unresponsive, sitting in urine/feces, and on the ground due to a fall. During an interview with ADON on 12/31/25 at 10:25 a.m., she stated R#1 was nonverbal. She stated staff observed facial expressions and behaviors to know how R#1 felt. She stated R#1 was not cognitively intact and could not give consent because she did not have the capacity. She stated R#2 was sent to the hospital and did not know why because she was gone when he was sent out to the hospital. She stated there was an incident that occurred on Saturday (12/27/25) that staff had to send R#2 out to the hospital for. She did not know what the incident was. She did not know why R#2 was discharged from the facility. She last seen R#2 on 12/23/25. She stated R#2 could communicate and understand to an extent. She stated R#2 had a guardian. She stated R#2 was not cognitively intact and did not know if R#2 could give consent. She stated R#2 did not have any wandering behaviors. She stated she did not work on 12/27/25. She stated she last worked on 12/23/25. She stated she did not know any incidents of resident-to-resident sexual abuse. She stated CNA J notified her of the incident on Saturday in the afternoon (12/27/25). She stated CNA J informed her that one of the staff walked in on R#2 on top of another resident and was having sexual intercourse. She stated CNA J told her that the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff separated R#2 and the other resident. She stated she did not know if anyone else was on duty. She stated she did not know if R#2 was placed on 1:1 monitoring. She stated R#2 had no past incidents. She stated she did in-service staff after the incident, but she could not recall what it was about because she was just coming back to work since being off from 12/23/25. She stated she expected staff to separate residents immediately, redirect residents away from each other, ensure resident safety, assess the residents, notify the staff and charge nurse, and ensuring resident community safety. She stated all staff (CNAs and nurses) checked on residents at least every 15-30 minutes in the memory care unit if residents were not within eyesight. She stated she did not know how management ensured CNAs and nurses were rounding. She changed her statement and stated she would walk the hallways to ensure staff were rounding on the floor once every hour. She stated she knew it was important to round on residents and said, For safety and security. Primarily for safety of residents. Residents could be at risk of falling or having a change in condition if staff did not round. During an interview with R#1's family and MPOA on 12/31/25 at 12:03 p.m., they stated R#1 was unable to get up on her own, not a wanderer, and did not wander into any other residents' rooms. They stated an unknown female staff member notified them by phone on 12/27/25 around 8:00pm that a male resident was found on top of R#1, their clothes were off, and R#1's brief was loosened on 12/27/25 at an unknown time in the male resident's room. They stated they did not know who walked in and that a staff member told them that it might have been a medication aide that knocked on the door, walked into the male resident's room, and observed the incident. They stated the ADM told them that R#1's clothes were off and her brief was still on. They stated R#1 was not sent out to the hospital on [DATE], they did not know why R#1 was not sent out to the hospital, learned two days later (12/29/25) that R#1 was not sent to the hospital on [DATE], and had to request the staff to send R#1 to the hospital for further evaluation. They stated they questioned the ADM why R#1 was not sent out to the hospital and he told them because he had staff examine R#1. They stated the male resident was sent out to the hospital on [DATE] and the ADM told them that the male resident would not be able to return from the hospital. During an interview with the SW on 12/31/25 at 1:40 p.m., she stated the ADM notified her on 12/29/25 of R#2's incident. She stated the ADM told them one of the CNAs went to check on R#1 in her room and observed R#2 on top of her. She stated the CNA did not know what R#2 was doing and suspected something inappropriate. She stated R#2 was sent out to the hospital and did not return on unknown date, but she believed the same day as the incident. She stated checked on R#1 on 12/29/25. She stated she did not conduct any assessments on R#1 because R#1 was nonverbal and the new facility owners did not instruct her to. She stated she did not conduct resident safety surveys because she was not there the day of the incident, did not do such on 12/29/25 and was not at the facility on 12/30/25. She stated there was no social services designee for assessments and safety surveys. She stated she knew it was important to assess residents after ANE allegations and said, To see how residents are doing, make sure they still feel safe, make sure there's no psychosocial adverse outcome and need to notify psych services. Residents could start to have other symptoms, such as depression, and not feel comfortable with other residents and staff. She stated the DON in-serviced staff on abuse and neglect policies and procedures and discussed the topics during staff meeting on 12/29/25. She stated the ADM and DON oversee to ensure abuse and neglect procedures were followed. She stated she knew to immediately report ANE to the ADM. She stated the ADM and DON report ANE to the SSA. She stated she did not know the reporting timeframe. She stated the ADM was the abuse and neglect coordinator. She stated she knew it was important to follow ANE procedures and said, To make sure basis was covered and make sure residents were safe. Residents quality of care could be affected and it could put them in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Adams	3011 W Adams Ave Temple, TX 76504

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	more harm. During an interview with R#2's RP on 12/31/25 at 2:10 p.m., they stated R#2 was cognitively in and out, schizophrenic and heard voices. They stated R#2 was at the VA. They stated an unknown female nurse on duty notified them on 12/26/25 that staff caught R#2 sexually assaulting another female resident in her room and they sent him to the ER because he was distraught. They stated the staff did not explain why R#2 was distraught. They stated the staff told them that the female resident was shaken up, okay and out of breath because she was a small person. The staff told them that R#2 was not allowed to come back to the facility and did not explain why he was not allowed to return to the facility. They stated the police have not notified or spoke with them about R#2. The staff told them that this was not the first incident involving R#2 and did not explain what the previous incident was. They stated they recalled R#2 sexually assaulted a female patient at a mental health facility about 30 years ago and served a prison sentence for it. The surveyor attempted to call CNA J on 12/31/25 at 2:29 p.m. and 01/01/26 at 1:49 p.m. and left a voicemail and call back number. CNA J did not return the surveyor's calls. The surveyor attempted to call LVN C on 12/31/25 at 2:31 p.m. and 01/01/26 at 1:50 p.m. and left a voicemail and call back number. LVN C did not return the surveyor's calls. During an interview with MA D on 12/31/25 at 2:53 p.m., she stated she was administering medications on 12/27/25 around 3:00 p.m., R#2'a door was closed, she heard moaning, she entered R#2's room and observed R#2 on top of R#1 in his bed, R#2 and R#1's pants were down, R#1's brief was still on, R#1 was making noises and had A flushed face, and R#2 was thrusting against R#1. She stated she did not believe R#2 penetrated R#1 because R#1's brief was on one of the sides. She stated she told R#2 to stop that, R#2 rolled off of R#1, she got R#2 up and out of the room, R#2 and R#1 were separated, and she called CNA E to help her because R#2 could be aggressive and she wanted CNA E there just in case he got aggressive. She stated she also notified LVN K, who ensured R#2 and R#1 were separated. She stated CNA E and LVN K notified the ADM. She stated she did not know if R#2 and R#1 were assessed. She stated R#2 was sent out to the hospital, did not return from the hospital and she did not know why. She stated she was unsure if R#1 was sent out to the hospital, but she believed R#1 was not. She stated she did not know if R#1's and R#2's families were notified. She stated she did not know if law enforcement came out to the facility. She stated she did not have to give a statement to law enforcement and they had not spoken with her. She stated R#2 was a big man and R#1 was a small woman

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NAME OF PROVIDER OR SUPPLIER Avir at Adams		STREET ADDRESS, CITY, STATE, ZIP CODE 3011 W Adams Ave Temple, TX 76504	

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, , investigate any such allegations, and ensure reporting of crimes occurring in federally-funded long-term care facilities for 1 of 6 residents (R#1). The facility failed to implement written policies and procedures in response to the sexual assault of R#1 in that R#1 was not offered emergency transportation services after the abuse incident with R#2 occurred on 12/27/25. An IJ was identified on 01/02/26. The IJ template was provided to the facility on [DATE] at 1:24 p.m. While the IJ was removed on 01/03/26, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk of continued abuse, neglect, harm, injury, or death.Findings include: Review of the facility's abuse, neglect, exploitation and misappropriation prevention program policy, revised April 2021, reflected, Residents have the right to be free from abuse, neglect .1. Protect residents from abuse, neglect, . by anyone including but not necessarily limited to: b. other residents.develop and implement policies and procedures to prevent and identify a. abuse or mistreatment of residents;.5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, . 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations. R#1Review of R#1's admission record, dated 12/31/25, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. She had medical diagnoses that included transient cerebral ischemic attack (a temporary blockage of blood flow to the brain, causing stroke-like symptoms that resolve within 24 hours, usually much sooner), noninflammatory vagina disorders (conditions affecting the vagina often due to hormonal changes, anatomical issues or irritation), unsteadiness on feet, gait and mobility abnormalities, need for assistance with personal care, anxiety disorder, pain disorder, major depressive disorder and dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities). Review of R#1's quarterly MDS assessment, dated 11/19/25, reflected the cognitive patterns section showed she had no BIMS score, which indicated she was unable to complete her BIMS interview. Staff assessment for her mental status also showed she had short- and long-term memory problems, was normally able to recall the location of her own room and was moderately impaired when making daily life decisions. The behavior section showed she did not exhibit physical, verbal and other behavioral symptoms and wandering behaviors. The functional abilities section showed she required supervision or touching assistance with lower body dressing, transfers and bed mobility. Review of R#1's care plan, revised on 12/31/25, reflected she had a behavior problem of wandering throughout the secure unit, often into other residents' rooms, and sometimes lying down in other residents' beds. Staff were required to implement interventions, which included administering medications as ordered, anticipating and meeting her needs, intervening as necessary to protect other residents' rights and safety, divert her attention and remove her from a situation and take her to an alternate location as needed. Staff were also required to redirect her to her room or another common area when she was observed wandering into other residents' rooms. Review of R#1's task care record for December 2025 reflected staff documented observing her on 12/27/25 at 3:00 p.m. Review of R#1's change in condition evaluation note created by LVN A on 12/27/25 at 4:04 p.m. reflected, Resident found in bed with another resident; staff (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	intervened and separated both without incident. Resident is non-verbal (BIMS 99) and was calm and cooperative. Full physical and skin assessment completed with no injuries or signs of penetration noted. Psychosocial assessment showed no acute distress. DON, responsible party, and abuse coordinator notified. Resident remains ongoing monitoring and care plan review. Review of R#1's skin check note created by LVN A on 12/27/25 at 4:09 p.m. reflected, No skin issues noted upon assessment, nurse and staff observed dried feces on resident's pubic hair. Resident's sister waspresent and gave her a shower. Review of R#1's BIMS evaluation note created by the DON on 12/27/25 at 4:46 p.m. reflected, Resident is nonverbal and unable to participate meaningfully in the assessment. When verbalizations occur, resident repeats words spoken by staff (echolalia), laughs inappropriately, and/or begins dancing. Resident is unable to comprehend, respond appropriately, or follow directions required to complete the BIMS assessment due to severe cognitive/mental impairment. Review of R#1's psychosocial note created by LVN B on 12/27/25 at 5:04 p.m. reflected, Resident observed in male resident's room in bed with male on top of her gyrating his hips. Residents immediately separated. Fullbody assessment completed with no apparent injuries observed. No c/o pain/discomfort. VS obtained and WNL. DON, Admin, sister, and MD all notified and aware. Review of R#1's incident note created by LVN A on 12/27/25 at 5:56 p.m. reflected, The female resident was found in bed with another resident during routine rounds, and staff intervened immediately, separatingboth residents without incident. The resident's BIMS score is documented as 99 (unable to assess) and she is non-verbal. At the time of assessment, the resident was observed to be calm, with non-verbal cues including facial expressions, body posture, eye contact, or lack thereof, and was cooperative with care. A thorough head-to-toe physical assessment, including a comprehensive skin check, was completed, with no penetration reported or observed and no bruising, bleeding, or signs of injury noted to the genital, groin, or buttocks areas. A psychosocial assessment was conducted using observation of non-verbal behaviors, with no signs of acute distress noted at the time. The Director of Nursing, responsible party, and facility abuse coordinator were notified per facility protocol. The resident remains on 1:1 supervision to ensure safety, with continued monitoring and interdisciplinary review for psychosocial support and care plan updates. Review of R#1's 15 minute check monitoring form, dated 12/27/25, reflected she was monitored by the DON from 12/27/25 at 3:30 p.m. through 12/27/25 at 5:15 p.m. and CNA F from 12/27/25 at 5:30 p.m. through 12/27/25 at 6:30 p.m. There were no other entries. Review of R#1's physician progress note created by the MD on 12/27/25 at 6:21 p.m. reflected, Resident has been on 1:1 supervision for her safety. She is stable at this time and no longer needs to be on 1:1 supervision. Will D/C the 1:1 supervision. Review of R#1's nurse's note created by LVN A on 12/29/25 at 4:33 p.m. reflected, Female resident involved in a recent incident, family requested transfer to the emergency room for further medical assessment.Resident assessed by nursing staff and medical provider, and based on family request, 911 was initiated for hospital transfer. Nurse called report to Emergency Department and provided pertinent resident information. MD and Director of Nursing werenotified and are aware of the transfer. Emergency Medical Services are currently in route to the facility. Resident remains under nursing supervision pending EMS arrival. Review of R#1's hospital after visit summary, dated 12/29/25, reflected she arrived at the hospital by EMS on 12/27/25 at 5:12 p.m. Her visit was due to medical clearance for diagnosis regarding possible STI exposure. Her right knee and right femur were x-rayed due to tenderness on exam due to possible recent abuse. The history and physical information reflected, [R#1] presenting for medical clearance. Presents with family for recent history of possible abuse per the family member. She is currently at her neurological baseline, unable to answer questioning or respond to instructions. Family states that 3 days ago a co-resident at her memory care facility (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was found on top of her in bed. Both the patient and the other individual appeared to be naked, but no known injuries occurred. Since that time, she has not complained of any pain, has been ambulatory, eating and drinking per normal. Final diagnosis as of 12/30/25 at 12:50 a.m. was possible STI exposure. Review of R#1's nurse's note created by LVN C on 12/30/25 at 3:28 a.m. reflected, Res returned from ED with an order for Flagyl 500mg BID x 7 days; order placed in EMAR and placed to pharmacy. Resappears in good spirits. No s/s of pain. Resps even and unlabored. No skin issues noted. Res. smiling at this writer. MD notified and clarified Vaginitis. Review of R#1 nurse's note created by LVN B on 12/30/25 at 11:48 a.m. reflected, After review of AVS from Xrays show no fxs or abnormalities. No STI test results included in AVS. New order for Flagyl500mg BID X 7 days prophylactically for possible STI exposure. Initial dose to be administered 12/30/25 at HS. R#2 Review of R#2's admission record, dated 12/31/25, reflected he was admitted to the facility on [DATE]. He had medical diagnoses that included intermittent angle-closure bilateral glaucoma (temporary, repeated episodes where the eye's drainage angle closes, causing brief pressure spikes and symptoms like headaches, blurry vision or halos), vascular dementia, schizophrenia and auditory and visual hallucinations. He was discharged to the hospital on [DATE]. Review of R#2's quarterly MDS assessment, dated 11/06/25, reflected the cognitive patterns section showed he had a 15/15 BIMS, which indicated he was cognitively intact. The behavior section showed he did not exhibit psychosis, physical, verbal, or other behavioral symptoms and wandering behaviors. The functional abilities section showed he was independent with lower body dressing, transfers and bed mobility. Review of R#2's care plan, dated 10/27/25, reflected he resided in the secure unit due to his wandering and poor safety awareness. Staff were required to implement interventions, which included providing him with activities, assistance where he need to be going, and monitor and report changes in behaviors to the ADM, DON, MD, and RP. Review of R#2's task care record for December 2025 reflected staff documented observing him on 12/27/25 at 2:57 p.m. Review of R#2's change in condition evaluation note created by LVN A on 12/27/25 at 4:23 p.m. reflected, Resident was observed by staff lying in bed next to a female resident when staff intervened. Review of R#2's struck out incident note created by LVN A on 12/27/25 at 5:29 p.m. reflected, The resident was found in bed with a female resident during routine rounds, and staff intervened immediately, separating bothresidents without incident. The resident has diagnoses of schizophrenia, unspecified, and dementia, unspecified, with a BIMS score of 6, indicating severe cognitive impairment. At the time of redirection, the resident appeared confused and disorganized, demonstrated impaired judgment and poor personal boundaries, and showed limited insight into the inappropriateness of the behavior, consistent with psychiatric and cognitive conditions. The resident was able to follow simple directions with repeated prompting and was escorted back to the room, no injuries were observed. A full head-to-toe physical assessment and psychosocial assessment were completed with no acute issues noted. A 1:1 supervision was initiated for safety. MD and responsible party was notified, and the VA ED was contacted and provided with report. Due to the severity of the incident, 911 was called, and emergency services responded with police presence. The resident is being transferred to the VA Emergency Department for further medical and psychiatric evaluation. Review of R#2's psychosocial note created by LVN A on 12/27/25 at 9:05 p.m. reflected, Resident assessed following aggressive behavior. BIMS score is 6, indicating severe cognitive impairment. Resident observed [NAME] withdrawn with periods of agitation, evidenced by tense body posture, limited eye contact, and restlessness. Verbal interaction was minimal with delayed and inconsistent responses. Affect appeared constricted. No signs of acute distress noted at time of assessment. Resident was redirectable with staff intervention and is currently in his room on one-to-one supervision with every 15-minute checks for safety. Continued (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitoring recommended, with interdisciplinary team involvement for behavior management and psychosocial support. Review of R#2's 15 minute check monitoring form, dated 12/27/25, reflected he was monitored by the DON from 12/27/25 at 3:15 p.m. through 12/27/25 at 3:45 p.m. and CNA F from 12/27/25 at 4:00 p.m. through 12/27/25 at 5:00 p.m. There were no other entries. Review of R#2's administration note created by the ADM on 12/29/25 at 8:23 a.m. reflected, While passing meds, [MA D] knocked and entered [R#2's] room and found [R#2] in bed with [R#1]. [R#2] found with pants downwith genitalia exposed. [R#1] pants down but brief up and intact. [MA D] verbalized, stop. [R#2] rolled to his side and witness observed an nonerect penis and intact brief on [R#1]. [MA D] separated immediately by ushering [R#1] out the room. Administration/Abuse coordinator notified. No penetration noted by witness and no evidence noted on either physical examination of alleged victim or alleged perpetrator. [R#2] immediately placed on 1:1 monitoring and 15 min observation. Physical assessment completed on both individuals. [R#1] noted to have no evidence of penetration but found to have liquid stool in brief. Upon being notified writer/administrator physically went to building to investigate in person. Writer inspected [R#2] genitals and no evidence of penetration or pelvic contact. Unable to interview [R#1], but when [R#2] interviewed, he verbalized incomprehensible speech and shook head and body. Witness statement obtained from [MA D]. Responsible parties notified along with psych NP, MD, EMS and VA. [R#2] subsequently sent out to VA by EMS for psych evaluation. [NAME] notified and onsite officer: PO. Psychosocial assessments completed on both, Safe surveys completed. [R#2] BIMS noted to be 6, and PM noted to be 99. When interviewing witness she state that there appeared to be no struggle. Abuse coordinator interviewed: [MA D], [CNA E], and [LVN A]. In-services being conducted: abuse and neglect, resident to resident, frequent rounding, redirection of resident to assigned room or common area. Additionally, all residents on MCU to have full body assessments and [R#1] placed on 1:1 and 15 min observations until cleared by physician. Review of R#2's administration note created by the ADM on 12/29/25 at 8:51 a.m. reflected, Called [R#2's] RP and rediscussed [R#2] recent incident with another resident. I notified her that [R#2] incident makes himsubject to immediate discharged based up on signed admissions agreement regarding safety and that this notification serves as notice of discharge. Writer on site and investigated event in person. Licensed nurse called report to VA and received acceptance. EMS on site with PD to transport [R#2]. Review of R#2's administration note created by the ADM on 12/29/25 at 8:58 a.m. reflected, Called multiple times by Case managers regarding [R#2]. I repeatedly stated that EMS were instructed to take [R#2] toVA Hospital and that report had been call for acceptance. The VA hospital has resources for [R#2] as PD had no intervention other than EMS escort. I also notified CM, that I personally contacted [R#2's] RP regarding incident and that he is subject to immediatetransfer/discharge and the conversation serves as notification. Review of R#2's nurse's note created by the DON on 12/31/25 at 11:40 a.m. reflected, Responsible parties were notified, including the psychiatric NP, attending MD, EMS, and the VA. Due to ongoing psychiatricconcerns, [R#2] was assessed and subsequently transported by EMS to the VA for further psychiatric evaluation and monitoring. Police Department was notified per protocol, and an onsite officer responded (PO). Comprehensive psychosocial assessments were completed on both involved residents. SAFE surveys were also completed in full. [R#2's] BIMS score was assessed and noted to be 6, indicating cognitive impairment. Due to the need for continued psychiatric follow-up and future evaluation, the resident was sent out to the VA for ongoing psychiatric services. A detailed report was called in to the VA by [LVN A] prior to transport to ensure continuity of care. Review of R#2's MD order, dated 12/27/25 at 11:08 a.m., reflected he was okay to discharge to alternative facility/all male facility. The order was confirmed by the DON. There was no MD signature and signed date indicated. Review of the (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility's incident report, from 12/01/25 through 12/31/25, reflected R#1's alleged abuse incident occurred on 12/27/25 at 4:21 p.m. R#1's alleged abuse incident occurred on 12/27/25 at 3:15 p.m. Review of the facility's discharge report, dated 12/31/25, reflected R#2 was transferred to the hospital on [DATE] at 3:21 p.m. and there was no return. R#1 was also transferred to the hospital on [DATE] at 5:06 p.m. and returned on 12/30/25 at 3:15 a.m. Review of the facility's self-report reflected the incident that occurred on 12/27/25 at 3:15 p.m. The narrative summary of reportable incident reflected it was identical to R#2's administration note created by the ADM on 12/29/25 at 8:23 a.m. Review of MA D's handwritten statement, dated 12/27/25, reflected, On this day I was passing medication at 3:15 and as I entered [R#2's] room I seen [R#2] laying on top of [R#1] and asked him to stop and made sure she was safe and then called for help.There were no other staff statements attached. Review of the facility's resident safety surveys completed by the ADM on unknown dates reflected 6 residents were interviewed. All 6 residents indicated, Yes, when asked did they feel comfortable asking the staff for assistance, did staff treat them with respect and dignity, did they feel safe, did they feel comfortable telling the staff about any concerns and were staff willing to listen and resolve their concerns. All 6 residents indicated, No, when asked if a staff member had physically harmed them, yelled or cursed at them, and if they had any questions for the ADM. Review of the facility's in-services, dated 12/27/25, reflected the DON taught staff about abuse, neglect, resident rights, resident to resident and immediately separating residents to ensure safety, routine checks/frequent rounding, 1:1 observations for safety and supervision of residents, and wandering and redirection. The in-services had attached copies of the abuse, neglect, exploitation and misappropriation prevention program policy, resident rights policy, resident to resident altercations policy, resident checks policy, safety and supervision of residents policy, and wandering and elopements policy. During an observation of the memory care unit on 12/31/25 at 9:44 a.m., R#1 was sitting in a recliner chair in the living area. The surveyor attempted to interview her, but she was unable to answer any questions. During an interview with CNA G on 12/31/25 at 9:45 a.m., she stated R#1 was nonverbal; she did not verbally communicate. She stated R#1 sometimes showed facial expressions whenever she was in distress or feeling discomfort and whenever she responded in single words, such as No and Stop. She stated R#1 wandered, but she would wander into her own room and no other residents' rooms. She stated R#1 was not on 1:1. She stated R#2 was no longer at the facility, did not know when he was discharged from the facility and did not know why he was discharged from the facility. She stated R#2 was verbal. She stated R#2 did not wander into other residents' rooms. She stated R#1 and R#2 were not cognitively intact. She stated R#1 could not give consent and she was unsure if R#2 could give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she recalled signing off on in-services, but she could not recall what in-services she received and could not recall what she learned. She stated she did not know who the abuse coordinator was. She stated she knew she would separate, notify staff for help, and notify management if there was a resident-to-resident incident. She stated CNAs and nurses checked on residents every less than two hours in the memory care unit. She stated she knew it was important to check on residents and said, Safety. A lot could happen to residents. Any form of accident could happen if they are not frequently rounded (checked) on. During an interview with CNA H on 12/31/25 at 9:47 a.m., she stated R#1 did not verbally communicate. She stated R#1 sometimes showed facial expressions whenever she was in distress or feeling discomfort and whenever she responded in single words, such as No and stop. She stated R#1 wandered into other residents' rooms. She stated R#1 was not on 1:1. She stated R#2 was not at the facility. She stated R#2 was at the facility (continued on next page)

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	675587	A. Building B. Wing	01/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Adams	3011 W Adams Ave Temple, TX 76504

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on 12/26/25. She stated she believed R#2 left the faciity on [DATE]. She did not know why R#2 was discharged from the facility. She stated R#2 was verbal. She stated R#2 did not wander into other residents' rooms. She stated R#1 and R#2 were not cognitively intact. She stated R#1 could not give consent and she was unsure if R#2 could give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she was in-serviced by CNA I, LVN A, and the ADON on abuse, neglect, reporting and resident-to-resident altercation on 12/29/25, 12/30/25 and 12/31/25. She stated she learned to report any abuse and neglect observed, separate residents, and notify the ADM, DON and ADON if there was a resident-to-resident incident. She stated the ADM was the abuse and neglect coordinator. She stated CNAs and nurses checked on residents every less than two hours in the memory care unit. She stated she knew it was important to round on residents and said, Safety. A lot could happen to residents. Any form of accident could happen if they are not frequently rounded on. During an interview with CNA I on 12/31/25 at 10:04 a.m., she stated R#1 communicated in and out. She explained R#1 responded with one words. She stated R#1 will do facial expressions for staff to know how she feels. She stated R#1 did not wander. She stated R#1 was not on 1:1. She stated R#2 was no longer at the facility. She last seen R#2 at the facility on 12/24/25. She did not know why R#2 was discharged from the facility. She stated R#2 was verbal. She stated R#2 did not wander and knew where to go from one place to another place. She stated R#1 and R#2 were not cognitively intact. She stated R#1 and R#2 could not give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she was in-serviced by the DON and ADON on ensuring resident safety, rounding and checking on residents, shift change, abuse and neglect, resident-to-resident, and 1:1 monitoring. She stated she learned she must immediately report abuse and neglect to the ADM and DON because they were both the abuse and neglect coordinators and investigated abuse and neglect, conduct 1:1 to prevent altercations, ensure resident safety, observe residents every 15 minutes, redirecting residents, alternating in between rounds, helping staff with duties and relieving staff of duties. She stated she would separate the residents, yell for help, notify the charge nurse DON and ADM, keep residents apart, and give a statement if there was a resident-to-resident incident. She stated CNAs checked on residents every 30 minutes in the memory care unit. She stated she knew it was important to round on residents and said, To make sure their breathing, alive, no safety issues, clean, not on the floor, know where they are at, ensure they are not in distress. Residents could be at risk of a lot happening if staff are not conducting rounds. We don't want to not round and find any resident unresponsive, sitting in urine/feces, and on the ground due to a fall. During an interview with ADON on 12/31/25 at 10:25 a.m., she stated R#1 was nonverbal. She stated staff observed facial expressions and behaviors to know how R#1 felt. She stated R#1 was not cognitively intact and could not give consent because she did not have the capacity. She stated R#2 was sent to the hospital and did not know why because she was gone when he was sent out to the hospital. She stated there was an incident that occurred on Saturday (12/27/25) that staff had to send R#2 out to the hospital for. She did not know what the incident was. She did not know why R#2 was discharged from the facility. She last seen R#2 on 12/23/25. She stated R#2 could communicate and understand to an extent. She stated R#2 had a guardian. She stated R#2 was not cognitively intact and did not know if R#2 could give consent. She stated R#2 did not have any wandering behaviors. She stated she did not work on 12/27/25. She stated she last worked on 12/23/25. She stated she did not know any incidents of resident-to-resident sexual abuse. She stated CNA J notified her of the incident on Saturday in the afternoon (12/27/25). She stated CNA J informed her that one of the staff walked (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675587	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Adams		STREET ADDRESS, CITY, STATE, ZIP CODE 3011 W Adams Ave Temple, TX 76504	

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in on R#2 on top of another resident and was having sexual intercourse. She stated CNA J told her that the staff separated R#2 and the other resident. She stated she did not know if anyone else was on duty. She stated she did not know if R#2 was placed on 1:1 monitoring. She stated R#2 had no past incidents. She stated she did in-service staff after the incident, but she could not recall what it was about because she was just coming back to work since being off from 12/23/25. She stated she expected staff to separate residents immediately, redirect residents away from each other, ensure resident safety, assess the residents, notify the staff and charge nurse, and ensuring resident community safety. She stated all staff (CNAs and nurses) checked on residents at least every 15-30 minutes in the memory care unit if residents were not within eyesight. She stated she did not know how management ensured CNAs and nurses were rounding. She changed her statement and stated she would walk the hallways to ensure staff were rounding on the floor once every hour. She stated she knew it was important to round on residents and said, For safety and security. Primarily for safety of residents. Residents could be at risk of falling or having a change in condition if staff did not round. During an interview with R#1's family and MPOA on 12/31/25 at 12:03 p.m., they stated R#1 was unable to get up on her own, not a wanderer, and did not wander into any other residents' rooms. They stated an unknown female staff member notified them by phone on 12/27/25 around 8:00pm that a male resident was found on top of R#1, their clothes were off, and R#1's brief was loosened on 12/27/25 at an unknown time in the male resident's room. They stated they did not know who walked in and that a staff member told them that it might have been a medication aide that knocked on the door, walked into the male resident's room, and observed the incident. They stated the ADM told them that R#1's clothes were off and her brief was still on. They stated R#1 was not sent out to the hospital on [DATE], they did not know why R#1 was not sent out to the hospital, learned two days later (12/29/25) that R#1 was not sent to the hospital on [DATE], and had to request the staff to send R#1 to the hospital for further evaluation. They stated they questioned the ADM why R#1 was not sent out to the hospital and he told them because he had staff examine R#1. They stated the male resident was sent out to the hospital on [DATE] and the ADM told them that the male resident would not be able to return from the hospital. During an interview with the SW on 12/31/25 at 1:40 p.m., she stated the ADM notified her on 12/29/25 of R#2's incident. She stated the ADM told them one of the CNAs went to check on R#1 in her room and observed R#2 on top of her. She stated the CNA did not know what R#2 was doing and suspected something inappropriate. She stated R#2 was sent out to the hospital and did not return on unknown date, but she believed the same day as the incident. She stated checked on R#1 on 12/29/25. She stated she did not conduct any assessments on R#1 because R#1 was nonverbal and the new facility owners did not instruct her to. She stated she did not conduct resident safety surveys because she was not there the day of the incident, did not do such on 12/29/25 and was not at the facility on 12/30/25. She stated there was no social services designee for assessments and safety surveys. She stated she knew it was important to assess residents after ANE allegations and said, To see how residents are doing, make sure they still feel safe, make sure there's no psychosocial adverse outcome and need to notify psych services. Residents could start to have other symptoms, such as depression, and not feel comfortable with other residents and staff. She stated the DON in-serviced staff on abuse and neglect policies and procedures and discussed the topics during staff meeting on 12/29/25. She stated the ADM and DON oversee to ensure abuse and neglect procedures were followed. She stated she knew to immediately report ANE to the ADM. She stated the ADM and DON report ANE to the SSA. She stated she did not know the reporting timeframe. She stated the ADM was the abuse and neglect coordinator. She stated she knew it was important to follow ANE procedures and said, To make sure basis was covered (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and make sure residents were safe. Residents quality of care could be affected and it could put them in more harm. During an interview with R#1's RP on 12/31/25 at 2:10 p.m., they stated R#2 was cognitively in and out, schizophrenic and heard voices. They stated R#2 was at the VA. They stated an unknown female nurse on duty notified them on 12/26/25 that staff caught R#2 sexually assaulting another female resident in her room and they sent him to the ER because he was distraught. They stated the staff did not explain why R#2 was distraught. They stated the staff told them that the female resident was shaken up, okay and out of breath because she was a small person. The staff told them that R#2 was not allowed to come back to the facility and did not explain why he was not allowed to return to the facility. They stated the police have not notified or spoke with them about R#2. The staff told them that this was not the first incident involving R#2 and did not explain what the previous incident was. They stated they recalled R#2 sexually assaulted a female patient at a mental health facility about 30 years ago and served a prison sentence for it. The surveyor attempted to call CNA J on 12/31/25 at 2:29 p.m. and 01/01/26 at 1:49 p.m. and left a voicemail and call back number. CNA J did not return the surveyor's calls. The surveyor attempted to call LVN C on 12/31/25 at 2:31 p.m. and 01/01/26 at 1:50 p.m. and left a voicemail and call back number. LVN C did not return the surveyor's calls. During an interview with MA D on 12/31/25 at 2:53 p.m., she stated she was administering medications on 12/27/25 around 3:00 p.m., R#2'a door was closed, she heard moaning, she entered R#2's room and observed R#2 on top of R#1 in his bed, R#2 and R#1's pants were down, R#1's brief was still on, R#1 was making noises and had A flushed face, and R#2 was thrusting against R#1. She stated she

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials for 1 of 6 residents (R#1). The facility failed to report R#1's and R#2's incident to the SSA and law enforcement within 2 hours after the abuse was observed. This failure could place residents at risk of continued abuse, neglect, harm, injury, or death. Findings include: R#1 Review of R#1's admission record, dated 12/31/25, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. She had medical diagnoses that included transient cerebral ischemic attack (a temporary blockage of blood flow to the brain, causing stroke-like symptoms that resolve within 24 hours, usually much sooner), noninflammatory vagina disorders (conditions affecting the vagina often due to hormonal changes, anatomical issues or irritation), unsteadiness on feet, gait and mobility abnormalities, need for assistance with personal care, anxiety disorder, pain disorder, major depressive disorder and dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities). Review of R#1's quarterly MDS assessment, dated 11/19/25, reflected the cognitive patterns section showed she had no BIMS score, which indicated she was unable to complete her BIMS interview. Staff assessment for her mental status also showed she had short- and long-term memory problems, was normally able to recall the location of her own room and was moderately impaired when making daily life decisions. The behavior section showed she did not exhibit physical, verbal and other behavioral symptoms and wandering behaviors. The functional abilities section showed she required supervision or touching assistance with lower body dressing, transfers and bed mobility. Review of R#1's care plan, revised on 12/31/25, reflected she had a behavior problem of wandering throughout the secure unit, often into other residents' rooms, and sometimes lying down in other residents' beds. Staff were required to implement interventions, which included administering medications as ordered, anticipating and meeting her needs, intervening as necessary to protect other residents' rights and safety, divert her attention and remove her from a situation and take her to an alternate location as needed. Staff were also required to redirect her to her room or another common area when she was observed wandering into other residents' rooms. Review of R#1's task care record for December 2025 reflected staff documented observing her on 12/27/25 at 3:00 p.m. Review of R#1's change in condition evaluation note created by LVN A on 12/27/25 at 4:04 p.m. reflected, Resident found in bed with another resident; staff intervened and separated both without incident. Resident is non-verbal (BIMS 99) and was calm and cooperative. Full physical and skin assessment completed with no injuries or signs of penetration noted. Psychosocial assessment showed no acute distress. DON, responsible party, and abuse coordinator notified. Resident remains ongoing monitoring and care plan review. Review of R#1's skin check note created by LVN A on 12/27/25 at 4:09 p.m. reflected, No skin issues noted upon assessment, nurse and staff observed dried feces on resident's pubic hair. Resident's sister waspresent and gave her a shower. Review of R#1's BIMS evaluation note created by the DON on 12/27/25 at 4:46 p.m. reflected, Resident is nonverbal and unable to participate meaningfully in the assessment. When verbalizations occur, resident repeats words spoken by staff (echolalia), laughs inappropriately, and/or begins dancing. Resident is unable to comprehend, respond appropriately, or follow directions required to complete the BIMS assessment due to severe cognitive/mental impairment. Review of R#1's psychosocial note (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	created by LVN B on 12/27/25 at 5:04 p.m. reflected, Resident observed in male resident's room in bed with male on top of her gyrating his hips. Residents immediately separated. Fullbody assessment completed with no apparent injuries observed. No c/o pain/discomfort. VS obtained and WNL. DON, Admin, sister, and MD all notified and aware. Review of R#1's incident note created by LVN A on 12/27/25 at 5:56 p.m. reflected, The female resident was found in bed with another resident during routine rounds, and staff intervened immediately, separatingboth residents without incident. The resident's BIMS score is documented as 99 (unable to assess) and she is non-verbal. At the time of assessment, the resident was observed to be calm, with non-verbal cues including facial expressions, body posture, eye contact, or lack thereof, and was cooperative with care. A thorough head-to-toe physical assessment, including a comprehensive skin check, was completed, with no penetration reported or observed and no bruising, bleeding, or signs of injury noted to the genital, groin, or buttocks areas. A psychosocial assessment was conducted using observation of non-verbal behaviors, with no signs of acute distress noted at the time. The Director of Nursing, responsible party, and facility abuse coordinator were notified per facility protocol. The resident remains on 1:1 supervision to ensure safety, with continued monitoring and interdisciplinary review for psychosocial support and care plan updates. Review of R#1's 15 minute check monitoring form, dated 12/27/25, reflected she was monitored by the DON from 12/27/25 at 3:30 p.m. through 12/27/25 at 5:15 p.m. and CNA F from 12/27/25 at 5:30 p.m. through 12/27/25 at 6:30 p.m. There were no other entries. Review of R#1's physician progress note created by the MD on 12/27/25 at 6:21 p.m. reflected, Resident has been on 1:1 supervision for her safety. She is stable at this time and no longer needs to be on 1:1 supervision. WillD/C the 1:1 supervision. Review of R#1's nurse's note created by LVN A on 12/29/25 at 4:33 p.m. reflected, Female resident involved in a recent incident, family requested transfer to the emergency room for further medical assessment.Resident assessed by nursing staff and medical provider, and based on family request, 911 was initiated for hospital transfer. Nurse called report to Emergency Department and provided pertinent resident information. MD and Director of Nursing werenotified and are aware of the transfer. Emergency Medical Services are currently in route to the facility. Resident remains under nursing supervision pending EMS arrival. Review of R#1's hospital after visit summary, dated 12/29/25, reflected she arrived at the hospital by EMS on 12/27/25 at 5:12 p.m. Her visit was due to medical clearance for diagnosis regarding possible STI exposure. Her right knee and right femur were x-rayed due to tenderness on exam due to possible recent abuse. The history and physical information reflected, [R#1] presenting for medical clearance. Presents with family for recent history of possible abuse per the family member. She is currently at her neurological baseline, unable to answer questioning or respond to instructions. Family states that 3 days ago a co-resident at her memory care facility was found on top of her in bed. Both the patient and the other individual appeared to be naked, but no known injuries occurred. Since that time, she has not complained of any pain, has been ambulatory, eating and drinking per normal. Final diagnosis as of 12/30/25 at 12:50 a.m. was possible STI exposure. Review of R#1's nurse's note created by LVN C on 12/30/25 at 3:28 a.m. reflected, Res returned from ED with an order for Flagyl 500mg BID x 7 days; order placed in EMAR and placed to pharmacy. Resappears in good spirits. No s/s of pain. Resps even and unlabored. No skin issues noted. Res. smiling at this writer. MD notified and clarified Vaginitis. Review of R#1 nurse's note created by LVN B on 12/30/25 at 11:48 a.m. reflected, After review of AVS from Xrays show no fxs or abnormalities. No STI test results included in AVS. New order for Flagyl500mg BID X 7 days prophylactically for possible STI exposure. Initial dose to be administered 12/30/25 at HS. R#2 Review of R#2's admission record, dated 12/31/25, reflected he was admitted to the facility on [DATE]. He had medical diagnoses (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individuals. [R#1] noted to have no evidence of penetration but found to have liquid stool in brief. Upon being notified writer/administrator physically went to building to investigate in person. Writer inspected [R#2] genitals and no evidence of penetration or pelvic contact. Unable to interview [R#1], but when [R#2] interviewed, he verbalized incomprehensible speech and shook head and body. Witness statement obtained from [MA D]. Responsible parties notified along with psych NP, MD, EMS and VA. [R#2] subsequently sent out to VA by EMS for psych evaluation. [NAME] notified and onsite officer: PO. Psychosocial assessments completed on both, Safe surveys completed. [R#2] BIMS noted to be 6, and PM noted to be 99. When interviewing witness she state that there appeared to be no struggle. Abuse coordinator interviewed: [MA D], [CNA E], and [LVN A]. In-services being conducted: abuse and neglect, resident to resident, frequent rounding, redirection of resident to assigned room or common area. Additionally, all residents on MCU to have full body assessments and [R#1] placed on 1:1 and 15 min observations until cleared by physician. Review of R#2's administration note created by the ADM on 12/29/25 at 8:51 a.m. reflected, Called [R#2's] RP and rediscussed [R#2] recent incident with another resident. I notified her that [R#2] incident makes himsubject to immediate discharged based up on signed admissions agreement regarding safety and that this notification serves as notice of discharge. Writer on site and investigated event in person. Licensed nurse called report to VA and received acceptance. EMS on site with PD to transport [R#2]. Review of R#2's administration note created by the ADM on 12/29/25 at 8:58 a.m. reflected, Called multiple times by Case managers regarding [R#2]. I repeatedly stated that EMS were instructed to take [R#2] toVA Hospital and that report had been call for acceptance. The VA hospital has resources for [R#2] as PD had no intervention other than EMS escort. I also notified CM, that I personally contacted [R#2's] RP regarding incident and that he is subject to immediatetransfer/discharge and the conversation serves as notification. Review of R#2's nurse's note created by the DON on 12/31/25 at 11:40 a.m. reflected, Responsible parties were notified, including the psychiatric NP, attending MD, EMS, and the VA. Due to ongoing psychiatricconcerns, [R#2] was assessed and subsequently transported by EMS to the VA for further psychiatric evaluation and monitoring. Police Department was notified per protocol, and an onsite officer responded (PO). Comprehensive psychosocial assessments were completed on both involved residents. SAFE surveys were also completed in full. [R#2's] BIMS score was assessed and noted to be 6, indicating cognitive impairment. Due to the need for continued psychiatric follow-up and future evaluation, the resident was sent out to the VA for ongoing psychiatric services. A detailed report was called in to the VA by [LVN A] prior to transport to ensure continuity of care. Review of R#2's MD order, dated 12/27/25 at 11:08 a.m., reflected he was okay to discharge to alternative facility/all male facility. The order was confirmed by the DON. There was no MD signature and signed date indicated. Review of the facility's incident report, from 12/01/25 through 12/31/25, reflected R#1's alleged abuse incident occurred on 12/27/25 at 4:21 p.m. R#1's alleged abuse incident occurred on 12/27/25 at 3:15 p.m. Review of the facility's discharge report, dated 12/31/25, reflected R#2 was transferred to the hospital on [DATE] at 3:21 p.m. and there was no return. R#1 was also transferred to the hospital on [DATE] at 5:06 p.m. and returned on 12/30/25 at 3:15 a.m. Review of the ADM's email correspondence to the SSA on 12/27/25 at 7:09 p.m. reflected, To whom it may concern, website was down and I was unable to submit report directly due to website malfunction. Review of the facility's self-report reflected the incident that occurred on 12/27/25 at 3:15 p.m. The narrative summary of reportable incident reflected it was identical to R#2's administration note created by the ADM on 12/29/25 at 8:23 a.m. Review of MA D's handwritten statement, dated 12/27/25, reflected, On this day I was passing medication at 3:15 and as I entered [R#2's] room I seen [R#2] laying on top of [R#1] and asked him to stop and (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	made sure she was safe and then called for help.There were no other staff statements attached. Review of the facility's resident safety surveys completed by the ADM on unknown dates reflected 6 residents were interviewed. All 6 residents indicated, Yes, when asked did they feel comfortable asking the staff for assistance, did staff treat them with respect and dignity, did they feel safe, did they feel comfortable telling the staff about any concerns and were staff willing to listen and resolve their concerns. All 6 residents indicated, No, when asked if a staff member had physically harmed them, yelled or cursed at them, and if they had any questions for the ADM. Review of the facility's in-services, dated 12/27/25, reflected the DON taught staff about abuse, neglect, resident rights, resident to resident and immediately separating residents to ensure safety, routine checks/frequent rounding, 1:1 observations for safety and supervision of residents, and wandering and redirection. The in-services had attached copies of the abuse, neglect, exploitation and misappropriation prevention program policy, resident rights policy, resident to resident altercations policy, resident checks policy, safety and supervision of residents policy, and wandering and elopements policy. During an observation of the memory care unit on 12/31/25 at 9:44 a.m., R#1 was sitting in a recliner chair in the living area. The surveyor attempted to interview her, but she was unable to answer any questions. During an interview with CNA G on 12/31/25 at 9:45 a.m., she stated R#1 was nonverbal; she did not verbally communicate. She stated R#1 sometimes showed facial expressions whenever she was in distress or feeling discomfort and whenever she responded in single words, such as No and Stop. She stated R#1 wandered, but she would wander into her own room and no other residents' rooms. She stated R#1 was not on 1:1. She stated R#2 was no longer at the facility, did not know when he was discharged from the facility and did not know why he was discharged from the facility. She stated R#2 was verbal. She stated R#2 did not wander into other residents' rooms. She stated R#1 and R#2 were not cognitively intact. She stated R#1 could not give consent and she was unsure if R#2 could give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she recalled signing off on in-services, but she could not recall what in-services she received and could not recall what she learned. She stated she did not know who the abuse coordinator was. She stated she knew she would separate, notify staff for help, and notify management if there was a resident-to-resident incident. She stated CNAs and nurses checked on residents every less than two hours in the memory care unit. She stated she knew it was important to check on residents and said, Safety. A lot could happen to residents. Any form of accident could happen if they are not frequently rounded (checked) on. During an interview with CNA H on 12/31/25 at 9:47 a.m., she stated R#1 did not verbally communicate. She stated R#1 sometimes showed facial expressions whenever she was in distress or feeling discomfort and whenever she responded in single words, such as No and stop. She stated R#1 wandered into other residents' rooms. She stated R#1 was not on 1:1. She stated R#2 was not at the facility. She stated R#2 was at the facility on 12/26/25. She stated she believed R#2 left the faciity on [DATE]. She did not know why R#2 was discharged from the facility. She stated R#2 was verbal. She stated R#2 did not wander into other residents' rooms. She stated R#1 and R#2 were not cognitively intact. She stated R#1 could not give consent and she was unsure if R#2 could give consent. She stated she did not work on 12/27/25. She stated she did not know any resident-to-resident sexual abuse incidents that occurred at the facility. She stated she was in-serviced by CNA I, LVN A, and the ADON on abuse, neglect, reporting and resident-to-resident altercation on 12/29/25, 12/30/25 and 12/31/25. She stated she learned to report any abuse and neglect observed, separate residents, and notify the ADM, DON and ADON if there was a resident-to-resident incident. She stated the ADM was the abuse and neglect coordinator. She stated CNAs (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Adams	3011 W Adams Ave Temple, TX 76504

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