STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Adams	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to update two residents care plans (Res#1 and Res#2) of 7 residents reviewed to reflect interventions in place because of an incident that happened between them. The facility failed to update Res#1's and Res#2's care plans to reflect interventions in place because of an incident that happened on 05/03/26 at 6:26 PM. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs.Finding included: Record review on 06/04/26 of Res#1's face sheet, dated 06/04/26, revealed an [AGE] year-old male, admitted [DATE]. His diagnoses included Vascular Dementia (a decline in thinking and memory skills caused by conditions that block or reduce blood flow to the brain, depriving brain tissue of vital oxygen and nutrients), Hyperlipidemia (high amounts of fats (lipids), such as cholesterol and triglycerides, circulating in your bloodstream), Type 2 Diabetes Mellitus (chronic metabolic disorder characterized by persistently high blood sugar levels, and major depression disorder). Res#1's BIMS score was 04, indicating severe cognitive impairment (problems with thinking, learning, memory, judgement, and concentration). Record review on 06/04/26 of Resident #2's face sheet, dated 06/04/26, revealed a [AGE] year-old female admitted [DATE]. Her diagnoses included Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out daily tasks), Hypokalemia (lower than normal level of potassium in the blood stream), Metabolic Encephalopathy (altered brain function caused by an underling systemic, chemical, or metabolic problem in the body rather than a direct head injury), and Hypertension (where the force of blood against your artery walls is consistently too high). Res#2's BIMS score was 03, indicating severe cognitive impairment. Record review on 06/05/26 of the incident reports, dated 03/05/26 through 06/04/26, revealed there was an incident that happened between Res#1 and Res#2 on 05/03/26. Record review on 06/05/25 of LVN A's risk management notes, dated 05/03/26, revealed the following for Res#1: This resident was observed with his disposable underwear pulled down standing up in his room trying to get in his bed. Upon further investigation it was observed by this writer that a female resident was laying on her back on the bed that he was trying to get into. Female resident immediately removed from the room. Female resident believes that he was her husband.Immediate Action: Both residents were separated and Q/15-minute monitoring started. MD, ADM, and IDON notified.Injury type: No injuries observed at time of the incident.Resident location: SU Record review on 06/05/25 of LVN A's risk management notes on 05/03/26 revealed the following for Res#2: This resident was observed laying on her back in the bed of a male resident without any underwear on.Immediate action taken: Both residents immediately separated and Q/15-minute monitoring started. MD, ADM, and DON notified.Injury type: No injuries observed at time of the incident.Resident location: SU Record review on 06/05/26 of Res#1's care plan, dated 04/01/26, revealed the last update to their care plan was 04/01/26. The care plan did not reflect interventions that were in place because of the incident that happened on 05/03/26. Record review on 06/05/26 of Res#2's care plan, dated 04/01/26, revealed that the last update to their care plan was 04/01/26. The care plan did not reflect interventions that were in place because of the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident that happened on 05/03/26 During an interview on 06/05/26 at 12:47 PM, the MD stated she was aware of the incident on 05/03/26 that happened between Res#1 and Res#2. The MD stated that she instructed staff to continue monitoring until discharged . She stated Res #2 was on 1:1 supervision since she appeared to be the initiator since she was laying across the bed without panties on and Res #1 was on Q/15 monitoring. She stated she spoke with the IDON on 05/06/26, who advised the MD verbally discharged the monitoring that day. During an interview on 06/05/26 at 2:47 PM, RNC stated she reviewed Res#1's and Res#2's care plans and saw they did not reflect the incident that happened on 05/03/26. The care plan policy was requested but not provided prior to exit. During an interview on 06/05/26 at 4:09 PM, LVN A stated she saw Res #1 in his room, and it looked as if he tried to crawl in his bed. LVN A walked in and saw Res #2 lying across the bed with only a T-shirt on. She said she did not have panties on. LVN A stated Res #1 appeared to be trying to unzip his pants. LVN A said she immediately separated them and called the IDON for further instructions. LVN A stated the IDON implemented Q 15 monitoring for Res #1 and 1:1 supervision for Res#2 since she was the aggressor. LVN A stated the IDON advised her to document Res#1's and Res#2's behaviors daily for three days. LVN A stated normally the MD would verbally discharge supervision after reporting no behaviors. During an interview on 06/05/26, the IDON stated each resident's care plan was updated when there was a change of condition and in care. She stated she was trained on and was familiar with facility's care plan policy. The IDON said the care plan was developed at admission and updated as new changes were identified or resolved. The IDON stated the importance of updating care plans was to keep track of each resident's condition so staff would be able to know what needs to properly address when there was a change. The IDON stated normally the MDSC was responsible for making sure that each resident's care plan was updated timely. However, the IDON stated at this time she was responsible for making sure each resident's care plan was updated properly. During an interview on 06/05/26, the RVPO stated the facility's former ADM's last day was 05/29/26 and the new ADM would start on 06/08/26. The RVPO stated she did not know that the care plans were not updated correctly. The RVPO stated she believed it was the MDSC's or the IDON's responsibility to ensure that each resident's care plan was updated correctly. The RVPO stated it was important for each care plan to be updated correctly and timely to ensure that each resident received the correct person-centered care. A copy of the care plan policy was requested, but not received During an interview on 06/05/26, the RNC stated , at this time, it was IDON's responsibility to ensure that care plans were updated correctly, since the facility did not have a MDSC. The RNC stated she did not know why the care plans were not updated to reflect the incident that happened on 05/03/26. The RNC said that resident's care plans should have been updated as soon as staff members reported behaviors or changes. The RNC said that it was important to update care plans to ensure that each resident received the correct person-centered care required to maintain the best quality of life possible.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. Based on observations, interviews, and record reviews, the facility failed to ensure it formulated, adopted, and enforced policies regarding smoking, smoking areas, and smoking safety that also consider non-smoking residents for 3 (Res#3, Res#4, and Res#5) of 3 residents reviewed. The facility failed to take residents who smoked out on a scheduled smoke break timely at 10:30 A.M. This failure could result in significant physical, emotional, and behavioral disruptions.Findings included: Record review on 06/05/26 of the smoking break schedule for the residents revealed they were scheduled to go to the designated area for a smoke break at 10:30 A.M. daily. It also revealed the following break times:8:30 AM, 10:30 AM, 1:30 PM, 3:30 PM, 6:30 PM, 8:30 PM. Record review on 06/05/26 of a list of smokers emailed by the RNC on 06/05/26 at 1:08 PM revealed 15 residents were included on the list. There was no printed list provided. A smoking policy was also requested but not provided prior to exit. During an observation on 06/05/26 at 10:50 A.M., the residents who smoked had not gone on the scheduled smoke break. Observation on 06/05/26 at 10:52 AM revealed the smoke break area was located outside at the end of hall B. Observation revealed that there was no one outside in the smoking area between 10:30 AM - 10:55 AM. During an interview on 06/05/26 with Res#3 at 10:53 a.m. revealed that she was supposed to go outside for a supervised smoking break at 10:30 AM with CNA A. Res#3 stated CNA A was often late taking the residents on their scheduled smoking breaks. Interview on 06/05/26 with Res#4 at 11:10 AM revealed she was supposed to go outside for a supervised smoking break at 10:30 AM with CNA A. Res#4 stated CNA A took the residents who smoked on their scheduled smoking break late a lot of times. Interview on 06/05/26 with Res#5 at 11:16 AM revealed he did not smoke but stated the residents who smoked were supposed to go on a scheduled smoke break at 10:30 AM. He stated they went on their smoke breaks later than scheduled several times a week. Interview on 06/05/26 with SS at 11:22 AM revealed she created the schedule for the residents who smoked. She stated that CNA A normally took them on their supervised scheduled break. She stated the facility had two staff members who called in and CNA A received another directive during that time and was unable to adhere to the smokers' schedule. The SS stated CNA B did not find out until almost 11:00 AM that he was supposed to supervise the scheduled smoke break at 10:30 AM. The SS stated that the nurses were responsible to ensure residents who smoked went to their scheduled breaks on time. She stated that residents normally knew when the break time was. She stated that the schedule was not changed until around 11:00 AM to reflect who would supervise the smoking break and she was responsible for that. She stated she and the nurses at the nurse's station were responsible to ensure the smoking break schedules were adhered to. She stated that at that time the nurse that was at the nurse's station may have overlooked the schedule because she oversaw two halls due to a nurse calling out. The SS stated she was not aware that the smoking breaks were late often. She stated the smoke break times were 8:30 AM, 10:30 AM, 1:30 PM, 3:30 PM, 6:30 PM, and 8:30 PM. Interview on 06/05/26 at 1:40 PM with CNA B who revealed he did not know he was supposed to take the residents who smoke on their scheduled break at 10:30 AM because it was not on the schedule when he arrived at work that morning. CNA B said he was scheduled to take them on break at 1:30 PM and 3:30 PM. He stated he was not notified that there was a change in who would take the residents out for their scheduled smoke break. He stated that smoke breaks were especially important to residents because this was their home. CNA B said it could affect their attitudes and their demeanor if they were denied their smoking breaks. He stated that the SS and the LVN B were responsible to ensure that the smoke schedule was adhered to. He stated that the smoke break times were 8:30, 10:30 AM, 1:30 PM, 3:30 PM and 6:30 PM, and 8:30 PM. Interview on 06/05/26 at 2:02 PM, LVN B stated the SS made the break schedule for the residents who smoke, but it was off today due to several staff members being out. She stated that CNA B was assigned a different task at that time by the SS and did not take the residents out for break. LVN B stated that the SS was supposed to ensure that someone was in place if there was a change in the schedule and to also ensure the (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses were aware of the changes. LVN B stated that the entire staff was supposed to make sure that residents went to the smoke breaks on time. She stated that residents were upset when they did not go on smoke breaks on time, which she stated happened often. Interview on 06//05/26 at 2:16 PM, CNA B revealed she was scheduled to supervise the smoking break at 10:30 AM but the SS changed the schedule because some staff members called in for the day. She said she was assigned to another task around 8:00 AM for her shift duration. She stated that the SS should have let the nurses know that the schedule changed. CNA B stated normally if there was a change in the smoking schedule, the SS would let everyone know. CNA B stated it was important for the smokers to go on their scheduled breaks because it could affect their attitudes and daily routines. She stated the smoke break times were 8:30 AM, 10:30 AM, 1:30 PM, 3:30 PM, 6:30 PM, and 8:30 PM. Interview on 06/05/26 on 5:01 PM, the VPO revealed the SS was responsible to ensure that smoke breaks were taken timely and to advise if there was a schedule change in time or a change in who would supervise the break. The VPO stated that this could affect their behaviors and their daily routines. The VPO stated it could violate their rights if there was not an emergency. The VPO stated the facility should have at least two or more backups to ensure that residents who smoked went on breaks in a timely fashion.