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	06/29/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and resident's representative(s) of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 (Resident #1) of 5 residents reviewed for discharge planning.The facility failed to notify Resident #1's RP of Resident #1's discharge, reasons for the move, and right to appeal in writing, in a language and manner they understand, and at least 30 days before Resident #1 was discharged from the facility on 06/10/2026 in a facility-initiated discharge to another skilled nursing facility. The facility failed to send a copy of the notice to the facility's Ombudsman before Resident #1 was discharged from the facility on 06/10/2026. This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services.Findings included:Record review of Resident #1's face sheet, dated 06/28/2026, revealed a sixty four year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, cognitive abilities, and the capacity to perform simple tasks), bipolar disorder (a lifelong mental health condition that causes extreme shifts in mood, energy, activity levels, and concentration), and metabolic encephalopathy (a broad term for brain dysfunction caused by chemical, hormonal, or systemic problems in the body).Record review of Resident #1's care plan revealed care plan closed dated 06/19/2026 had a focus of Resident #1 had a behavioral problem of verbal aggression towards staff and residents related to Alzheimer's Disease dated 03/18/2026 has combative, physical aggression, fluctuating calm to aggressive mood swings, wheels her wheelchair very fast and rams into walls/furniture, restless, impulsive behaviors, unclothes self in public spaces, throws water on others initiated 03/13/2026 and revised on 04/01/2026 with interventions administer medications as ordered, monitor/document for side effects and effectiveness dated 03/13/2026, anticipate and meet Resident #1's needs dated 03/13/2026, monitor and document behaviors every shift dated 04/01/2026, psychiatric referral, evaluation, and treatment 04/01/2026, and staff to redirect behaviors and remove resident to a safe location until behavior deescalates 04/01/2026.Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 03/27/2026 reflected:Nursing Home Comprehensive Section C - Cognitive Patterns revealed a BIMS score of 3 indicating severe cognitive impairment. E0100 Section E - Behavior Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality), behavioral SymptomsE0200. - Behavioral Symptom - Presence and Frequency Behavior of this type occurred 1 to 3 days - physical behavioral symptoms directed toward others (e.g., hitting, kicking pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others), other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds).Record review of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's progress notes dated 03/12/2026 by nursing staff reflected Resident #1 placed on secure unit for safety. Record review of Resident #1's progress notes dated 04/07/2026 by SW reflected spoke with Resident #1's RP regarding the possibility of transferring of Resident #1 to another facility due to difficulty managing behaviors on the secured unit. RP asked if Resident #1 was being the aggressor and SW confirmed this. SW informed RP that referrals were sent to 2 different facilities. Resident #1's RP stated, Well, do what you got to do. Record review of email dated 04/08/2026 at 8:51 AM from the former facility Administrator to the Ombudsman reflected we are planning to transfer Resident #1 to a facility that can better manage her behaviors. We contacted Resident #1's RP and he agreed to the transfer. Record review of Resident #1's progress notes dated 04/22/2026 by nursing staff reflected Resident #1 came up behind a staff member and started choking her. Resident #1's RP notified and he stated, okay let me know if she leaves. Record review of Resident #1's progress notes dated 05/07/2026 by SW reflected Resident #1 required new nursing home placement due to increased negative behaviors. Resident #1's clinical records faxed to other nursing facilities for potential transfer. Record review of email dated 05/12/2026 at 4:46 PM from the former facility Administrator to the DD of SS reflected the former Administrator was referred to the DD of SS for assistance with a difficult discharge/transfer. She has assaulted several staff members, attempted sexual contact with another male resident. We have had no luck getting her accepted at other facilities. Record review of email dated 05/12/2026 at 5:28 PM from the DD of SS to the former facility Administrator reflected the DD of SS asked if the Ombudsman was involved and had a 30-day discharge letter been issued. Record review of email dated 05/12/2026 at 6:03 PM from the RNC to the DD of SS reflected the facility had a full time SW and she did not believe a 30-day had been issued by the facility. The RNC stated she was unsure of the Ombudsman involvement, but the Ombudsman would not be of assistance. The Ombudsman would fight their efforts in relocating Resident #1. Record review of email dated 05/13/2026 at 2:51 PM from the DD of SS to the former facility Administrator. Is [Resident#1's RP] open to her moving to a different town?Record review of email dated 05/13/2026 at 3:26 PM from the former facility Administrator to the DD of SS reflected, [Resident#1's RP] is ok with her being moved. He is not actively in her life but had been notified of her behavior and has no objections to moving her elsewhere.Record review of Resident #1's progress notes dated 06/08/2026 by the SW reflected that she attempted to call Resident #1's RP but received no answer. SW left a voicemail reminding RP of the continued search for alternative and safe placement for resident. SW left a callback number for any questions or concerns. SW added on voicemail that resident had not yet been accepted and there was no generalized location of where resident may be accepted. Record review of Resident #1's progress dated 06/10/2026 reflected Resident #1 discharged from the facility; all paperwork and personal items sent with her. Resident #1 unable make needs know unless prompted. During an interview on 06/28/2026 at 3:21 PM with the Administrator he said he did not know anything about Resident #1's transfer to another facility, the SW had that information. During an interview by phone on 06/28/2026 at 4:21 PM with Resident #1's RP he said he was not informed about Resident #1's discharge to another facility. Resident #1's RP said the facility had discussed transferring her, but he did not know when it happened or where she was transferred. The RP said Resident #1 was moved about 2.5 hours away from him to a new facility. The RP said the first he learned that Resident #1 was sent to another facility was when the new facility called him. He said the SW did not call him and tell him the name of the facility Resident #1 was transferred to or when she was transferred. The RP said he could not take care of her because of her past drug addiction, but he loved her. During an interview on 06/29/2026 at 10:37 AM with the SW she said Resident #1 had difficult behaviors and a decision was made by the previous Administrator and the corporate office to transfer Resident #1 to another facility. The SW said the facility was looking for another facility that could manage her behavior and keep her safe. The SW said when Resident #1 was transferred she did call the RP and inform him that Resident #1 was going to be discharged and where she was going to be discharged , but she did not chart that she did so. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SW said it was a rookie foul on her part that she did not chart the conversation with Resident #1's RP. During an interview on 06/29/2026 at 12:04 PM the SW said she did not believe she had read the facility policy on facility initiated resident discharges. The SW said she did not give a thirty (30)-day advance written notice of an impending transfer or discharge from this facility to the RP in writing and did not give the specific reason for the transfer or discharge, the effective date of the transfer or discharge, the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident was being transferred or discharged , an explanation of the resident's rights to appeal the transfer or discharge. During an interview on 06/29/2026 by phone at 1:06 PM with the DON of the facility Resident #1's was transferred to, the DON said that Resident #1 was doing well and had not had any issues at the facility. The DON at Resident #1's current facility said they recently had a care plan meeting for Resident #1's RP and he commented that he wanted Resident #1 to be moved closer to where he was located. During an interview by phone on 06/29/2026 at 1:10 PM with the PNP she said that the facility asked her about transferring Resident #1 to another facility because of her behaviors and she did not have any objections to Resident #1's transfer but said that the facility needed to follow their facility discharge policy. During an interview by phone on 06/29/2026 at 2:06 PM with the Ombudsman he said he did not have any official notice that Resident #1 was being discharged . The Ombudsman said he did not receive a 30-day discharge notice the included the reason for Resident #1's discharge, the effective date of Resident #1's discharge, or the location where Resident #1 was being discharged .During an interview by phone on 06/29/2026 at 3:02 PM with the DD of SS she said she oversaw the corporate office social work programs. The DD of SS said for a facility initiated discharge the facility would want to have a meeting with the RP to work through whatever might be going on with the resident. The DD of SS said the facility wanted to find the best placement for the resident and said it involved care planning and involvement with the facility Ombudsman. She said if the RP was not involved, then the facility should issue a written 30-day discharge notice. The DD of SS said the facility should document conversations with the RP about discharges. The DD of SS said the facility should specifically document conversation with the RP about the resident transferring to a different area. The DD of SS said if they do not have documentation of conversations with the RP about discharge and where the resident was going, no documentation of a 30-day discharge notice to the RP or the Ombudsman then the facility SW did not follow the discharge policy. During an interview on 06/29/2026 at 3:46 PM with the DON she said the SW was responsible for facility-initiated discharges. The DON said there was no written 30-day notice to the RP or the Ombudsman and the Resident, through her RP, was not notified of her right to appeal. The DON said the SW should follow the discharge policy. She said there was a discharge summary that was created but not completed and the facility did not follow their discharge policy which was made to ensure a safe discharge of residents. The DON said a possible negative effect of not notifying the Ombudsman or the RP as outlined in the facility procedures was family members not knowing where the resident was in case of an emergency. The DON said it was a resident rights issue to not follow the facility discharge procedure. Resident #1, through her RP, did not receive the information about their right to make an appeal. The DON said it was the responsibility of the interdisciplinary team that included the Administrator, the DON, SW, and PNP to make sure residents were properly discharged . The DON said in the future she would make sure residents, RPs, and Ombudsman were notified of discharges and given the required 30-day notice.During an interview on 06/29/2026 at 4:50 PM with the Administrator he said he was minimally involved with Resident #1' discharge. The Administrator said her discharge was in the works when he got there and he was aware they were looking for a place for her. The Administrator said the SW was the person who was responsible for facility discharges and he expected her to follow the facility policy. The Administrator said if the SW did not know the facility policy she needed to pull it and review it. The Administrator said a negative effect of not following the discharge procedure was a resident right issue. The Administrator said if the RP did not receive the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	proper notice of a discharge, the Resident was not informed of their rights. Review of Facility Policy Transfer or discharged , Facility Initiated dated May 2026 reflected once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Facility-Initiated Transfer or Discharge means a transfer or discharge which the resident objects to or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. Notice of Transfer or Discharge (Planned)Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility.The resident and representative are notified in writing of the following information:The specific reason for the transfer or discharge, including the basis under S483.15(c)(1)(i)(A)-(F);The effective date of the transfer or discharge;The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged ;An explanation of the resident's rights to appeal the transfer or discharge to the state, including:the name, address, email and telephone number of the entity which receives such appeal hearing requests;information about how to obtain an appeal form; andhow to get assistance in completing and submitting the appeal hearing request;The Notice of Facility Bed-Hold and policies;The name, address, and telephone number of the Office of the State Long-term Care Ombudsman;The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies);The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); andThe name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.If information in the notice changes, the facility will update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately.For significant changes, such as a change in the transfer or discharge destination, a new notice will be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30-day advance notification and permit adequate time for discharge planning.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews and record reviews, the facility failed to maintain an effective pest control program so that the facility was free from pests for 1 of 1 kitchen rooms and 3 (Resident #2, Resident #4, and Resident #5) of 10 Resident rooms reviewed for environment.The facility failed to ensure the kitchen and dining room was free of cockroaches.The facility failed to ensure Resident #2, Resident #4, and Resident #5's room were free of cockroaches. These failures could place residents at risk for insect borne illness, not having a home free of pests and a comfortable environment in which to live.Findings included:Observation on 06/29/2026 at 11:01 AM revealed two Catchmaster Mouse and Insect Super Glue Traps in the kitchen on the floor located by a trashcan. Observed one Catchmaster box filled with dead cockroaches and a second box with two dead cockroaches. Observation on 06/28/2026 at 2:02 PM revealed a live cockroach in the right corner of Resident #2's room by the door stopper. During an interview on 06/29/2026 at 11:35 AM with Resident #3 she said she has been at the facility for about 4 months and the cockroaches were horrible. Resident #3 said she did not see them in her room, but on the walls in the kitchen. She said she had seen them when she was eating in the dining room. Resident #3 said the cockroaches made her feel dirty.During an interview on 06/29/2026 at 1:39 PM with the DC she said she saw three live cockroaches today. The DC said she saw two in the kitchen and one in the dining room. She said she told the DM when she saw them. She said a negative effect of residents having cockroaches where they live could be the spread of infection. She said she had seen an average of 3 cockroaches a day for about 1 year. During an interview on 06/29/2026 at 1:50 PM the MD said residents had complained about the cockroaches, but they are beginning to get ahead of them. The MD said Residents #4 and #5 had told him about the cockroaches. The MD said a negative effect of having bugs in the facility was germs and the overall negative appearance of the cockroaches. The MD said he heard a couple of days ago that there were cockroaches in the kitchen. He said the bugs are mostly water bugs, giant cockroaches, that come in from the drains. He said it was the responsibility of all staff to keep bugs out of the facility. The MD said he told the Administrator about the cockroaches and the Administrator approved him to get the pest control company to work specifically on the cock roach situation.During an interview on 06/29/2026 at 2:45 PM with Resident #4 she said she had seen cockroaches for about a month. She said she has seen 1 or 2 cockroaches a day in her room. She said she told the MD, but she feels the staff knew about the bugs. She said she tried to kill them when she saw them. Resident #4 said she did not like the cockroaches in her room. During an interview on 06/29/26 at 3:38 PM with the DM she said there were large water cockroaches in the kitchen on the ground mainly, in the storeroom, and by the back door. The DM said the water cockroaches had been bad during the big rains in the past months. The DM said pest control sprayed good last week, and it had gotten a lot better. The DM said the negative effect of having bugs in your kitchen was that bugs were nasty. The DM said they were always on the floor and she had not seen them on anything else. During an interview on 06/29/2026 at 4:43 PM with Resident #5 she said gosh yes, she had seen cockroaches in the facility. She said the MD knew about them. She said she saw a roach yesterday in her room. Resident #5 said she felt scared when she saw bugs. She said those big old water cockroaches scared her. During an interview on 06/29/2026 at 4:50 PM the Administrator said there were cockroaches in the facility but from one week to the next there was a massive decline in the number of bugs in the facility. The Administrator said things were getting better. The Administrator said the negative effect of having bugs in a building was infection from the bugs. During an interview on 06/29/2026 at 5:18 PM the DON said the facility had water bugs. The DON said the water bugs look like cockroaches. She said it makes the facility appear dirty because no one wants to see bugs. The DON said it was almost impossible to prevent. The DON said the facility was actively trying to eliminate the water bugs. She said the possible negative effect of having bugs in the facility was they might be carrying some kind of infection. The DON said the MD was responsible for making sure there was pest control at the facility and for the (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility to be bug free.Record review of Facility Pest Control Policy Statement dated May 2007 reflected Policy StatementOur facility shall maintain an effective pest control program.Policy Interpretation and ImplementationThis facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.Pest control services are provided by a licensed pest control exterminator.Windows are screened at all times.Only approved FDA and EPA insecticides and rodenticides are permitted in the facility, and all supplies are stored in areas away from food storage areas.Garbage and trash are not permitted to accumulate and are removed from the facility daily.Maintenance services assist, when appropriate and necessary, in providing pest control services.