

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675646	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2026
NAME OF PROVIDER OR SUPPLIER  Avir at Snyder		STREET ADDRESS, CITY, STATE, ZIP CODE  210 E 37th St Snyder, TX 79549	
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 0921  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 4 of 6 resident bathrooms (Rooms 10 , 22, 24, and 45) and 2 of 6 resident bedrooms in that: The bed/wall protector board (bumper board) in Resident room [ROOM NUMBER] was loose and not fastened to the wall. The shelf in the bathroom of Resident room [ROOM NUMBER] was not secured on the left side of the shelf, causing it to lean into the adjacent wall. The toilet tank lid in the bathroom in Resident room [ROOM NUMBER] did not fit the toilet tank, which left an open space on both ends and exposed the water in the tank. Baseboard strips in Resident room [ROOM NUMBER] were not secured. Baseboard strips in the bathroom of Resident room [ROOM NUMBER] were not secured. The toilet in the bathroom of Resident room [ROOM NUMBER] was loose and could be moved 2-3 inches from left to right. The towel bar in Resident room [ROOM NUMBER] was not secured on the right side. These failures could place residents at risk for falls and/or injuries. The findings included: During an observation on 02/25/2026 at 11:10 AM the bed/wall protector in Resident room # 10 was observed at a diagonal angle, with the left side of the board behind the bed, touching the floor, and the right side loose, but fastened to the wall. The shelf in the bathroom of Resident room [ROOM NUMBER] was observed to contain hand towels and wipes. The shelf was not fastened to the wall on the left side, causing the shelf to lean on the adjacent wall for support. During an observation on 02/25/2026 at 11:21 AM the baseboard strip on the left side of Resident room [ROOM NUMBER] was observed to be loose and not fastened to the wall. In addition, a baseboard strip in the bathroom of Resident room [ROOM NUMBER] was observed on the floor and not fastened to the wall. During an observation on 02/25/2026 at 11:30 AM the toilet tank in the bathroom of Resident room [ROOM NUMBER] was observed to not fit the toilet tank. The toilet tank lid did not cover the toilet tank and left the water exposed on the left and right side of the toilet tank. During an observation on 02/25/2026 at 11:40 AM the towel bar in the bathroom of Resident room [ROOM NUMBER] was observed to be loose. The towel bar was not fastened to the wall on the right side, causing the towel bar to hang down. In addition, the toilet in the bathroom of Resident room [ROOM NUMBER] was loose, and the toilet could be moved from left to right, approximately 2 to 3 inches. During an interview on 02/25/2026 at 3:50 PM the MD stated he was responsible for completing repairs within the facility. The MD stated the facility used an online system to report and track repairs. The MD stated he checked the system daily and had an application on his phone to allow him to receive notifications of all new repair requests. The MD stated all repairs were organized based on necessity as well as safety. The MD stated he also did weekly checks of the facility to observe repairs that may be needed. The MD stated he was not aware of the loose toilet in Resident room [ROOM NUMBER]. He stated this was a high priority level repair, and he stated he would ensure it was fixed as soon as possible. The MD stated he was not aware the towel bar in Resident room [ROOM NUMBER] was loose. The MD stated he</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:	Facility ID: 675646
		If continuation sheet Page 1 of 3

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>was not aware of the loose baseboard strips in Resident room [ROOM NUMBER] as well as the bathroom of Resident room [ROOM NUMBER]. The MD stated he was not aware of the loose bed/wall protector board in Resident room [ROOM NUMBER] or the loose shelf in the bathroom of Resident room [ROOM NUMBER]. The MD stated he was not aware that the toilet tank lid did not fit the toilet tank in Resident room [ROOM NUMBER]. The MD stated none of the mentioned repairs were previously reported to him verbally or through the online system. The MD stated any staff could report needed repairs via the online system or verbally. The MD stated residents were also able to report repairs to him directly or to any other facility staff, verbally, when needed. The MD stated it was important for the mentioned repairs to be completed to prevent accidents from occurring. The MD stated residents were at risk of falls or incurring injuries due to the loose toilet, loose baseboard strips, loose towel bar, loose shelf, and loose bed/wall protector board. During an interview on 02/25/2026 at 4:30 PM the DON stated the MD was responsible for completing repairs within the facility. The DON stated needed repairs were reported through an online system. The DON stated any staff could have reported a need for repair. The DON stated she was not aware of any of the mentioned repairs. The DON stated a loose toilet and loose baseboard strips were a potential fall hazard from a resident. The DON stated if a shelf were loose in a resident's bathroom, it was a safety concern as it could have potentially fell on a resident. The DON stated it was her expectation for repairs to be completed as soon as possible. During an interview on 02/25/2026 at 4:15 PM the ADON stated the MD was responsible for completing repairs within the facility. The ADON stated the facility used an online system to report maintenance requests. The ADON stated she entered maintenance orders frequently, as this was a newer system for the facility and not all staff were as familiar with the system. The ADON stated the facility was working on completing training with all staff on the use of the online reporting system for maintenance requests. The ADON stated she was not aware of the loose toilet and loose towel bar in Resident room [ROOM NUMBER]. The ADON stated she was not aware of the loose baseboard strips in Resident room [ROOM NUMBER]. The ADON stated she was not aware of the loose bed/wall protector board or the loose shelf in Resident room [ROOM NUMBER]. The ADON stated she was not aware of the toilet tank lid in Resident room [ROOM NUMBER] not fitting the toilet tank. The ADON stated none of the repairs needed had been reported to her by any staff. The ADON stated the repairs needed could pose safety concerns to residents as they could have led to falls and/or injuries. During an interview on 02/25/2026 at 5:30 PM the ADM stated the MD was responsible for completing repairs within the facility. The ADM stated the facility used an online system to report maintenance requests. The ADM stated the MD received notifications of any maintenance requests and prioritized them based on necessity. The ADM stated it was her expectation that all high priority repairs and necessary repairs that could pose a safety concern were completed as soon as possible. The ADM stated the facility also did checks of resident rooms on a daily basis. The ADM stated this was done by all staff, and it was her expectation that all staff report any repairs needed to the MD either verbally or via the online system as soon as they were observed. The ADM stated she was not aware of the loose toilet and loose towel bar in Resident room [ROOM NUMBER]. The ADM stated she was not aware of the loose baseboard strips in Resident room [ROOM NUMBER]. The ADM stated she was not aware of the loose bed/wall protector board or the loose shelf in Resident room [ROOM NUMBER]. The ADM stated she was not aware of the toilet tank lid in Resident room [ROOM NUMBER] not fitting the toilet tank. The ADM stated none of the above mentioned repairs had been reported to her. The ADM stated a loose toilet was a high priority maintenance order and she stated this would be fixed immediately as it could have resulted in a resident fall. The ADM stated loose baseboards, strips a loose shelf, a loose bed/wall protector board, and an exposed toilet</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>tank also posed safety risks to residents and she stated those repairs would be completed as soon as possible. Record review of the facility's policy titled, Maintenance Service dated December 2009, reflected the following: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: b. maintaining the building in good repair and free from hazards. f. establishing priorities in providing repair service. Record review of the facility's policy titled, Work Orders, Maintenance undated, reflected the following: Policy Statement: Maintenance work orders shall be completed in order to establish a priority of maintenance service. Policy Interpretation and Implementation: 1. In order to establish a priority of maintenance services, work orders must be filled out and forwarded to the maintenance director. 2. It shall be the responsibility of the department directors to fill out and forward such work orders to the maintenance director.</p>		