STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Coronado	1751 N 15th St Abilene, TX 79603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interviews and record review, the facility failed to ensure the DON did not serve as a charge nurse when the facility had an average daily occupancy of 60 or more residents for 6 (03/07/2026, 03/16/2026, 04/04/2026, 04/11/2026, 04/18/2026, and 04/19/2026) of 54 days (03/01/2026 - 04/24/2026) reviewed for DON coverage. The facility failed to ensure the DON did not serve as a charge nurse when the facility had an average daily occupancy of 60 or more residents on 03/07/2026, 03/16/2026, 04/04/2026, 04/11/2026, 04/18/2026, and 04/19/2026.This failure leaves residents without the nursing administrative oversight that only the DON can provide.Findings include:During an interview on 04/23/2026 at 5:40 p.m., the DON stated she was falling behind on monitoring the nurses had performed their assessments and making sure the care plans were updated because she was having to work at night as a CNA and nurse to fill in open shifts. She stated she knew that she was not supposed to serve as a charge nurse when there were more than 60 residents but there were times when they did not have any other staff able to fill in the unassigned shifts. During an interview on 04/23/2026 at 6:24 p.m., the RCN stated the DON was getting behind on the comprehensive care plans. She stated changes in leadership nurses and turnover staff had led to the DON having to work on the floor as a nurse and CNA at times. She stated she was aware the DON should not work as a charge nurse when there were over 60 residents in the facility. She stated the DON not being able to monitor the nurses were performing assessments and making sure the care plans were updated could disrupt resident care.During an interview on 04/24/2026 at 8:25 a.m., the ADMN stated he was aware that the DON had been working on the floor helping fill in open CNA and nursing shifts. The ADMN stated he was responsible for ensuring the staff positions were filled. He stated he had attempted to hire nurses and CNAs. He stated the obstacle in filling the CNA and nursing positions were that the facility could not offer competitive wages as other nursing homes in the area. He stated he has lost staff members in the last couple of months and was trying to hire more. He stated the facility had over 60 residents and the DON should not be working on the floor as a CNA or charge nurse, but it was better to have the shifts filled to perform resident care.Review of daily staffing schedule revealed DON worked as a charge nurse on 03/07/2026, 03/16/2026, 04/04/2026, 04/11/2026, 04/18/2026, and 04/19/2026.Record review of facility policy titled, Staffing, Sufficient and Competent Nursing dated August 2022, reflected: The director of nursing services (DNS) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer residents.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 3 (Resident #37, Resident #54 and Resident #67) of 5 residents reviewed for resident rights. The facility failed to:Ensure Resident #37's ileostomy collection bag was obscured from view.Ensure Resident #54's urinary catheter collection bag was obscured from view.Ensure Resident #67 colostomy and indwelling urinary collection bags were emptied and obscured from view.These failures could place residents at risk for feeling uncomfortable and disrespected, leading to isolation and deterioration in general health conditions.Findings included:Record review of Resident #37's undated face sheet revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident #37 was admitted with the medical diagnoses of personal history of malignant neoplasm of large intestine (colon cancer), and abdominal distention (enlarged abdomen).Record review of Resident #37's Comprehensive MDS, dated [DATE], Section C - Cognitive Patterns, subsection C0500 BIMS Score Summary revealed Resident #37 scored a 15 out of 15 indicating intact cognition. Section H - Bladder and Bowel, subsection H0100 Appliances, C Ostomy (including urostomy, ileostomy, and colostomy) Yes was entered. Record review of Resident #37's care plan, dated 04/23/2026, revealed, Problem: I have a colostomy related to malignant neoplasm of the large intestines. Goal: I prefer to perform my own colostomy care and change my bag independently . Approach: [Resident] will report any decrease in output to the nurse; monitor abdomen for distention/bowel sounds.; observe the stoma (a surgically created opening on the abdomen at redirects feces out of the body to an external collection device) and surrounding skin for any s/s of skin breakdown or infection; provide assistance as needed.During an observation on 04/22/2026 at 9:45 a.m., Resident #37 was walking down the hallway and other staff and residents were present. His shirt was raised showing an ileostomy (a surgically created opening in the abdominal wall that connects the small intestine to the outside of the body) bag. Record review of Resident #54's undated face sheet revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #54 was admitted with the medical diagnoses of neuromuscular dysfunction of bladder (difficulty in controlling the muscles of the urinary bladder), retention of urine (inability to completely empty the bladder), and urinary tract infection.Record review of Resident #54's Quarterly MDS, dated [DATE], Section C - Cognitive Patterns, subsection C0500 BIMS Score Summary revealed Resident #54 scored a 15 out of 15 indicating intact cognition. Section H - Bladder and Bowel, subsection H0100 Appliances, C Ostomy (including urostomy, ileostomy, and colostomy) Yes was entered. Record review of Resident #54's physician orders, dated 01/20/2026, revealed, Privacy bag for urinary drainage bag at all times while in bed, while walking or in wheelchair every shiftRecord review of Resident #54's care plan, dated 12/01/2025, revealed Problem: EBP: r/t foley catheter . Goal: [Resident's] dignity will be maintained .During an observation on 04/21/2026 at 11:24 a.m., Resident #54 was lying in bed with a urinary catheter collection bag hanging on the door side of the bed and not in a privacy bag, visible to anyone walking by her room. During an observation on 04/21/2026 at 2:37 p.m., Resident #54 was lying in bed. The urinary catheter collection bag was hanging on the left side of the bed and not in a privacy bag. During an observation on 04/22/2026 at 9:42 a.m., Resident #54 was sitting in a chair in her room. She had a urinary catheter collection bag attached to the right side of the chair that was not in a privacy bag. Record review of Resident #67's undated face sheet revealed a [AGE] year-old female, admitted on [DATE] and readmitted on [DATE]. Resident #67 was admitted with medical diagnoses of dementia (inability to think, remember, and make decisions, affecting daily life), dehydration, constipation, and lower abdominal pain. Record review of Resident #67's Quarterly MDS, dated [DATE], Section C - Cognitive Patterns, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	subsection C0500 BIMS Score Summary revealed Resident #67 scored a 6 out of 15 indicating moderately impaired cognition. Section H - Bladder and Bowel, subsection H0100 Appliances, C Ostomy (including urostomy, ileostomy, and colostomy) Yes was entered. Record review of Resident #67's care plan, dated 07/04/2025, revealed, Problem: [Resident] has a [indwelling urinary] catheter (a tube inserted into the urinary bladder held in place by an inflated balloon to drain urine from the bladder into a collection bag) related to neuromuscular disorder of the bladder. Goal: [Resident] will not have s/s of urosepsis (fever, pain on the lower sides of my back where my kidneys are located, nausea, vomiting, extreme tiredness) related to recurring urinary infections .; Approach: [indwelling urinary] bag to have a privacy bag. Problem: [Resident] has a colostomy. Goal: [Resident's] colostomy will be managed without complication . ; Approach: Provide colostomy care every shift and prn. Provide full staff assistance with colostomy care. During an observation on 04/21/2026 at 12:17 p.m., Resident #67 wheeled self into dining room. Resident #67's shirt was not pulled down in the back causing the front of her shirt to expose the colostomy (a surgically created opening in the abdominal wall that connects the large intestines to the outside of the body) bag that appeared to be more than 3/4 full of liquid stool to full view of other residents in the dining room. Resident #67's urinary collection bag hanging under her wheelchair was approximately 1/2 full and not in a privacy bag. Observed one staff member assist Resident #67 to sit farther back in her wheelchair but did not cover the colostomy bag or take the resident to empty the bags.During an observation and interview on 04/21/2026 at 12:24 p.m., the visible colostomy bag was brought to the DON's attention. The DON's response was Oh good lord. The DON then removed Resident #67 from the dining room. During an observation and interview on 04/22/206 at 11:07 a.m., Resident #67 was sitting in her wheelchair in her room. Resident #67 allowed assessment of the colostomy bag. The collection bag appeared to be approximately 1/2 full. Resident #67 stated the bag was due to be changed Friday. Resident #67 stated she experienced occasional itching around the colostomy bag's adhesive and when the bag was too full it caused pain and discomfort due to pulling on her skin. Resident #67 denied knowing the colostomy and urinary collection bags were not covered when she was in the dining room on 04/21/2026. She stated she did not like it when the colostomy bag was not covered. During an interview on 04/24/2026 at 8:31 a.m., CNA E stated she had worked at the facility for 4 years. She stated CNAs were trained and checked off on colostomy care skills. CNA E stated training was provided by the nursing staff. She stated it was not acceptable for a resident to leave a room with a collection bag visible and not empty. She stated Resident #67's colostomy bag fills up fast. CNA E stated she checked and emptied colostomy and urinary collection bags during rounds every 2 hours. She stated the failure may have occurred due to some just don't check them or take the time to empty them and some don't think to pull the resident's shirt down to cover the collection bag. During an interview on 04/24/2026 at 9:55 a.m., LVN B stated she had worked in the facility for 4 years. She stated CNAs and nurses were responsible for colostomy care. LVN B stated collection bags were checked every 2 hours during rounds. She stated it was not acceptable for a resident to be brought out of their room with the colostomy or urinary collection bags visible. She explained training was provided by initial CNA or nursing education and reinforced on the job by the nurses. LVN B stated an effect on residents of failing to cover collection bags was some might not like to see it. LVN B denied receiving complaints from residents with colostomy or urinary collection bags about bags not being covered. During an interview on 04/24/2026 at 10:02 a.m., LVN C stated all nursing staff were responsible for checking and providing care of colostomy and urinary collection bags. She stated the nurses provided training to the CNAs on colostomy and urinary catheter care. LVN C stated it was not acceptable for a colostomy collection bag to be exposed or a urine collection bag to not have a privacy cover. She explained she had offered privacy bags and provided them when needed. She stated Resident #67's constant body movement frequently caused her clothing to ride up. LVN C stated she expected staff to make sure to pull the resident's shirt down to cover the colostomy bag. During an interview on 04/24/2026 at 10:29 a.m., the DON stated when she took Resident #67 out of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the dining room on 04/21/2026 she took the resident to her room, emptied her colostomy bag and assisted the resident to change her shirt. The DON stated the bag was 90% air and appeared over 1/2 full due to stool sticking to the inside of the bag. She stated Resident #67 had a one-piece appliance and the nurses changed it every 3 days. The DON denied reports from Resident #67 complaining of pain or discomfort associated with stool in the bag. The DON explained the colostomy bag should be emptied as needed, checked every 2 hours during rounds, and at least once a shift. She stated skills check offs for colostomy and urinary catheter care were done annually. The DON stated all nursing staff were responsible for monitoring the contents of collection bags. She stated effects on a resident for failure to provide cover of collection bags was a dignity issue, and a resident may not feel as pretty, or may feel self-conscious. The DON stated her expectations were for staff to keep an eye on it and for staff to know their resident's needs. Record review of the facility policy titled, Colostomy/Ileostomy Care, updated 02/2026, revealed, Preparation 1a. CNAs may empty and assist with routine ostomy care.Record review of the facility policy titled, Dignity, revised 02/2021, revealed, 1. Residents are treated with dignity and respect at all times . 5e. provided with a dignified dining experience . and 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered;Record review of the National Library of Medicine article titled, Colostomy Care, dated 05/28/2023, page 4, accessed on 04/22/2026, at https://www.ncbi.nlm.nih.gov/books/NBK560503/, revealed, As a rule, the stoma (surgically created opening in the skin that connects to part of the body's digestive or urinary system) bag should be emptied when it is filled up to 1/3rd to prevent peeling off of the baseplate from the skin and leaks.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to consider the views of the resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility or to demonstrate their response and rationale for such response for 12 of 15 confidential residents reviewed for meeting grievances.The facility failed to provide a verbal or written response to the Resident Council addressing the grievances reported from their meetings on May 2025, August 2025, September 2025, January 2026, February 2026, and March 2026, which included issues with nursing services, dietary services, and housekeeping services. This failure could place residents at risk of unresolved grievances, a decreased sense of self-worth, and a decline in quality of life.Findings included:Record review on 04/23/2026 of the Grievance logs for May 2025 reflected the Resident Council filed one grievance involving bed sheets not being changed for a month or more. Record review reflected there was no name or group listed in notification of representative and the date resolved was 5/25/2025.Record review of the Grievance logs for August 2025 reflected the Resident Council filed one grievance involving housekeepers not being respectful of residents still sleeping in the morning by making too much noise and hitting the mop on trash cans repeatedly. Record review reflected there was no name or group listed in notification of representative and the date resolved was 8/25/2025.Record review of the Grievance logs for September 2025 reflected the Resident Council filed seven grievances. The first grievance involved residents asking if the exterminator could come more often. There was the ADMN's name listed in notification of representative and the date resolved was 9/26/2025. The second grievance involved the heater in the shower room needed to be fixed before winter. There was the ADMN's name listed in notification of representative and the date resolved was 9/26/2025. The third grievance involved staff talking too loudly in the hallway during the morning. There was the ADMN's name listed in notification of representative and the date resolved was 9/26/2025. The fourth grievance involved wanting to have boiled eggs instead of powdered eggs. There was the ADMN's name listed in notification of representative and the date resolved was 9/27/2025. The fifth grievance involved requesting more outside activities. There was the ADMN's name listed in notification of representative and the date resolved was 9/27/2025. The sixth grievance involved requesting beds be made daily with fresh sheets. There was the ADMN's name listed in notification of representative and the date resolved was 9/26/2025. The seventh grievance involved nursing staff who made negative remarks about other staff members. There was the ADMN's name listed in notification of representative and the date resolved was 9/26/2025.Record review of the Grievance logs for January 2026 reflected the Resident Council filed four grievances. The first grievance involved the staff talking too loud in the halls. There was no name or group listed in notification of representative and date 1/4/2026. The second grievance involved staff banging carts into the walls and slamming medication drawers. There was the ADMN's name listed in notification of representative and the date resolved was 1/4/2026. The third grievance involved staff asking residents to label their own personal items and the council wanted laundry staff to label them. There was no name or group listed in notification of representative and date 1/4/2026. The fourth grievance involved not being served toast because the bread was too soft or too hard. There was the ADMN's name listed in notification of representative and the date resolved was 1/4/2026. Record review of the Grievance logs for February 2026 reflected the Resident Council filed four grievances. The first grievance involved meal trays not being picked up timely and left in the hallway overnight. There was no name or group listed in notification of representative and the date resolved was 3/1/2026. The second grievance involved a night nurse aide spending too much time with one resident and being loud in his room. There was no name or group listed in notification of representative and the date resolved was 3/1/2026. The third grievance involved nurse aides not paying attention to the residents during shower chair transfers. There was no name or group listed in notification of representative and the date resolved was (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/1/2026. The fourth grievance involved daily menus not being posted and meals being changed at the last minute. There was no name or group listed in notification of representative and the date resolved was 3/1/2026.Record review of the Grievance logs for March 2026 reflected the Resident Council filed three grievances. The first grievance involved not getting showers on Saturdays. There was no name or group listed in notification of representative and the date resolved was 3/30/2026. The second grievance involved the dinner trays not being picked up at night. There was no name or group listed in notification of representative and the date resolved was 3/30/2026. The third grievance involved the menu not being followed and residents were not notified until the last minute about the changes. There was no name or group listed in notification of representative and the date resolved was 3/30/2026.During a confidential group interview on an undisclosed date and time, 12 of 15 residents stated they attended Resident Council meetings regularly. The 12 of 15 residents stated no one had gotten back with them about their grievances in the past. They stated some of the issues continued and they would like to be notified about what the facility was doing to resolve those issues. During an interview on 04/23/2026 at 1:06 p.m., the AD stated she attended Resident Council meetings and was invited to the meetings by the resident council members. She stated the council liked her writing the minutes about the meetings for them. She stated she would then write concerns on a grievance form and give the grievance form to the ADMN. She stated she had not gotten any form of resolution back in writing or verbally after she gave the grievance form to the ADMN. She stated she did not know how the information should be relayed to the resident council members. She stated she recently kept a copy of the grievance forms and would give two copies to the ADMN so that he could give one to the department head that the grievance involved. She stated the resident council should get notified about what was done to correct their grievances so that they felt their concerns were heard.During an interview on 04/24/2026 at 8:25 a.m., the ADMN stated he was responsible for grievances at the facility. He stated he received the resident council's grievances from the AD. He stated he would get with the department head that the grievance was about and work with them to resolve the issue. He stated sometimes he would attempt to figure out who had made the grievance and notify them about the resolution. He stated he had gotten back to the Resident Council President before but did not address the resident council because he was not invited to those meetings. He stated the grievances were voiced in the managers' meetings and the AD was present for those. He stated he expected the AD to relay the resident council's grievance resolutions to the council members.Record review of facility's policy titled, Resident Council, dated February 2021, reflected, The purpose of the resident council is to provide a forum for: a. residents, families and resident representatives to have input in the operation of the facility; b. discussion of concerns and suggestions for improvement; c. consensus building and communication between residents and facility staff.6. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern.Record review of the facility's policy titled, Grievances/Complaints, Filing, dated April 2017, reflected, 12. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. a. The administrator, or his or her designee, will make such reports orally within _____ working days of the filing of the grievance or complaint with the facility. b. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 7 of 19 (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) resident rooms observed for environmental conditions. The facility failed to ensure rooms 231 B, 233 A, 234 A, 234 B had mattresses that the nonpermeable outer cover was intact and not peeling. The facility failed to ensure rooms 201, 209, 210, and 218's sinks had hot water.These failures could place residents at risk for diminished quality of life, discomfort, and safety.Findings included:During an observation on 04/22/2026 at 8:57 a.m., room [ROOM NUMBER]'s hot water temperature was 74.1 degrees F in the sink.During an observation on 04/22/2026 at 8:59 a.m., room [ROOM NUMBER]'s hot water temperature was 73.9 degrees F in the sink.During an observation on 04/22/2026 at 9:10 a.m., room [ROOM NUMBER]'s hot water temperature was 74.3 degrees F in the sink.During an observation on 04/22/2026 at 9:13 a.m., room [ROOM NUMBER]'s hot water temperature was 74.1 degrees F in the sink.During an observation and interview on 04/21/2026 at 2:13 p.m., Resident #72's mattress had cracks and the nonpermeable outer cover was peeking on the top half of the mattress. Resident #72 stated his mattress was peeling and it bothered him when he slept on it because he could feel the cracks. room [ROOM NUMBER] B mattress did not have sheets on it and the protective nonpermeable outer cover was cracked and peeled throughout the whole mattress. Resident #26 was not in the room at the time of the observation of his mattress in room [ROOM NUMBER] B.During an interview on 04/22/2026 at 8:49 a.m., Resident #53's family member stated they had concerns with the facility not having hot water for residents and their family members to wash their hands. Resident #53's family member stated they had spoken to the ADMN about the hot water issue on Hall 1 before when Resident #53 resided on that hall and Resident #53 was moved rooms because of the hot water issue. Resident #53's family member stated they felt sorry for the other residents who continued to reside on hall 1 because they did not have hot water in their bathroom. Resident #53's family member stated the hot water issue had been going on for a while but did not know exactly how long. During an observation and interview on 04/22/2026 at 9:51 a.m., Resident #27 stated his mattress was peeling and it was uncomfortable to sleep on because of the cracks and peeling. Resident #27's, room [ROOM NUMBER] A, mattress was observed and the nonpermeable outer cover was cracked and peeling.During an observation and interview on 04/22/2026 at 9:58 a.m., Resident #53's bed had a mattress where the protective nonpermeable outer cover was cracked and peeling. Resident #53 stated the mattress was uncomfortable because she could feel the cracked and peeling mattress.During an interview on 04/22/2026 at 10:05 a.m., Housekeeper H said some of the mattresses had cracks and were peeling. She said she had not reported it, but she was sure management was aware. Housekeeper H said she used disinfect spray to sanitize the mattresses. During an interview on 04/22/2026 at 11:50 a.m., Resident #26 stated his mattress had been that way for some time and he had reported it to staff. He said the mattress was miserable to sleep on because of the cracks and peeling.During a confidential group interview on an undisclosed date and time, 3 of 15 residents interviewed stated they had no hot water in their rooms. They stated that the Maintenance Director was aware of the issue and it had not been fixed. The AD present in the meeting stated the 3 residents all resided on the same hallway. During an interview on 04/23/2026 at 2:44 p.m., the ADMN stated he had been replacing the mattresses as needed but corporate would only let him order 4 mattresses per month. He stated he continued to work on replacing all of the mattresses that needed it in the facility. He stated he was not currently aware of any residents that were sleeping on cracked and peeling mattresses. The ADMN stated residents should have mattresses that were not cracked or (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	peeling and that were comfortable. He said a potential negative outcome was the mattresses were not comfortable for the residents and the staff would not be able to sanitize the mattresses properly. During an interview on 04/23/2026 at 6:28 p.m., the Maintenance Director stated he was aware of the hot water not working on Hall 1. He stated he was informed about the issue on 04/07/2026 and called out a repair company the next day. He stated he had received a quote including the scope of work and was waiting for corporate to approve the repairs. He stated residents could use hand sanitizer and cold water to wash their hands to help prevent infection spread. He stated he would want to have access to hot water if he resided in the building and a reasonable person would want hot water to function to wash their hands and face. He stated the issue with the hot water continued at that time.During an interview on 04/24/2026 at 8:25 a.m., the ADMN stated he was aware of the hot water issues in the building including multiple halls. He stated the Maintenance Director had gotten an estimate on the work needed to correct the issue and the facility was waiting for the scope of work to be approved by upper management before the repairs could be made. He stated staff and residents could use cold water to wash their hands and then utilize the hand sanitizer in the hall to help prevent infections in the time being. He stated a reasonable person would want hot water in the sink to wash their hands and face for comfort. During an interview on 04/24/2026 at 9:55 a.m., the DON stated the mattresses were being replaced when the staff found a new one. She stated a potential negative outcome was that the mattresses were not comfortable and infection control risk. Record review on 04/23/2026 of estimate to correct hot water issue, dated 04/08/2026, reflected scope of work included remove existing receptacle, wiring, and box. Relocate to above water heater as to be accessible. Install new box, wiring, and receptacle. Provide new cord set to connect water heater. Excludes any drywall repair, paint, etc.Record review on 04/24/2026 of facility policy titled Homelike Environment, dated February 2021, reflected The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.

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	675746	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Coronado	1751 N 15th St Abilene, TX 79603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 4 of 18 (Resident #2, 3, 4, 33) residents reviewed for care plans. The facility failed to develop a comprehensive care plan for Resident #2 that included her Diagnoses of Anxiety and Major Depressive Disorder. The facility failed to develop a comprehensive care plan for Resident #3 that included smoking cigarettes. The facility failed to develop a comprehensive care plan for Resident #4 that included orders for flushing her Gastrostomy tube This failure could place residents at risk of infection, injury, unmet psychosocial needs and not receiving needed care to maintain optimal level of physical and emotional health. Findings included: Resident #2Record review of Resident #2 face sheet, dated 4/24/26, on 4/24/26 revealed a [AGE] year-old female, readmitted on [DATE]. Diagnoses included dementia (a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia and mood disorders, such as depression or mania), bipolar disorder (a mental health condition characterized by significant mood swings, including manic (or hypomanic) and depressive episodes), major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), and anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 2, indicating severe cognitive impairment. Section I revealed active diagnosis of anxiety disorder and depression. Record review of Resident #2's care plan, dated 11/01/2025, on 4/24/26 revealed there was no care plan addressing the diagnosis of Major Depressive Disorder and Anxiety Disorder. During an interview on 04/24/2026 at 9:53 a.m., the DON said she was responsible for the care plans. The DON said there should have been care plans for Major Depressive Disorder and Anxiety, but stated it was not there. Resident #3Record review of Resident #3's face sheet, dated 4/24/26, 04/04/2026 revealed a [AGE] year-old male, admitted [DATE]. He had a primary diagnosis of unspecified sequelae of cerebral infarction (stroke). Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS score of 15, indicated cognitively intact. During an interview on 04/22/2026 at 9:34 a.m., Resident #3 said he smoked and had no issues with the smoking process. Record review of Resident #3's care plan, last revised 1/20/26, revealed no care plan that addressed smoking. During an interview and record review with the ADMN and DON on 4/24/26 at 9:46 am, both said Resident #3 wmoked and there should have been a care plan specifically for smoking. The care plan was reviewed and they both said there was no care plan that addressed Resident #3's smoking status. The DON said she would add it to the care plan and stated that she had assessed Resident #3 for safe smoking and there was not a negative outcome since he did not require any special safety precautions. Resident #4Record review of Resident #4 s electronic face sheet, dated 04/24/2026, on 04/24/2026 reflected a [AGE] year-old female, admitted [DATE], with diagnoses including neuro genic bladder (urinary bladder does not function properly due to trauma, disease, or injury to the nervous system), dysphagia (difficulty swallowing), nontraumatic cerebral hemorrhage (a type of stroke caused by bleeding in the brain). Record review of Resident #4's admission MDS assessment, dated 03/14/2026, reflected a BIMS score of 00 indicating she was severely cognitively impaired. Further review reflected Resident #4 had gastrostomy tube (a tube placed directly in the stomach through the abdominal wall to deliver nutrition, fluids and medications, or to drain the stomach contents) since admission. Record review of Resident #4's Physician Orders, dated 04/23/2026, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected an order with a start date of 4/21/26 monitor and assess non used gastrostomy tube and flush every 12 hours with 30 milliliters of fluid every 12 hours as needed. Record review of Resident #33's comprehensive care plan on 04/24/2026 reflected no focus, goal, or interventions related to flushing the resident's unused gastrostomy tube. During an observation and attempted interview on 4/22/24 at 1:30 p.m., Resident #4 was not interviewable and did not answer direct questions when asked about her care. During observation of ADL care, it was observed that the resident had a gastrostomy tube that was plugged. During an interview with the DON on 04/23/2026 at 2:00 p.m. she stated she was responsible for updating resident care plans and she should have updated Resident 4's care plan to reflect the changes in his care. She stated she was responsible for all the care plans in the facility and Resident #4 had not had a negative outcome due to the failure to update her care plan. She stated failure to develop, update, and implement care plans could result in a resident not getting the care they need. She stated Resident #4 had not had a significant weight loss since admission and was eating a diet from the kitchen and taking her medication orally. Resident #33Record review of Resident #33's electronic face sheet, dated 04/24/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] for diagnosis including neuromuscular dysfunction of bladder (urinary bladder does not function properly due to trauma, disease, or injury to the nervous system), and UTI (bladder infection). Record review of Resident #33's admission MDS assessment, dated 03/05/2026, reflected a BIMS score of 15 indicating she was cognitively intact. Further review reflected Resident #33 had an indwelling catheter (tube to drain urine from the bladder) and was always incontinent of bowel movement. Record review of Resident #33's Physician Orders, dated 04/22/2026, reflected an order to change foley catheter every 24 hours as needed for neuromuscular dysfunction of bladder. Further review reflected an order dated 02/20/2026 to monitor urinary output every shift related to neuromuscular dysfunction of bladder. Record review of Resident #33's Comprehensive Care Plan on 04/24/2026 reflected no focus, goal, or interventions related to foley catheter care. During an interview on 04/23/2026 at 6:24 p.m., the RCN stated she expected comprehensive care plans to have all care needs present. She stated changes in leadership nurses and turn over in staff had led to the care plan issues. She stated she did monitor the DON and care plans and had identified issues with the care plans but had not been able to implement her action plan she had come up with in March. She stated not having completed comprehensive care plans could disrupt continuity of care for the residents. Record review on 4/24/26 of the facility's policy titled: Care Plans - Comprehensive Person Centered dated revised March 2022, revealed the following: The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including; services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; any specialized services to be provided as a result of PASARR recommendations; and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to provide each resident with a nourishing, well-balanced diet to meet the daily nutritional and special dietary needs for 21 of 73 residents reviewed for food and nutrition services. The facility did not provide 21 residents on a regular diet who were supposed to be served refried beans for lunch or offer a comparable substitute when they ran out of refried beans. This failure could place residents who ate food from the kitchen at risk of not having their nutritional needs met and possible weight Findings included:Record review of the posted menu dated 4/21/26 revealed the following menu for a regular diet. Soft tacos, refried beans, tortilla soup and Brownie. Observation of food preparation and service in the kitchen on 4/21/26 at 11:21 am revealed that the facility failed to have enough refried beans or a comparable substitute which resulted in 21 residents not receiving refried beans. After 17 residents were served their tray without refried beans, the Dietary Manager provided rice to the 4 last trays/residents. In an interview on 4/21/26 at 12:00 pm, the DM said there were 53 residents who received a regular diet. She was going to try to find out who the residents were who did not receive refried beans and give them some rice. In an interview on 4/22/26 at 2:49 pm, the Dietician said that rice was not an appropriate substitute for refried beans and she would not have approved that substitution. She said that when the kitchen runs out of food, a nutritional equivalent substitute should be provided. The Dietician said when she visits the facility, they review the substitution log. The Dietician said the failure had the potential for residents not to have their nutritional needs met. In an interview and record review on 4/23/26 at 10:18 am, the DM said she did not know why they ran out of refried beans. The menus were followed for the number of residents they were serving, and the correct portion size was used. The DM said she did not know why when they ran out of refried beans, a substitute wasn't provided at that time. The DM was asked if rice was a comparable nutritional substitute for refried beans, she said she was not sure and that she should have called the Dietician before she made the substitute. Record review of the substitution log for April 2026 was blank. The DM said she had not filled it out yet for the month. The DM said the failure had the potential for residents not to have their nutritional needs met. In an interview on 4/23/26 at 10:52 am, the DON said the nurses check each resident's tray before it was served to make sure they were getting the right textures. They depend on the kitchen to make sure they were receiving the correct calories. She said a potential negative outcome would be residents would have weight loss. The DON said there were no residents identified that was having weight loss related to food or food portions served. In an interview on 4/23/26 at 2:44 pm, the ADMN said the kitchen prepared the correct amount of refried beans, as the menu shows the correct amount to make for the facility census. They must have given the residents too large of a portion of refried beans. He said they went back and found the residents who did not receive the refried beans on their tray and gave them rice. Record review of CMS-802 Resident Matrix, dated 4/21/26, revealed there were no residents identified as having excessive weight loss, except for one resident whose excessive weight loss was unrelated to nutrition. Record review of the facility policy Substitutions, dated as revised April 2007, revealed the following [in part]: Policy Statement: Food substitutions will be made as appropriate or necessary.Policy Interpretation and Implementation:1. The food service manager, in conjunction with the clinical dietician, may make food substitutions as appropriate or necessary. The food services shift supervisor on duty will make substitutions only when unavoidable. 2. The food services manager will maintain an exchange list identifying the seven (7) exchanges of food groups. When in doubt about an appropriate substitution, the food services manager will consult with the dietitian prior to making the substitution.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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, for 1 of 1 kitchen as evidence by: The facility failed to ensure:A. The floors throughout the kitchen were clean and free from dirt and food crumbs. B. The stand that the mixer was on was clean and free from dirt and food crumbs. C. The plastic container that contained the food thickener was free from spilled food and not soiled. D. The convection oven and stove were clean on the inside and outside. E. The shelf above the stove was clean and not soiled with food crumbs and dust. F. The refrigerator was clean and free of food crumbs and dust. G. The stand that held the residents' plates was clean and free of food crumbs. These failures could place residents at risk for foodborne illness, compromised nutritional health status, and being served food items that may not be fresh, taste stale, or be contaminated.In an observation on 4/21/26 at 9:13 am, during the initial tour of kitchen, the floors throughout the kitchen were soiled with dirt and food crumbs especially around the baseboards of the kitchen. The stand that the mixer was on was soiled with dirt and food crumbs and underneath the stand there was a food thickener or flour in a pile. The plastic container that contained the food thickener had spilled dried food and dust on the outside of the container with a plastic scoop lying on the top of the container. The convection oven and the stove had dried baked on food on the inside and grease and dust on the outside of the appliances. On top of the convection oven there were additional oven shelves that were covered with old baked food and grease. The shelf above the stove was soiled with food crumbs and dust. The bottom shelf of the refrigerator was soiled with food crumbs. The stand that held the resident's plates was soiled with had food crumbs. In an interview on 4/23/26 at 2:05 pm, the findings of the initial tour were discussed with the DM. She said that it was her expectation for the kitchen to be clean after every meal. The DM said potential negative outcomes of not keeping the kitchen free of food crumbs, and dirt/dust could attract pests and lead to sickness. In an interview on 04/23/2026 at 2:44 pm, the ADMN said it was his expectation for the kitchen to be clean. A policy regarding kitchen sanitization was requested but not provided by time of exit from the Dietary Manager on 4/23/2026 at 2:05 pm.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately assess each resident's status for 1 of 19 (Resident #4) residents reviewed for assessment accuracy. The facility failed to ensure the assessment information in Resident #4' s admission MDS, dated [DATE], was accurate. This failure could place residents at risk of not receiving the proper care and services due to inaccurate assessment records. Findings included: Record review of Resident #4's electronic face sheet, dated 04/24/2026, reflected a [AGE] year-old female, admitted [DATE], diagnoses included dysphagia (difficulty swallowing) and nontraumatic cerebral hemorrhage (a type of stroke caused by bleeding in the brain). Record review of Resident #4's admission MDS assessment, dated 03/14/2026,0n 04/24/2026 reflected a BIMS score of 00 indicating she was severely cognitively impaired. Further review reflected Resident #4 had gastrostomy tube (a tube placed directly in the stomach through the abdominal wall to deliver nutrition, fluids and medications , or to drain the stomach contents) since admission. The MDS assessment documented the resident had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. The MDS documented, Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident as partial to moderate assistance. Record review of Resident #4's Physician Orders, dated 04/23/2026, reflected an order with a start date of 4/21/2026 to monitor and assess non-used gastrostomy tube (a tube placed directly into the stomach to deliver nutrition, fluids and medication and flush every 12 hours with 30 milliliters of fluid every 12 hours as needed. The resident's regular diet was Mechanical Soft texture, Regular consistency. Record review of Resident #33's Comprehensive Care Plan on 04/24/2026 reflected no focus, goal, or interventions related to weight loss or gastrostomy tube feedings. During an interview on 04/24/2026 at 9:30 a.m., the MDS coordinator stated she was responsible for MDS assessments. She stated she answered MDS assessment questions to the best of her ability. The MDS coordinator stated she made a mistake in the documentation when she did the MDS. The MDS coordinator stated she did not believe any negative effect occurred to the resident #4 from coding MDS assessment incorrectly for weight loss. She stated she had mistakenly coded the assessment incorrectly. She stated she monitored that MDS assessments were correct. She stated she referred to the RAI manual when she had questions regarding documentation for the MDS. The MDS coordinator stated she could refer directly to the RAI manual for any questions that she might have through a link in her computer program for completing the MDS. During an interview on 04/23/2026 at 1:00 p.m., the DON stated the MDS coordinator was responsible for MDS assessments. She stated her expectation was for the MDS assessment to be completed in a timely manner and for them to be accurate. Record review of the Policy titled Resident Assessment date revised 3/2026 stated in part. 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements:a. OBRA required assessments - conducted for all residents in the facility:(1) admission Assessment (Comprehensive);(2) Quarterly Assessment;(3) Annual Assessment (Comprehensive);(4) Significant Change in Status Assessment (SCSA) (Comprehensive);(5) Significant Correction to Prior Comprehensive Assessment (SCPA) (Comprehensive);(6) Significant Correction to Prior Quarterly Assessment (SCQA); and(7) Discharge Assessment (return anticipated and return not anticipated).b. PPS required assessments - conducted (in addition to the OBRA required assessments) for residents for whom the facility receives Medicare Part A SNF benefits:(1) 5-day Assessment;(2) Interim Payment Assessment; and(3) Part A PPS Discharge Assessment.2. The RAI User's Manual (Chapter 2) provides detailed information on timing and submission of assessments.3. A comprehensive assessment includes:a. completion of the Minimum Data Set (MDS);b. completion of the care area assessment (CAA) process; andc. development of the comprehensive care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #33) of 2 residents reviewed for catheter care.The facility failed to ensure Resident #33's indwelling urinary catheter tubing was secured to her leg, and her catheter bag was emptied every shift. These failures could place residents at risk of catheter tubing leakage, resulting in cross-contamination and development of infections.Findings included: Record review of Resident #33's electronic face sheet, dated 04/24/2026, reflected a [AGE] year-old female, admitted [DATE], with diagnoses including neuromuscular dysfunction of bladder (urinary bladder does not function properly due to trauma, disease, or injury to the nervous system) and UTI (bladder infection). Record review of Resident #33's admission MDS assessment, dated 03/05/2026, reflected a BIMS score of 15 indicating she was cognitively intact. Further review reflected Resident #33 had an indwelling catheter (tube to drain urine from the bladder) and was always incontinent of bowel movement. Record review of Resident #33's Physician Orders, dated 04/22/2026, reflected an order to change indwelling urinary catheter every 24 hours as needed for neuromuscular dysfunction of bladder. Further review reflected an order dated 02/20/2026 to monitor urinary output every shift related to neuromuscular dysfunction of bladder.Record review of Resident #33's MAR, dated April 2026, reflected, There was no urine output documented the day shift on 04/09/2026, 04/14/2026, 04/19/2026, or 04/22/2026.Record review of Resident #33's Comprehensive Care Plan on 04/24/2026 reflected no focus, goal, or interventions related to foley catheter care.Record review of Resident #33's Progress Notes, dated 04/21/2026, indwelling urinary catheter was changed because resident complained of pain in abdomen and resident felt better after catheter was changed. Further review reflected on 04/22/2026 foley catheter was leaking and catheter changed. During an interview on 04/21/2026 at 3:32 p.m., Resident #33 was lying in her bed. She stated her foley catheter had to be replaced the day before because it was hurting her. She stated it hurt sometimes when she was transferred from the bed to the chair.During an observation on 04/22/2026 at 3:25 p.m., Resident #33's foley catheter was leaking into a brief and there was no securement device holding the tubing in place on Resident #33's leg. LVN A removed and replaced foley catheter and no infection control concerns were observed during foley catheter change. LVN A did not place a securement device for indwelling urinary catheter tubing during the catheter change.During an observation and interview on 04/23/2026 at 10:07 a.m., Resident #33 was lying in her bed in her room. The DON was present during observation and Resident #33 did not have a privacy bag over her catheter bag. There was no tape securing the catheter to her leg. Resident #33 stated she continued to have pain when they moved and staff sat her wrong in the wheelchair. She stated she did not know how long the tape had been off her leg or if they had put tape on her leg when they changed out her catheter out the day before. Resident #33 stated she would like there to be a privacy bag so that her family did not see her urine when they visited. She stated she was unaware the bag was not covered.During an interview on 04/23/2026 at 10:20 a.m., the DON stated she expected for nurses to secure the catheter tubing to a resident's leg when they had a catheter. She stated not securing could cause discomfort and leaking if the tubing was being pulled during care. She stated the nurses were responsible for making sure the catheter was secured to the leg. She stated she expected there to be a privacy bag covering the catheter bag. She stated the nurses were responsible for making sure there was a privacy bag in place. During a telephone interview on 04/23/2026 at 3:37 p.m., LVN A stated she had changed out Resident #33's indwelling urinary catheter on 04/22/2026. She stated there was no securement device from the catheter she had removed and she did not get one during the catheter change. She stated she should have secured the catheter tubing but was nervous from being watched and had (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forgotten to do so. She stated the catheter bag should have a privacy bag on it. She stated the nurse aides emptied the catheter bags and would tell the nurses the output so it could be documented in the chart. She stated she did not know why there were no documented outputs in the MAR on 04/09/2026, 04/14/2026, or 04/19/2026. She stated if outputs were not documented then she could not prove the outputs were taken or the bag had been emptied. She stated on 04/22/2026 the indwelling urinary had been leaking. She stated indwelling urinary catheters could leak due to the tubing not being secured if the catheter tubing was being pulled on during transfers. She stated the catheter she removed was leaking because there was another port for another bag to be connected to and no other bag had been secured to that port. During a follow-up interview on 04/23/2026 at 5:40 p.m., the DON stated urine output should be documented on the MAR when a resident had a indwelling urinary catheter. She stated she did not know why the output was not documented on certain days. She stated she would expect for a progress note to be in the system to explain why no output documented. She stated she did not believe any negative outcome had occurred from the indwelling urinary catheter not being on Resident #33's care plan because nurses looked at physician orders and the MAR to determine care needed. She denied the indwelling urinary catheter privacy bag or securement device not being present would be because those items had not been care planned. She stated not having a privacy bag could cause the resident to be embarrassed from other residents and visitors seeing urine in bag. She stated not having the securement device could cause the catheter tubing to become loose if the tubing was being pulled during resident care. She stated she was responsible for updating the care plans monitored by the RCN. She stated she monitored the nurses documented tasks on the MAR after they had performed the tasks and completed the tasks. She stated she was only one person and could not monitor everything along with helping on the floor to provide resident care.Record review of the facility policy, Catheter Care, Urinary dated July 2024, reflected The purpose of this procedure is to prevent catheter-associated urinary tract infections.If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered.Maintain an accurate record of the resident's daily output, per facility policy and procedure.Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks.Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.).Documentation The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Coronado	1751 N 15th St Abilene, TX 79603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible and systematically organized for 1 of 19 (Resident #54) residents reviewed for nursing assessments. The facility failed to ensure readmission Assessment was included in the medical record for Resident #54 after hospitalization on 4/18/2026 per facility policy.This failure could put residents at risk of records not being completed and staff not having all information needed to provide quality care to its residents.Findings included:Record review of Resident #54'a electronic face sheet, dated 04/22/2026, reflected she was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including diastolic congestive heart failure (left lower chamber in the heart cannot fill with blood properly reducing blood flow to the body), atrial fibrillation (irregular heartbeat that can prevent the heart from pumping blood effectively), and hypertension (high blood pressure). Record review of Resident #54's quarterly MDS assessment, dated 03/24/2026, reflected she was readmitted from acute care hospital on [DATE]. Her BIMS score was a 14 indicating cognitively intact. Record review of Resident #54's clinical record accessed on 04/22/2026 reflected no evidence that a readmission assessment had been performed or any vital signs had been documented on 04/18/2026, 04/19/2026, 04/20/2026 or 04/21/2026.Record review of Resident #54's progress notes reflected on 04/18/2026 at 6:39 p.m., Resident #54 arrived back to the facility from being hospitalized for sepsis (widespread inflammation and damage to organs from body's immune system overacting to an infection) and a UTI. on 04/22/2026 at 1:15 p.m., Resident #54 was transported after facility staff called 911 after resident became nonresponsive. During an interview and observation on 04/21/2026 at 11:24 a.m., Resident #54 was lying in her bed. She stated she had been transferred to the facility on [DATE] after being hospitalized for a weak heart.During an interview on 04/22/2026 at 4:05 p.m., LVN A stated the nurse who admitted a resident was responsible for obtaining vital signs during the admission assessment. She stated the admitting nurse would put in an order to take daily vital signs for three days. She stated she was present when Resident #54 was readmitted on [DATE] but it was change of shift and she gave over responsibility of the resident to another nurse. She stated the oncoming nurse should have finished up the readmission including performing an assessment on the resident and putting in the order for daily vital signs. She stated taking vital signs for three days was to help reduce rehospitalization risk. During an interview on 04/22/2026 at 4:19 p.m., LVN D stated she had not taken vital signs including blood pressure and pulse on Resident #54 because there was no order to take the blood pressure or pulse. She stated she did not know why the blood pressure had not been taken prior to that morning because she did not work every day. She stated typically the admission nurse would get orders when a resident was admitted to the facility. She stated the admitting nurse should perform an assessment on a resident when they arrive at the facility including vital signs.During a telephone interview on 04/23/2026 at 9:40 a.m., the MD stated he expected the nurses to perform assessments when a resident was admitted or readmitted into the facility. He stated he did not expect nurses to continue to take vital signs unless there were orders to do so after the readmission. He stated the nurse not performing a nursing assessment or taking the vital signs did not have any negative effect on Resident #54 and would not have prevented her hospitalization on 04/22/2026. During an interview on 04/23/2026 at 5:40 p.m., the DON stated she expected the nurse to perform an assessment on the resident when they were readmitted into the facility including vital signs. She stated the nurses should perform daily vital signs for three days to help prevent rehospitalization. She stated she monitored that nurses were performing those assessments but there was only one of her and she was having to help out working on the floor. She stated she was falling behind on monitoring that the nurses were completing the assessments.Record review of the facility's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy titled Return to Acute/Hospital -Readmission, dated 04/17/2026, reflected This policy establishes the criteria, process, documentation requirements, and follow-up procedures for transferring a nursing facility resident to an acute care hospital. The facility will make every effort to manage changes in condition in-house when clinically appropriate to reduce avoidable hospitalizations.READMISSION.On Return (within 4 hours): Assessment, med reconciliation, infection screen, notify provider, update care plan.Record review of facility policy titled, Staffing, Sufficient and Competent Nursing dated August 2022, reflected: Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; c. assessing, evaluating, planning and implementing resident care plans; and d. responding to resident needs.

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F 0850 Level of Harm - Potential for minimal harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility, with a capacity of more than 120 beds, failed to employ a qualified social worker on a full-time basis for 1 of 1 facility reviewed for qualified staffing. The facility failed to ensure they had a full-time licensed Social Worker. This failure could affect all residents of the facility by placing them at increased risk of psychosocial decline and poor quality of life. Findings included:During an interview on 04/23/2026 at 09:30 a.m., the SSD stated she was working to get her license in the state of Texas. She stated she had a master's degree in social work from [NAME] Rico and then was licensed in the state of New York. She stated she was working with the state of Texas to get reciprocity (licensure by endorsement) but was not licensed at this time. She stated she had been working for the facility performing Social Work duties since December of 2025. She stated she had corporate support, but she did not come to the facility and all communication was over the phone or virtual. During a telephone interview on 04/23/2026 at 6:34 p.m., the VP of HR stated she was unfamiliar with the regulations for a Social Worker in the state of Texas and would have to review regulations before she could answer any questions about whether they needed to be licensed.During an interview on 04/24/2026 at 8:18 a.m., the ADMN stated his expectation was to have a full-time social worker that was licensed. He stated the SSD was working on getting her license transferred to the state of Texas and she was one of the best Social Service employees he has ever worked with. He stated she only had to take a test to become licensed in Texas. He stated no other SW was in the building to perform SW duties, but the SSD did have corporate oversite. He stated he did not see any negative effect on the residents and felt that the SSD was going above and beyond for the residents at the facility. The ADMN stated he was responsible for ensuring the staff positions were filled.Record review of the job description for Social Services, dated 12/12/2025, reflected Licensure preferred.Record review of the job posting for Social Services Director, no date, reflected Licensure required.Record review of the facility policy titled, Social Services dated September 2021, reflected Not all medically-related social services are provided by a qualified social worker. However, the facility is responsible for ensuring that all residents are provided these services whether by a staff member or through referrals to an outside agency. Record review of Form 3740 titled Bed Classification dated 04/24/2026 revealed the facility had a licensed capacity of 188 resident beds.