

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 01/14/2026
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #1) of 6 residents reviewed for resident's rights. The facility failed to provide peri care in a timely matter for Resident #1 thus causing her to be left sitting in a soiled brief for over four hours. This failure could place residents at risk for decreased quality of life, decreased self-esteem and diminished dignity, leaving the residents feeling helpless, sad and hopeless. Findings included: Record review of Residents #1 face sheet dated 01/14/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of paranoid schizophrenia, abnormalities of gait and mobility, furuncle of groin, dehydration, anxiety disorder unspecified, and hypocalcemia (a condition of low calcium in blood) Record review of Resident #1's most recent MDS dated [DATE], reflected a BIMS of 15, indicating cognition was intact. MDS reflects that Resident #1 is bowel continent and is not on a toileting program used to manage the resident's bowel continence. Resident #1 requires assistance with toileting transfer and requires supervision or touching assistance with toileting hygiene. Record review of Resident #1's care plan dated 12/30/2025 reflected the resident received Resident #1' care plan did not reflect that she had any adverse reaction due to sitting in wet briefs for a long period of time. During an interview with Resident #1 held on 01/13/2026 at 12:49pm Resident #1 stated that she liked being at the facility and felt safe, however she revealed that she was often left sitting in a wet brief. Resident #1 revealed that when she was left in her brief it made her feel sad, hopeless, helpless. Resident #1 revealed that she mentioned it to the DON and Admin, however nothing had changed. Resident #1 revealed that she had not had a breakdown in skin and that she had been left in a wet brief for hours mostly at night. Record review of Resident #1's skin assessment dated [DATE], did not reflect any skin breakdown. During an interview on 1/14/2026 at 01:15pm with the DON, she revealed that she was unaware of residents being left sitting in soiled briefs for hours at a time. The DON stated that she had no concerns about there being a shortage of staff in the facility. She reported that during the day the facility staffed two nurses, two med aides, and 6 CNAs. She reported that the staff worked 12-hour shifts. The DON reported that at night the facility staffed two nurses, they had two med-aides until 08:45pm, and six CNAs. The DON reported that she expected for staff to be checking residents frequently, and they should be answering call light as soon as possible. The DON reported that staff didn't document how many times with supervision or touching assistance - changed a resident's brief. She reported that it was documented if a resident had complications throughout the night or was exhibiting abnormal behavior. The DON stated that if a resident was kept sitting in a wet brief for a substantial amount of time it could cause skin breakdown. During an interview with the ADMIN on 01/14/2026, at 02:26pm, it was revealed that no residents or staff had approached him with concerns about a shortage of</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675587	Facility ID: 675587

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>staff. He reflected that no residents had ever approached him to the issues of sitting in a wet brief for hours at a time. He stated that the facility could use more staff and that he was aggressively recruiting new staff, setting up partnerships with CNA schools, and hiring a hospitality staff. The ADMIN reported that he expected for staff so respond to call lights as soon as possible and they should be doing rounds every two hours. The ADMIN stated that not answering a call light in an appropriate time frame could create poor quality and poor resident satisfaction. During an interview with CNA A held on 01/14/2026 at 03:49pm, he revealed that he received an in-service on abuse and neglect last week. CNA A stated staff leaving a resident in a soiled brief and not helping them eat as a form of neglect. He said that he made his rounds every two hours if not more often than that. The CNA reported that he did not document each time he entered a resident room or when he changed their brief. The CNA A stated that residents had come to him with concerns of being kept sitting in a wet brief for too long. CAN A stated that he reported it to the charge nurse and had yet to see an outcome. He reported that when a resident was kept in a solid brief could cause pressure ulcers, skin tears. CNA A reported that Resident #1 had mentioned being left in soiled briefs once or twice. During an interview with CNA B on 01/14/2026 at 04:05pm, she revealed that she received an in-service on resident rights. She stated that a resident had a right to be treated with dignity and respect. CNA B reported that staff should be making rounds every two hours, however she typically did it every hour. CNA B reported that she could document when she provided peri care on a resident through Point Click Care system. Point Clinic Care login refers to the process of accessing the Point Click Care platform, which is used for patient care and management. To log in, you typically need to enter your username and password on the login page. If you encounter issues, you may need to reset your password or contact support for assistance. CNA B reported that it should take no more than 5 minutes for someone to respond to a call light. She reported that she had come into work several times and found a resident sitting in a soiled brief. CNA B stated that this comes from lack of structure because they have plenty of time to check in on residents throughout the night. CNA B stated that residents could obtain rashes, redness, or skin breakdowns when left in a solid brief. During an interview with LVN A on 01/14/2026 at 04:27pm, she reported that her last in-service on abuse and neglect was last week. She said that an example of neglect is if you fix a call light to not work or not feeding a resident. LVN A reported that they did not document everything, just baths, bowel movements, and if they did not eat all their food. LVN A reported that residents have told her that they were often left in wet briefs in the daytime. LVN A stated that she told the DON who stated, true. I work the day shift. LVN A stated that lack of staffing could be why residents were left sitting in solid brief. Review of Accommodation of Need policy statement dated March 2021 reflected: Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to: a. a dignified existence. b. be treated with respect, kindness, and dignity.</p>		