

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                 |
| F 0727<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interviews and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 7 (1/5, 1/6, 1/16, 1/19, 1/23, 1/24, and 1/25/2026) of 30 days reviewed for RN coverage. The facility failed to maintain RN coverage of eight hours a day for 1/5, 1/6, 1/16, 1/19, 1/23, 1/24, and 1/25/2026. This failure could place residents at risk of not having their nursing and medical needs met and receiving improper care. Findings included: Record review of daily timecards dated 12/27/25 to 01/27/26 for RN A, RN B, and RN C revealed no RN hours for 1/5, 1/6, 1/16, 1/19, 1/23, and 1/24/2026. Record review of daily timecards dated 12/27/25 to 01/27/26 for RN B revealed 5.40 hours for 01/25/26. Record review of the previous DON's hours undated revealed no RN hours for 1/5, 1/6, 1/16, 1/19, 1/23, and 1/24/2026. During an interview on 01/30/26 at 11:00 a.m. with ADM, she stated there was no RN coverage for 1/5, 1/6, 1/16, 1/19, 1/23, and 1/24/2026. She stated on 1/25/2026 there was 5.40 hours of RN coverage. During an interview on 01/30/26 at 02:40 p.m. with ADON, she stated she was responsible for scheduling nurses. She stated there were currently 3 PRN RNs. She stated 2 of the PRN RNs work alternate weekends and 1 PRN RN works when she can. She stated she tries to get all days covered but could not get the following days covered: 1/5, 1/6, 1/16, 1/19, 1/23 and 1/24. She stated if she cannot find an RN to work, she will notify the ADM. She stated the potential negative outcome of not having an RN eight hours a day could be not having someone to lead and direct the LVN staff related to resident assessment and not being able to complete the higher-level assessments. During an interview on 01/30/26 at 03:00 p.m. with ADM, she stated the ADON was responsible for scheduling nurses. She stated she was aware there was no RN coverage for the following days: 1/5, 1/6, 1/16, 1/19, 1/23 and 1/24/2026. She stated they did have RNs scheduled to work but due to the ice storm they had called in. She stated they tried to get an agency RN, but none was available. She stated they currently do not have a DON but have hired one to start on 02/09/26. She stated her expectations were to have an RN in the building 8 hours a day 7 days a week. She stated the potential negative outcome could be missed assessments and not having leadership for the LVN staff. Record review of the policy provided by the facility titled, Staffing, Sufficient and Competent Nursing, revised 08/22 revealed the following: Policy Statement - Our facility provides sufficient number of nursing staff with the appropriate skills and competencies necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Policy and Implementation.3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.</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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                 |
| <p>F 0550</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interviews and record reviews, the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of 10 of 14 residents in that: The facility failed to ensure staff were not on their personal cell phones while providing care, which included peri-care to residents. This could place residents at risk for diminished quality of life and loss of dignity and self-worth. Findings include: During an interview with confidential residents at an undisclosed date and time ten confidential residents stated the use of cell phones by CNAs while performing care made them feel ignored, not a priority, embarrassed, concerned the CNA could make a mistake due to distraction by the cell phone conversation, and, most of all, their privacy was violated. During an interview ten confidential residents stated the use of cell phones by CNAs occurred on every shift. Confidential residents also stated staff utilize their cell phones while feeding residents during meals; residents stated the use of the cell phones while feeding residents forces those residents to have significant wait times between bites. During an interview ten confidential residents stated they did not know the names of the CNAs who utilized their cell phones while performing care. The confidential residents stated cell phone usage of the CNAs while performing care happened in the facility so often, they said every CNA in the facility utilized their cell phone while performing care. During an interview on 01/30/26 at 2:35pm, the ADM stated residents should be provided with privacy during resident care. She stated all staff were trained on privacy, resident rights, dignity, and cell phone usage during orientation and through continuous education by department heads and the ADM. She stated staff were monitored by making rounds and correcting any issues found, and by addressing complaints and grievances concerning cell phone usage by staff while performing resident care. She stated cell phones should never be used in resident rooms, hallways, or nurses' stations. She stated the potential negative outcome could be mistakes and HIPAA violations. Record review of the undated facility policy titled Resident Rights revealed the following: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence to be treated with respect, kindness, and dignity. privacy and confidentiality</p> |                                                                                |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                 |
| <p>F 0585</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</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 information to residents and their representatives on their rights related to filing grievances or concerns for 10 of 14 confidential residents. The facility failed to ensure 10 of 14 confidential residents were provided, through postings in prominent locations, the Grievance Procedure, were provided information who the facility grievance official was, their contact information, how to file an anonymous grievance, and their right to obtain a written decision related to their grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. In Interviews and Record Review during an undisclosed date and time, 10 of 10 confidential residents stated they did not know they could file a Grievance anonymously, the Grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the Grievance procedure in prominent locations. Residents stated they did not know where to acquire a grievance form, who to turn the form into, and what happens once a grievance was filed. The Residents did not know they had the right to receive a written decision once their grievance was resolved. Record Review of the Grievance policy on 01/30/2026 at 8:15am; reflected a copy of the Grievance/complaint procedure should be posted on the resident bulletin board. Observed prominent postings on 01/30/2026 at 08:45am; the facility did not include instructions regarding the Grievance procedure with any of the prominent postings. Interview with the ADM on 01/30/2026 at 02:35pm; the ADM stated she was the Grievance Officer for the facility. The ADM stated she reviews Grievances and assigns them to department heads. The ADM stated the Grievance form was kept on a wall in the lobby. The ADM stated the Resident Council President completes Grievance forms during monthly meetings. The ADM stated staff also complete Grievance forms for some complaints that are discussed with them face to face with residents. The ADM stated there is a box below the Grievance forms for Residents to submit Grievances anonymously. The ADM stated the facility has 5 working days to solve Grievances once they are submitted. The ADM stated she assigns the Grievance to the appropriate department, that department addresses the grievance with the complainant, resolves the grievance, and explains the resolution to the complainant. The resolution is documented on the Grievance form, and the completed form is submitted to the ADM for review. The ADM stated completed Grievance forms are kept in a notebook for 3 plus years. The ADM stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance. The ADM stated she will also meet with the complainant to ensure they were satisfied with the resolution. The ADM stated she was responsible for ensuring staff were trained on the Grievance process. The ADM stated she was not aware the Grievance procedure was not being discussed in Resident Council; the ADM agreed the availability of the Grievance forms, the Grievance procedure, and procedure for submitting a Grievance form anonymously should be explained to Residents at admission and education of the Grievance process should continue in monthly Resident Council meetings. Record Review of the Grievance Policy last updated in 2017 reflected: Policy Statement:Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or their representative. Residents and their representatives have the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Policy Interpretation and Implementation: Any resident, family member, or representative may file a (continued on next page)</p> |                                                                                |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                 |
| F 0585<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>grievance or complaint. Residents, family, and representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. All grievances from resident or family concerning issues of residents' care in the facility will be considered. Actions will be responded to in writing. Upon admission residents are provided with written information on how to file a grievance. Grievances may be submitted orally or in writing and may be filed anonymously. The contact information for the individual with whom a grievance may be filed is provided to the resident or representative upon admission. The ADM has delegated the responsibility of grievance investigation to the grievance officer who is [NAME]. The grievance officer will review and investigate the allegations and submit the written report of such findings to the ADM with five working days of receiving the grievance. The grievance officer will coordinate actions with the appropriate state and federal agencies depending on the nature of the allegations. The ADM and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. The ADM will review the findings with grievance officer to determine what corrective actions need to be taken. The resident or person filing the grievance on behalf of the resident, will be informed (verbally or in writing) of the findings of the investigation and actions will be taken to correct any identified problems. A written summary of the investigation will be provided to the resident and a copy will be filed in the business office. If the grievance is filed anonymously the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance and report the findings. The results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision. This policy will be provided to the resident or the resident's representative upon request.</p> |                                                                                |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                 |
| <p>F 0812</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed on 01/28/26 to seal food stored in the dry storage and date food stored in the refrigerator. This failure could place residents at risk for food contamination and foodborne illness. Findings included: The following observation was made on 01/28/26 at 01:10 p.m. during the initial tour of the kitchen: Bag of garlic with no date in the refrigerator. Dry Storage: Bag of pecans in zip lock bag not sealed. Bag of instant milk not sealed. Bag of Fast and Fancy Mousse mix in zip lock bag not sealed. During an interview on 01/29/26 at 06:00 p.m., [NAME] A stated all food in the refrigerator should be dated. She stated it was everyone's responsibility to seal, label and date food stored in the refrigerator and dry storage. She stated she received training on how to properly store food in the refrigerator and dry storage. She stated the purpose of dating food was to know when it was going bad and needed to be thrown out. She stated the purpose of sealing food was to prevent cross contamination and insects from getting in food. She stated the potential negative outcome could be residents getting sick. During an interview on 01/30/26 at 01:10 p.m., the DM stated all food items in the refrigerator and dry storage should be labelled, sealed, and dated. She stated all staff received training on how to properly store food and were responsible for checking items stored in the refrigerator and dry storage. She stated the purpose of labelling and dating food was to know how long it was in the refrigerator/dry storage and when to dispose of the food. She stated the potential negative outcome could be cross contamination, food going bad faster, food borne illness, and food poisoning. During an interview on 01/30/26 at 02:22 p.m., the ADM stated she was not aware food was being stored without dates and not sealed. She stated her expectations were that all food be properly stored. She stated all staff have been trained in how to properly store food. She stated the DM was responsible for monitoring and checking the refrigerator and dry storage. She stated the potential negative outcome could be residents getting food borne illness and pests could get in the food. Record review of the facility's policy, titled Food Receiving and Storage, dated revised November 2022, reflected the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: .Dry Food Storage.4. Dry foods that are stored in bins are removed from original packaging, labeled and dated ( use by date).Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled, and dated ( use by date) .7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen or discarded.</p> |                                                                                |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Provide and implement an infection prevention and control program.</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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents (Resident #15, Resident #19 and Resident #42) reviewed for infection control. CNA E did not change gloves between groin area and buttocks area when providing incontinence care to Resident #42. CNA F did not perform hand hygiene between all glove changes when providing incontinent care to Resident #15. CNA G did not perform hand hygiene or gloves changes when providing incontinent care to Resident #19. These failures could place residents at risk for cross contamination and infection. Findings included: 1. Record review of the admission record for Resident #15, dated 01/30/26, revealed a [AGE] year-old male who was admitted on [DATE] and readmitted on [DATE] with the following diagnoses: cerebral infarction (stroke), anxiety (feeling of fear and worry), Schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), diabetes (high blood sugar), hypertension (high blood pressure) and muscle weakness. Record review of the quarterly MDS assessment for Resident #15, dated 12/12/25, revealed Resident #15 required partial/moderate assistance for toileting hygiene - the helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the support. The MDS further revealed Resident #15 was always incontinent. Record review of the current care plan for Resident #15, dated 12/09/25, revealed there was a focus area: Resident experiences bowel and bladder incontinence with interventions to provide incontinence care after each incontinent episode. During an observation on 01/29/26 at 11:10 a.m., CNA F provided incontinence care for Resident #15. CNA F washed her hands with soap and water and then put on gloves. CNA F then unfastened the brief for Resident #15 and cleaned the groin area using wipes. CNA F removed gloves and put on clean gloves. No observation of hand hygiene observed. CNA F then rolled resident to the side and removed the dirty brief and applied a clean brief. CNA F rolled resident to his back and fastened the brief. CNA F then removed her gloves and used ABHR. During an interview on 01/29/26 at 03:45 p.m., CNA F stated she was trained on hand hygiene between all glove changes. CNA F stated she was nervous and forgot to use hand sanitizer between glove changes. CNA F stated she did not clean his coccyx area and stated she should have cleaned his coccyx. She stated the potential negative outcome to the residents could be cross contamination, odor, rash and skin breakdown. 2. Record review of the admission record for Resident #19, dated 01/30/26 revealed an [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE] with the following diagnoses: dementia (cognitive loss), diabetes (high blood sugar), anxiety (feeling of fear and worry) and hypertension (high blood pressure). Record review of the comprehensive MDS assessment for Resident #19, dated 01/09/26, revealed Resident #19 required partial/moderate assistance for toileting hygiene - the helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the support. The MDS further revealed Resident #19 was occasionally incontinent. Record review of the current care plan for Resident #19, dated 01/30/26, revealed there was focus area: Resident experiences bowel and bladder incontinence with interventions to provide incontinence care after each incontinent episode. During an observation on 01/29/26 at 02:45 p.m., CNA G provided incontinence care for Resident #19 with the help of CNA E. CNA G used ABHR and put on a gown and clean gloves. CNA G unfastened Resident #19's brief and cleansed her groin area with wipes. CNA G turned Resident #19 on her side and cleansed the buttocks with wipes, removed the old brief and placed a clean brief under resident. Resident #19 was turned on her back, and the brief was secured. CNA G repositioned Resident #19 and covered her with a blanket. CNA G then removed her gloves and used ABHR. There was no observation of gloves changes or hand washing during incontinence care. (continued on next page)</p> |                                                                                |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>During an interview on 01/29/2026 at 04:00 p.m., CNA G stated she forgot to change her gloves during incontinence care. She stated there was no reason why she should not have changed her gloves and washed her hands. CNA G stated she was nervous and forgot. She stated she has been trained to change gloves after cleaning the groin area and before applying the new brief. She stated the potential negative outcome to the residents could be infection and cross contamination. 3. Record review of the admission record for Resident #42, dated 01/30/26 revealed an [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE] with the following diagnoses: dementia (cognitive loss), anxiety (feeling of fear and worry), and muscle weakness. Record review of the comprehensive MDS assessment for Resident #42, dated 06/06/25, revealed Resident #42 was dependent for toileting hygiene - the helper does all of the effort and the resident does none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity. The MDS further revealed she was always incontinent with bowel and bladder. Record review of the current care plan for Resident #42, dated 09/10/25, revealed there was a focus area: Resident experiences bowel and bladder incontinence with interventions to provide incontinence care every two hours and as voiding pattern changes. During an observation on 01/29/26 at 10:45 a.m., CNA E provided incontinence care for Resident #42. CNA E washed her hands with soap and water and put on clean gloves. CNA E unfastened the brief for Resident #42 and cleansed her groin area with wipes. No observation of glove change or hand hygiene observed. CNA E turned resident on her side and cleansed her buttocks area with wipes. CNA E removed the old brief, removed gloves and used ABHR. CNA E put of new gloves and placed a clean brief under Resident #42. CNA E then rolled resident to her back and secured the brief. CNA E removed gloves and used ABHR. During an interview on 01/29/26 at 03:24 p.m., CNA E stated she had been trained to change gloves and wash hands after cleaning the groin area. She stated she did not change her gloves and there was no reason why she should not have changed her gloves. She stated she got nervous and forgot. She stated the possible negative outcome to the residents could be them getting sick from germs. During an interview on 01/30/26 at 02:04 p.m., ADON stated during incontinence care CNAs should change their gloves and wash hands after cleansing the groin area. She stated hands should be washed with soap and water or ABHR before starting, between glove changes and after care. She stated the DON trained staff and completed competency evaluations, but they currently do not have a DON. She stated she was not sure when the last competency evaluations were done. She stated DON and ADON were responsible for monitoring staff. She stated her expectations were for CNAs to provide proper incontinent care. She stated the potential negative outcome to the residents was urinary tract infections. During an interview on 01/30/26 at 02:22 p.m., ADM stated she was not aware staff was not properly providing incontinent care. She stated all staff have been trained in proper incontinent care. She stated the previous DON had completed competency evaluation, but she was not sure where the evaluations were. She stated her expectations were for CNAs to provide proper care according to the policy and procedure. She stated the potential negative outcome to the residents was urinary tract infections. Record review of the facility policy titled, Handwashing/Hand Hygiene, with a revised date of 01/2025 reflected the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation:2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Indications for Hand Hygiene.1. c. after contact with blood, body fluids, or contaminated surfaces;d. after touching a resident;.f. before moving from work on a soiled body site to a clean body site on the same resident, andg. immediately after glove removal. 5. The use of gloves does not replace hand washing/ hand hygiene.</p> |                                                                                |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interview, the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 (Resident #3 and Resident #35) of 14 residents reviewed for accidents and supervision. The facility failed to consistently supervise Residents #3 and #35 while smoking and failed to ensure the need for safety restrictions due to the absence of smoking assessments. These failures had the potential to result in resident harm, including burns or other smoking-related injuries. A record review of Resident #3's face sheet dated 1/30/26 revealed that Resident #3 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that include dementia (decline in memory, thinking, and behavior), need for assistance with personal care, muscle wasting (reduction in muscle strength), and difficulty with walking. A record review of Resident #3's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C (Brief Interview for Mental Status) score of 15, indicating intact cognition. Section J (Health Conditions) revealed Resident #3 used tobacco. A record review of Resident #3's care plan dated 10/19/25 revealed Resident #3 was a safe smoker but must be counseled for going outside to smoke unsupervised. The stated goal was for Resident #3 to be able to smoke without causing risk of injury; including redirecting Resident #3 to scheduled smoking times. A record review of Resident #3's smoking assessment indicated a smoking assessment had not been completed for Resident #3. The need for safety restrictions while smoking had not been evaluated. A record review of Resident #35's face sheet dated 1/30/26 revealed that Resident #35 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that include mild cognitive impairment (decline in memory, thinking, and behavior), need for assistance with personal care, muscle weakness (reduction in muscle strength), and difficulty with walking. A record review of Resident #35's Comprehensive Minimum Data Set, dated [DATE] revealed: Section C (Brief Interview for Mental Status) score of 15, indicating intact cognition. Section J (Health Conditions) revealed Resident #35 used tobacco. A record review of Resident #35's care plan dated 11/19/25 revealed Resident #35 is a safe smoker. The stated goal was for Resident #35 to be able to smoke without causing risk of injury. A record review of Resident #35's smoking assessment indicated a smoking assessment had not been completed for Resident #35. The need for safety restrictions while smoking had not been evaluated. During an observation of supervised smoking on 1/28/2026 at 4:00pm an unknown staff member was observed to be focused on her cell phone, and the staff member was not supervising residents #3 and #35. The staff members' head was in a downward position while she was focused on her cell phone throughout the 15-minute observation. During an observation of supervised smoking on 1/29/2026 at 1:30pm an unknown staff member was observed to be focused on her cell phone, and the staff member was not supervising residents #3 and #35. The staff members' head was in a downward position while she was focused on her cell phone throughout the 12-minute observation. During an interview on 01/30/26 at 2:35 PM, the ADM stated that she was familiar with the expectations and policy regarding incidents and accidents. She stated that the potential negative outcome for not preventing incidents and accidents was resident harm. She stated that Residents could potentially burn themselves if not supervised. She stated her expectation of supervised smoking is the staff member is consistently supervising residents while they smoke; the supervision should be completed without the distraction of a cell phone. She stated it is the department head's responsibility to train staff to properly supervise smoking. She stated the department heads are responsible for ensuring proper supervision of smoking by monitoring staff during scheduled smoking times. The ADM stated the DON is responsible for completing smoking assessments; in addition, she stated the ADON is responsible for completing smoking assessments in the absence of the DON. The ADM stated smoking assessments should be completed upon admission and quarterly. She stated the absence of the smoking (continued on next page)</p> |                                                                                |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |                                                 |
| F 0689<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>assessments was due to a shortage in staffing and human error. She stated the potential negative outcome for not having smoking assessments is proper safety precautions may not be utilized in order for the resident to safely smoke. The ADM stated she had been trained on incident and accident prevention. She stated that she completed training on incidents and accidents a few months prior. The ADM stated that she expected the safety of Residents #3 and #35 and all residents to be maintained. She stated that all staff were responsible for ensuring resident safety and preventing incidents and accidents. Record review of the facility's policy titled Smoking Policy date October 2022, reflected:Smoking policies must be formulated and adopted by the facility. The policies must comply with applicable codes, regulations and standards, including local ordinances. The facility is responsible for informing residents, staff, visitors, and other affected parties of smoking policies through distribution in or posting. The facilities responsible for enforcement of smoking policies which must include at least the following provisions:Matches, lighters or other ignition sources for smoking are not permitted to be kept or stored in a residence room.A safe smoking assessment will be done regularly for each resident who smokes. Smoking by residents classified as unsafe will be prohibited except when the resident will be directly supervised by facility personnel or visitors who are aware of the residents' limitations with smoking. The resident must be within direct view of smoking supervisor, and reasonably close proximity the supervisor, and the supervisor must be able to quickly respond in the event of an emergency. Additionally, the supervisor, whether staff or visitor must be aware of these responsibilities.Smoking designated location smoking patio area offset of dining area.</p> |                                                                                |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675646                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                       | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Snyder                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>210 E 37th St<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                 |
| <p>F 0805</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, interview and record review, the facility failed to provide food that was palatable for 2 of 2 meals reviewed for palatability. The facility failed to provide food that was palatable for 1 of 3 food forms served (puree) at 2 of 2 meals observed (01/28/26 dinner and 01/29/26 lunch). This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During an observation on 01/28/26 at 04:45 p.m., observed [NAME] A prepared a puree meal. Observation revealed pureed pork ribs with pea size chunks. Surveyor tasted puree pork ribs with pea size chunks that had to be chewed. Observation revealed puree whole butter corn with corn husks. Surveyor tasted puree butter corn that had corn hulls that had to be chewed. Observation revealed puree chili beans were runny. During an observation of a puree test tray on 01/29/26 at 01:14 p.m., observed puree ground pork and greens that had visible small pea size chunks. Surveyor tasted pureed pork and greens and both had small pea size chunks that had to be chewed. During an interview on 01/29/26 at 06:00 p.m., [NAME] A stated pureed should be smooth, like pudding. She stated a pureed diet was for residents who had a hard time chewing or swallowing regular textured food. She stated she was trained in how to prepare puree meals. She stated she prepares the puree the best she can. She stated the potential negative outcome could be the resident choking. During an interview on 01/30/26 at 04:00 p.m., the DM stated she was responsible for training staff, and all staff were trained to prepare puree diet. She stated pureed should be thick like pudding with no chunks. She stated the cook was responsible for properly preparing puree meals. She stated her expectations were for cooks to serve proper texture. She stated the potential negative outcome could be choking or weight loss from not eating. During an interview on 01/30/26 at 1:40 p.m., the ADM stated the cooks were responsible for preparing puree meals. She stated all staff have had proper training. She stated she was not aware puree was being served runny and with chunks. She stated her expectations were for the cooks to serve food at the right consistency. She stated puree should be smooth like pudding with no chunks and not runny. She stated the potential negative outcome could be residents choking, not eating and weight loss. Record review of the facility policy titled Diets Available on the Menu dated 2023, revealed the following documentation: Policy. Procedure: .1. c. Pureed or Level 4 IDDSI.Foods: .Pureed Level 4 - Extremely: Smooth with no lumps, not sticky, no chewing ability needed. Sits in a mound or pileDoes not dollop or drip continuouslyHolds its shapeFalls off easily if the spoon is tilted and continues to hold shape on a plate. Must not be sticky.</p> |                                                                                |                                                 |