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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675641	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Seguin	1215 Ashby Seguin, TX 78155

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 - Some	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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 4 residents (Residents #2, #3, and #4) reviewed for care plans: The facility failed to ensure Resident #2, Resident #3 and Resident #4's comprehensive care plans were developed and implemented to include care areas identified in the admission MDS assessments. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included:Record review of Resident #2's face sheet dated 2/06/2026 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: chronic combined systolic and diastolic congestive heart failure, chronic obstructive pulmonary disease (progressive lung disease making it difficult to breathe), vitamin deficiency, drusen (degenerative) of macula bilateral (small white or yellow deposits that accumulate on the retina and lead to vision problems), atherosclerotic heart disease of native coronary artery with unstable angina pectoris (plaque buildup in the coronary arteries leading to reduced blood flow and episodes of chest pain), dysphagia following cerebral infarction (trouble swallowing after a stroke), pain, diabetes mellitus due to underlying condition with diabetic autonomic poly neuropathy (diabetes resulting in damage to the nerves and nerve pain), hyperlipidemia (high levels of fat in the blood), essential primary hypertension, acute myocardial infarction (heart attack), constipation, anxiety disorder, muscle wasting and atrophy (decrease in muscle mass and strength), generalized muscle weakness, need for assistance with personal care and unsteadiness on foot. Record review of Resident #2's admission MDS assessment dated [DATE] revealed the resident had impaired vision and required corrective lenses, a BIMS score of 10 which indicated a moderate cognitive impairment. Her function ability was maximal assistance for toileting and showering, moderate assistance with dressing and personal hygiene. She was dependent on staff for moving and positioning and used a wheelchair. The assessment indicated Resident #2 was incontinent of bowel and bladder. She had active diagnoses which included medically complex conditions, coronary artery disease (heart disease), heart failure, hypertension (high blood pressure), renal insufficiency, renal failure or end-stage renal disease (kidney disease), diabetes mellitus, hyperlipidemia, cerebrovascular accident (stroke), anxiety disorder, asthma, chronic obstructive pulmonary disease or chronic lung disease, cataracts (cloudiness of the lens of the eye), glaucoma or macular degeneration (eye disease causing visual problems), dysphagia (trouble swallowing) and polyneuropathy (nerve pain in multiple locations). The assessment was coded for therapeutic diet, antidepressant, antiplatelet use, and oxygen use. The MDS assessment triggered the following care areas: cognitive loss/dementia, visual function, communication, ADL Function/Rehabilitation potential, urinary (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675641	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Avir at Seguin		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 Ashby Seguin, TX 78155	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence and indwelling catheter, falls, nutritional status, pressure ulcer and psychotropic drug use. Record review of Resident #2's comprehensive care plan revealed the resident desired to be full code status was the only portion of the care plan that had been started/developed. No other conditions/problems were addressed. Record review of Resident #3's face sheet dated 2/06/2026 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: Type 2 diabetes mellitus, vitamin D deficiency, depression, insomnia, essential hypertension, low back pain, dementia, muscle wasting and atrophy, generalized muscle weakness, difficulty in walking, unsteadiness on feet, lack of coordination and cognitive communication deficit. Record review of Resident #3's admission MDS assessment dated [DATE] revealed a BIMS score of 12 which indicated a moderate cognitive impairment. The assessment indicated a functional status of supervision or touch assistance and independence with rolling, sit to stand and transfers. The resident was continent of both bowel and bladder. He had active diagnoses which included: hypertension, diabetes, non-Alzheimer's dementia, depression, insomnia, low back pain, cognitive communication deficit (difficulty with communication), muscle wasting and atrophy of multiple sites, generalized muscle weakness, lack of coordination and unsteadiness on feet. The assessment indicated Resident #3 utilized a pressure reducing device for bed, was taking antidepressants and was utilizing speech therapy and physical therapy. The assessment triggered the following care areas: cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence/indwelling catheter, falls, nutritional status, and psychotropic drug use. Record review of Resident #3's comprehensive care plan initiated on 12/31/2025 revealed it listed the resident as full code status. No other care area had been developed. Record review of Resident #4's face sheet dated 2/06/2026 revealed a [AGE] year-old male admitted on [DATE] with diagnoses that included: cerebral infarction (stroke), age-related osteoporosis (weakening of the bones), hyperlipidemia, vascular dementia with agitation and behavioral disturbance, alcohol dependence in remission, major depressive disorder, single episode severe without psychotic features, generalized anxiety disorder, insomnia, chronic pain, essential hypertension, atherosclerotic heart disease of nature coronary artery without angina pectoris, atrial fibrillation, combined systolic and diastolic congestive heart failure, speech and language deficits following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and paralysis on one side of the body), disorder of arteries and arterioles (blood vessels), constipation, gout (a type of arthritis), contracture left hand (muscle stiffness and tightness), chronic kidney disease, overactive bladder, benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate), dysphagia, lack of coordination, cognitive communication deficit, weakness and inferior subluxation of left humorous sequela (dislocation of shoulder joint). Record review of Resident #4's admission MDS assessment dated [DATE] revealed a minimal difficulty hearing loss in some environments, impaired vision with the use of corrective lenses, a BIMS score of 5 which indicated a severe cognitive impairment without behaviors. The assessment indicated Resident #4 utilized a wheelchair for movement, was unable to ambulate and required maximal assistance with movement and transfers. He required maximal assistance with dressing, showering and toileting/hygiene and set up assistance with personal hygiene, oral hygiene and eating. He was frequently incontinent of bowel and bladder. The assessment indicated active diagnoses which included: medically complex conditions, atrial fibrillation or other dysrhythmias (irregular heartbeat), coronary artery disease, heart failure, hypertension, benign prostatic hyperplasia, renal insufficiency, renal failure of end-stage renal disease, hyperlipidemia, arthritis, osteoporosis, cerebrovascular accident, non-Alzheimer's dementia, hemiplegia or hemiparesis, anxiety disorder, depression, cerebral infarction, chronic kidney disease, contracture, left hand, speech/language (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	deficits following cerebral infarction. The assessment indicated the resident received scheduled pain medication, for pain that occasionally affected sleep and interfered with therapy activities and day-to-day activities. The assessment indicated the resident had shortness of breath when lying flat, was a current tobacco user and was at risk for pressure ulcers/injuries. Resident #4 was coded for taking the following classes of medication: antidepressant, anticoagulant, diuretic, opioid, antiplatelet, and anticonvulsant. The MDS assessment triggered the following care areas for the care plan: cognitive loss/dementia, visual function, communication, ADL functional/Rehabilitation Potential, urinary Incontinence and indwelling catheter, falls, nutritional status, pressure ulcer, psychotropic drug use, and pain. Record review of Resident #4's comprehensive care plan initiated on 1/14/2026 revealed a care area for verbally inappropriate behaviors. No other care areas had been developed. During an interview on 2/06/2026 at 2:40 p.m., the Administrator stated the facility did not currently have a MDS Coordinator. She stated Corporate was doing the work remotely. During an interview on 2/06/2026 at 2:44 p.m., a Corporate LVN stated she had been remotely assigned MDS Coordination for the facility for about one week. She stated the facility's full time MDS Coordinator left. She stated they were looking to hire someone permanently at the facility for the position. The Corporate LVN stated she had not looked at any care plans yet, since she had just started about one week ago. During an interview on 2/06/2026 at 2:50 p.m., the DON stated she was aware some residents did not have comprehensive care plans. She stated she had been working on them when she could Corporate had started filling in for that role. The DON stated Resident #2, #3 and #4's comprehensive care plans had not been developed. She stated she was not certain why the care plans were not developed in December when they had a MDS Coordinator before she left a couple of weeks ago. The DON stated it seemed like the previous MDS Coordinator had been struggling even though she had tried to make the things easier for her and gave her samples of care plans to use when she completed the MDS assessments for triggered care areas. The DON stated a comprehensive care plan should be developed and implemented within 20 days of admission. The DON stated the comprehensive care plans were important, so staff knows how to care for each resident. She stated the comprehensive care plan paints a general picture of the resident and the care they need. Record review of the facility policy, titled Care Plans, Comprehensive Person-Centered dated March 2022 revealed: 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.