

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 interview and record review the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis or have a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for nursing services. The facility did not have 8 hours of RN coverage for 17 of 121 days (10/10/25, 10/11/25, 10/12/25, 10/16/25, 10/17/25, 10/18/25, 10/19/25, 11/15/25, 12/01/25, 12/14/25, 12/21/25, 12/25/25, 01/18/26, 01/24/26, 01/27/26, 01/28/26 and 02/06/26). The facility did not have a designated DON to work full time of at least 40 hours a week from 01/20/26 till current (02/12/26). This deficient practice could place 49 residents at risk of not receiving adequate care by not having staff available with the ability to perform assessments as needed. Findings included: Record review of the facility RN timesheets revealed there were no RN hours for 10/10/25 10/11/25, 10/12/25, 10/16/25, 10/17/25, 10/18/25, 10/19/25, 11/15/25, 12/1/25, 12/14/25, 12/21/25, 12/25/25, and 1/24/26. Record review of the facility RN timesheets revealed there were not 8 hours of RN coverage on the following dates: 1/18/26 had 7.32 hours, 1/27/26 had 3.25 hours, 1/28/26 had 6.25 hours and 2/6/26 had 4.75 hours. Record review of the facility time sheets revealed RN K was employed 10/01/25 through 11/23/25. The time sheet did not indicate any hours worked on 10/10/25, 10/11/25, 10/12/25, 10/16/25, 10/17/25, 10/18/25, and 10/19/25 for RN K. Record review of the facility time sheets revealed RN L was employed 12/15/25 through 01/20/26. The time sheet did not indicate any hours worked on 12/1/25, 12/14/25, 12/21/25, or 12/25/25 for RN L. Record review of the facility time sheets revealed the ADON was employed 12/22/25 through present (02/12/26). The time sheet did not indicate any hours worked on 12/25/25 or 1/24/26 and 7.32 hours on 1/18/26, 3.25 hours on 1/27/26, 6.25 hours on 1/28/26, and 4.75 hours on 2/6/26. During an observation and interview 02/12/26 at 9:16 a.m., Human Resources said she knew they had no RN coverage on 10/10/25 10/11/25, 10/12/25, 10/16/25, 10/17/25, 10/18/25, and 10/19/25 because RN K had requested those dates off. She said she could not say about the other days but verified she had no time punch for RN's on 12/1/25, 12/14/25, 12/21/25, 12/25/25, and 1/24/26. She said the prior DON E's last physical day of work was 01/20/26. She said they have not had a DON for the facility since 01/20/26. During an interview 02/12/26 at 11:08 a.m., the ADON said she started working at the end of December 2025 till present. She said she started out as the weekend supervisor and started the ADON position three weeks ago. She said when she did work at the facility she clocked in for her time. She said she did not work 12/25/25 because she thought she was sick, or 1/24/26 because of the weather. She said she thought she had worked 8 hours on 1/18/26. She said she had doctors' appointments on 1/27/26, 1/28/26 and 2/6/26 and had left early. She said during those times there was not another RN working the facility to cover for her. During an interview 02/12/26 at 1:58 p.m., RN K said she worked from October 2025 through end of November 2025 as the ADON. She said she had prior engagement on the following days and did not work them, 10/10/25 10/11/25, 10/12/25, 10/16/25, 10/17/25, 10/18/25, and 10/19/25. She said she had told an unknown person prior to being hired that she could not work those days. She said she could not say about 11/15/25 but said she clocked in when she did work at the facility. During an interview on 02/12/26 at 3:56 p.m., the ADON said they did not have a DON currently. She said they hired a new (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 675788	If continuation sheet Page 1 of 24

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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	DON whose attentive date of hire would be in March 2026. She said she did not know the last date of employment for the previous DON but knew it was in January 2026. During an interview on 02/12/26 at 4:15 p.m., the Administrator said he did not have a waiver for the DON. He said he started at the facility 01/28/26 and when he was hired, they did not have a DON. He said he was aware of the regulation that an RN had to be in the facility for 8 hours daily. He said he had the ADON who was an RN and thought she was working 8 hours per day. He said he was not aware of the DON or RN hours before he started working at the facility. The Administrator said they required an RN to work 8 hours daily to carry out the daily aspects of the facility. The policy for RN/DON coverage was requested but was not provided. During a phone interview on 02/12/26 at 6:00p.m., RN L said she was employed from the middle of December 2025 to the end of January 2026 but could not recall exact dates. This surveyor asked about the following dates: 12/1/25, 12/14/25, 12/21/25, and 12/25/25. She said she did not work 12/25/25 but could not recall if she worked the other dates. She said when she did work, she clocked in. Review of document titled, Job Description Director of Nursing undated, revealed: The primary role of the Director of Nursing (DON) is to plan, develop, organize, and direct the day-to-day functions of the Nursing Services Department in accordance with current Federal, State and local regulations as well as maintain compliance with policies and procedures. The DON ensures that the highest degree of quality care is maintained. The Director of Nursing has delegated administrative authority, responsibility, and accountability to carry out your assigned duties. In the absence of the Administrator, you are charged with carrying out the policies established by the Facility. The DON Maintains the Rights of Residents as set forth by the Texas Department of Health laws and regulations. Review of document titled, Job Description Registered Nurse undated, revealed: The primary purpose of your job position is to provide direct nursing care to the residents and to supervise the day-to-day nursing activities of your assigned unit. Such supervision must be in accordance with current Federal, State, and local standards, guidelines and regulations that govern the Long-term care facility, as well as our established policies and procedures, and as may be directed by the Director of Nursing Services, to ensure that the highest degree of quality care is always maintained.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review program (PASRR) to the maximum extent practicable to avoid duplicative testing and effort for 3 of 3 residents (Residents #17, #12, and #16) reviewed for PASRR. 1. The facility failed to provide documentation of Residents #17 and #16's habilitation coordination as requested in the PCSP Form. 2. The facility failed to provide documentation of Resident #12's independent living skills services as requested in the PCSP Form. These failures could cause residents with mental health disorders and psychiatric conditions to have a delay in services or not receive specialized services or equipment that may be needed. Findings included: Resident #17 1. Record review of Resident #17's face sheet, dated 02/12/26, reflected Resident #17 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included cerebral palsy (lifelong neurological disorders caused by abnormal brain development or damage, typically before, during, or shortly after birth). Record review of Resident #17's annual MDS assessment, dated 11/6/25, reflected Resident #17 Section A1500 asked Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? This section was marked 1 which meant Yes. Resident #17 understood others and made herself understood. Resident #17 had a BIMS score of 15, which reflected her cognition was intact. Resident #17 had an active diagnosis of cerebral palsy. Record review of Resident #17's comprehensive care plan, revised 01/28/26, reflected Resident #17 had been identified as having PASRR positive status related to a developmental disability. Resident #17 was receiving habilitation coordination. The care plan interventions included: provide service coordination with a representative from LIDDA. Record review of PCSP meeting dated 12/22/25 reflected that habilitation coordination services were recommended for Resident #17. Record review of PCSP meeting dated 02/05/26 reflected that habilitation coordination services were recommended for Resident #17. Record review of Resident #17's EMR dated 02/12/26 reflected no documentation of habilitation coordination notes. Resident #16 Record review of Resident #16's face sheet, dated 02/12/26, reflected Resident #16 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included cerebral palsy. Record review of Resident #16's annual MDS assessment, dated 01/26/26, reflected Resident #16 understood others and made herself understood. Resident #16 had a BIMS score of 15, which reflected her cognition was intact. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #16's comprehensive care plan, revised 12/22/25, reflected Resident #16 had been identified as having PASRR positive status related to an intellectual/ developmental disability. Resident #16 was receiving habilitation coordination. The care plan included interventions of: Provide service coordination with a representative from LIDDA. Record review of Resident #16's PASRR Comprehensive Service Plan (PSPC) Form, dated 02/05/2026, reflected that habilitation coordination was recommended for Resident #16. Record review of Resident #16's EMR dated 02/12/26 reflected no documentation of habilitation coordination notes. During a telephone interview on 02/12/26 at 9:54 a.m., the Habilitation Coordinator Supervisor stated the habilitation coordinator comes to the facility monthly to meet with the residents to ensure their needs were being met such as an advocate. The Habilitation Coordinator stated documentation was not left because they were not the ones being audited by the state. During an interview on 02/12/26 at 10:17 a.m., the MDS Coordinator stated she was responsible for ensuring monthly visits were conducted by the habilitation coordinator. The MDS Coordinator stated she was not aware when the coordinator comes to the facility. The MDS Coordinator stated she was at the facility on Monday, Wednesday, Thursday, Friday and if she happened to be at the facility when the coordinator comes, she would follow up verbally. The MDS Coordinator stated they have never left anything in writing such as a progress note, letter, etc. The MDS Coordinator stated it was important documentation was received after every visit to ensure the best possible care was received. During an interview on 02/12/26 at 3:27 p.m., the ADON stated she expected some type of documentation to be provided after every visit to show the coordinator was in the building that month. The ADON stated she was not aware there was no documentation in the residents EMR of when the coordinator came to the facility. The ADON stated she believed the social worker was responsible for ensuring notes of some kind were put in the resident's file. The ADON stated it was important to ensure documentation was provided for continuity of care. During an interview on 02/12/26 at 4:12 p.m., the Social Services stated she did not deal with PASRR. The Social Services stated the MDS Coordinator coordinates with PASRR. During an interview on 02/12/26 at 4:17 p.m., the Administrator stated he expected to maintain documents regarding PASRR that fall in line with the required documents per the facility policy. The Administrator was unable to provide what exact documents were required per the policy. The Administrator stated medical records were responsible for ensuring documentation was provided monthly after every visit. The Administrator stated he would monitor the PASSR process moving forward. The Administrator stated it was important to ensure documentation was provided to fulfill the residents PASRR needs. 2. Record review of Resident #12's face sheet, dated 02/12/26, reflected Resident #12 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included cerebral palsy. Record review of Resident #12's annual MDS assessment dated [DATE], reflected Resident #12's Section A1500 asked Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? This section was marked 1 which meant Yes. The assessment did not address Resident #12's BIMS score but reflected he had (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	long term and short-term memory problems. Record review of Resident #12's comprehensive care plan, revised 01/26/26, reflected Resident #12 had been identified as having PASRR positive status related to an intellectual/developmental disability. Resident #12 was receiving habilitation services and independent living skills. The care plan included interventions of: provide service coordination with a representative from LIDDA. Record review of Resident #12's PASRR Comprehensive Service Plan (PSPC) Form, dated 01/16/2026, reflected that habilitation coordination and independent living skills were recommended for Resident #12. Record review of Resident #12's EMR dated 02/12/26 reflected no documentation of habilitation coordination notes or independent living skills notes. Call attempted to special services/ independent living skills supervisor on 2/12/26 at 12:10pm. Phone extension does not receive voicemails. Call attempted to special services/ independent living skills supervisor on 2/12/26 at 2:50 pm. Phone extension does not receive voicemails. During an interview on 02/12/26 at 2:23 p.m., the MDS Coordinator stated she was responsible for ensuring monthly visits were conducted by the habilitation coordinator and independent living services. The MDS Coordinator stated she was not aware when independent living services came to the facility. The MDS Coordinator stated she was at the facility on Monday, Wednesday, Thursday, Friday and if she happened to be at the facility when the coordinator comes, she would follow up verbally. The MDS Coordinator stated the independent living skills services coordinator does not document in writing anywhere at the facility they have visited. The MDS Coordinator stated it was important documentation was received after every visit to ensure the best possible care was received. During an interview on 02/12/26 at 3:27 p.m., the ADON stated she expected the same thing from independent living skills services as she does from habilitation coordination, that some type of documentation is to be provided after every visit to show the independent living skills services coordinator was in the building that month. The ADON stated she was not aware there was no documentation in the residents EMR of independent living skills visits to the facility. The ADON stated she believed the social worker was responsible for ensuring notes of some kind were put in the resident's file. The ADON stated it was important to ensure documentation was provided for continuity of care. During an interview on 02/12/26 at 4:12 p.m., the Social Services stated she did not deal with PASRR. Social Services stated the MDS Coordinator coordinates with PASRR. During an interview on 02/12/26 at 4:31 p.m., the Administrator stated he expected to maintain documents regarding PASRR that fall in line with the required documents per the facility policy. The Administrator was unable to provide what exact documents were required per the policy. The Administrator stated medical records was responsible for ensuring documentation was provided monthly after every visit. The Administrator stated he would monitor PASSR either by taking part or having a representative in the PASRR meeting to obtain documentation. The Administrator stated it was important to ensure documentation was provided to fulfill the residents PASRR needs. (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled PASRR dated 07/29/25 reflected, . The PASRR program aims to ensure that individuals with mental illness or intellectual disabilities receive appropriate care and services. It assessed whether the nursing home is the most suitable setting for the individual's needs. 3. Documentation: Facilities must maintain thorough documentation of the PASRR assessments, including the Level I and Level II evaluation, as well as the recommendations made.5. Ongoing Review: Residents who are admitted under PASRR guidelines may undergo periodic reviews to ensure that their needs are being met and that they continue to require nursing home care .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 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 and 1 of 2 residents (Resident #23 and Resident #35) reviewed for food safety. 1.The facility failed to ensure they had pasteurized eggs in the refrigerator. 2.The facility failed to ensure the Maintenance Supervisor wore a hairnet and beard guard while in the kitchen on 02-09-26. These failures could place residents at risk for food contamination and foodborne illness. Findings included:1. During observations with Dietary Manager on 02/09/25 beginning at 9:39 am, the following observation was made in the kitchen Refrigerator (1 of 2): 1 box of 80 unpasteurized eggs.During an observation and interview on 02/10/26 at 10:00 a.m., the Dietary Manager said she did not know the eggs were unpasteurized until state surveyor intervention. The Dietary Manager said two residents received fried eggs, Resident #23 and Resident #35. She said sometimes their eggs would be soft fried (characterized by fully set, tender whites and a warm, liquid yolk) but mostly hard fried. She said she instructed staff not to prepare any more fried eggs until the pasteurized eggs were delivered. She said she knew the potential of fried eggs not cooked properly could make the resident sick.During an interview on 02/10/26 at 2:16 p.m., Resident #23 said she received fried eggs. She said sometimes they were runny or soft fried eggs and other times they were fried hard. She said she never had any illness related to the eggs being runny.During an interview on 02/10/26 at 2:17 p.m., Resident #35 said she received fried eggs, but could not say if they were fried hard or soft fried. She denied being sick related to receiving fried eggs.2. During an observation and interview on 02/09/26 at 12:34 p.m., the Maintenance Supervisor walked into the kitchen without a hair net or beard covering. He proceeded to walk past the stove to the sink where he washed off a part belonging to the ice machine. The Maintenance Supervisor said he was supposed to put on a beard guard when he entered the kitchen. He said he forgot. He said he had not been wearing a hairnet when he entered the kitchen because he wore a baseball cap. The Maintenance Supervisor was observed with hair hanging outside of the baseball cap. The Maintenance Supervisor said there was hair hanging and uncovered by the baseball cap. He said he should have worn a beard guard and hairnet to prevent hair from getting into the food.During an interview on 02/10/26 at 10:00 a.m., the Dietary Manager said she was responsible for the kitchen and was responsible for ensuring any person who entered the kitchen wore a hairnet and beard guard if needed. She said a hairnet or beard guard should be worn to prevent hair from getting into the food. During an interview on 02/10/26 at 3:56 p.m., the ADON said everyone that entered the kitchen should have on a hairnet. She said if someone had a beard then they should put on a beard guard. She said both were needed to protect hair from getting in the food. She said the kitchen staff should redirect anyone coming into the kitchen without a hairnet or beard guard and the Dietary Manager was responsible to ensure no one came into the kitchen without a hairnet or beard guard. She said she was not sure about the process of pasteurized eggs or the potential if not cooked properly. She said the Dietary Manager was responsible for ensuring they had the correct type of eggs in the kitchen.During an interview on 02/10/26 at 4:15 p.m., the Administrator said he expected the kitchen staff to follow the policy. He said if someone did not have proper protection (hairnet/beard guard) they could potentially get hair in the food. The Administrator said if a resident had an unpasteurized egg, it could potentially place the residents at risk for food-borne illness. He said the Dietary Manager was responsible for monitoring and overseeing the kitchen. Record review of the facility's policy titled, Food Preparation and Service revised 11/2022, indicated, Policy Statement: Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. General Guidelines: #1. Identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of foodborne illness. #3. Food preparation staff adhere to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food Preparation, Cooking and Holding Time temperature: #12. Only pasteurized shell eggs are cooked and served when: a. residents request undercooked, soft-served, or sunny side up eggs; and b. preparing foods that will not be thoroughly cooked (e.g., hollandaise sauce, French toast, ice cream etc.), #13. Unpasteurized eggs are cooked until all parts of the egg (yolk and whites) are completely firm. Food Distribution and Service: #8 Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. Record review of FDA 2-402.11, dated 2022, revealed FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE_SERVICE and SINGLE-USE ARTICLES.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. Based on observation, interview, and record review, the facility failed to establish policies regarding smoking areas, and smoking safety for 1 of 1 smoking area reviewed for physical environment. 1. The facility failed to provide a metal container with a self-closing cover device. 2. The facility did not ensure smoked cigarettes were extinguished in a fire-retardant receptacle. This failure could place residents at risk of unsafe smoking and injury. Findings Included: During an observation on 02/10/26 at 6:01 p.m., a group smoke break of five residents smoking revealed cigarette butts on the ground outside in the smoking area, trash in the red noncombustible cigarette butt receptacle can, and the self-closing ashtray was malfunctioning. During the observation cigarettes were put on top of the self-closing ashtray with other old cigarette butts. During an interview on 02/10/26 at 6:15 PM, the Director of Dietary Services stated she was responsible for the 6:00 p.m. smoke break. The Director of Dietary Services stated there should not be trash in the red receptacle where cigarette butts were thrown, cigarette butts were to not be on the ground, and the ashtrays should be fully functioning. The Director of Dietary Services stated the residents were at risk of fire and burning due to incorrectly extinguishing the cigarette butts. During an interview on 02/11/26 at 9:15 a.m., the Maintenance Director stated he was unaware there was trash in the red receptacle can, there were cigarette butts on the ground, and the ashtrays were not functioning properly. The Maintenance Director stated he was responsible for ensuring the facility was in good repair. The Maintenance Director stated the residents were at risk of fire when cigarettes were not properly extinguished. The Maintenance Director stated he was one of the many people from each department that was assigned to take the residents out to smoke. The Maintenance Director stated he did not have any in-services to ensure all staff were aware of their responsibilities. The Maintenance Director stated he performed morning rounds daily, Monday-Friday, to check for issues in the repair of the facility and in these rounds, he observed the smoking area. The Maintenance Director stated that he did random rounds, indicating he did not check daily. During an interview on 02/12/26 at 2:31 p.m., the Housekeeping Supervisor stated she was responsible for ensuring the facility was well kept and cleaned. The Housekeeping Supervisor stated she was unaware of the cigarette butts on the ground, the trash in the cigarette butt disposal can, and the malfunctioning ashtray. The Housekeeping Supervisor stated the facility was at risk of fire. During an interview on 02/12/26 at 3:50 p.m., the ADON stated she expected the Maintenance Director to get a cigarette disposal metal can that did not have trash in it and ashtrays that were fully functioning. The ADON stated the facility was at risk of causing a fire and putting residents at a safety risk. The ADON stated she had not done an in-service since she took the ADON position three weeks prior. The ADON stated the facility scheduled smoking breaks by department. The ADON stated at each scheduled smoking time, a staff member was assigned to the outdoor smoking area to directly observe residents during the smoking break to ensure supervision and safety. The ADON stated nursing completed safe smoking assessments. During an interview on 02/12/2026 4:48 p.m., the Administrator revealed he expected the smoking area to be free of cigarette butts on the ground, functional ashtrays, and there should not be trash in the red can used to dispose of cigarette butts. The Administrator stated residents during smoke break were at risk of fire due to the cigarette butts on the ground, the trash in the red can, and self-closing ashtrays not functioning. The Administrator stated housekeeping, and maintenance should be checking those areas daily during their rounds and smoking schedule assignments are done by department. The Administrator stated it was his responsibility to educate and in-service them on smoking safety. The Administrator stated nursing clinical staff completed safe smoking assessments. The Administration stated he along with other department administrators were responsible for rounding every day to check for safety. The Administration claimed responsibility for ensuring and monitoring staff scheduled to supervise smoking breaks were informed of their duties related to resident safety, disposal of cigarette butts, and the smoking areas. Record review of the facility policy titled, Smoking Policy- Resident, dated (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	October 2022, revealed.Metal containers, with self-closing cover devices, are available in smoking area and ashtrays are emptied only into designated receptables.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 unable to carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 18 (Resident #40) residents reviewed for ADL care. 1. The facility did not ensure Resident #40 was provided with his scheduled bath/showers. 2. The facility did not ensure Resident #40's fingernails were trimmed and free from a black colored substance routinely. These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. Findings included: Record review of Resident #40's face sheet, dated 02/12/26, reflected Resident #40 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to embolism of left middle cerebral artery (when a blood clot forms in one part of the body and then travels through the blood to the brain, where it blocks adequate oxygen and blood flow). Record review of Resident #40's quarterly MDS assessment, dated 12/17/25 reflected Resident #40 usually made herself understood and usually understood others. Resident #40 had a BIMS score of 11, which reflected her cognition was moderately impaired. Resident #40 required partial/moderate assistance with personal hygiene and substantial/maximum assistance with shower/bath. Record review of Resident #40's comprehensive care plan, revised on 02/09/26, reflected Resident #40 had ADL self-care performance deficit related to history of CVA. The care plan interventions included: Resident #40 required assistance by 1 staff with bathing/showering and check nail length, trim and clean on bath day and as necessary. Record review of Resident #40's North Side Shower Schedule reflected Resident #40 was scheduled to receive showers on Monday, Wednesday and Friday. The sheet dated 01/02/26-02/11/26 reflected no documentation for scheduled bath/showers on 01/09/26, 01/12/26, 01/30/26, 02/06/26, 02/09/26, and 02/11/26. During an observation and interview on 02/09/26 at 10:50 a.m., Resident #40 was lying in bed wearing a hospital gown. Resident #40's hair was oily with white substance noted. Resident #40's fingernails on both hands were jagged and appeared to be approximately 0.25-0.50 cm long with a thin line of black substance under them. Resident #40 stated she preferred a bed bath and did not know the last time she received one. Resident #40 stated not getting her bed bath made her feel dirty. During an observation on 02/10/26 at 8:44 a.m., Resident #40 was lying in bed wearing a hospital gown. Resident #40 hair was oily with white substance noted. Resident #40 fingernails on both hands were jagged and appeared to be approximately 0.25-0.50 cm long with a thin line of black substance under them. During an observation on 02/11/26 at 9:05 a.m., Resident #40 was lying in bed wearing a blue/teal color shirt. Resident #40 stated an aide changed her out of the gown yesterday. Resident #40 was unable to recall the aide's name. Resident #40 stated the aide did not provide her with a bed bath or shower when she changed her from her gown. Resident #40 hair was oily with white substance noted. Resident #40 fingernails on both hands were jagged and appeared to be approximately 0.25-0.50 cm long with a thin line of black substance under them. An attempted telephone interview on 02/12/26 at 10:30 a.m., with LVN F, the 6p-6a charge nurse for 02/11/26. An attempted telephone interview on 02/12/26 at 10:32 a.m. with CNA E, the CNA that was responsible for providing Resident #40 a bed bath or shower on 02/09/26, was unsuccessful. During a telephone interview on 02/12/26 at 10:33 a.m., CNA C stated CNAs were responsible for giving residents baths or showers. CNA C stated Resident #40 should receive a bed bath or shower on Monday, Wednesday, and Friday on the 2p-10p shift. CNA C stated 02/10/26 was her first day working at the facility. CNA C stated she did not provide Resident #40 a bed bath or shower on 02/11/26. CNA C stated she believed Resident #40 refused a bed bath. CNA C stated she did not report that to her charge nurse nor document it. CNA C stated it was important for the residents to receive their baths/showers to make sure they were getting the care they needed. During an observation and interview on 02/12/26 at 9:01 a.m., LVN A stated CNAs were responsible for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	giving bed baths or showers. LVN A stated Resident #40 should receive showers or bed baths on Monday, Wednesday, and Friday on the 2p-10p shift. LVN A observed Resident #40 with the state surveyor and agreed Resident #40's hair was greasy with white substances and fingernails on both hands were jagged and appeared to be approximately 0.25-0.50 cm long with a thin line of black substance under them. LVN A stated the aides for this week were new to the facility. LVN A stated if the CNAs could not provide a shower or bed bath, they were supposed to report that to her or the 6p-6a charge nurse. LVN A stated it was not reported to her by either aide they were not able to give the shower or Resident #40 refused. LVN A stated the charge nurses were responsible for monitoring by reviewing the shower sheets daily. LVN A stated she did not review the shower sheets this week because the shower was not given yet. LVN A stated the aide had until 10p to give residents a shower. LVN A stated this failure was a dignity issue. An attempted telephone interview on 02/12/26 at 2:40 p.m., with LVN D, the 6p-6a charge nurse for 02/09/26. During an interview on 02/12/26 at 3:27 p.m., the ADON stated the charge nurses were responsible for ensuring the CNAs performed ADLs. The ADON stated CNAs were supposed to complete bed baths/showers according to their schedule and the nurses were supposed to follow up and ensure the baths/showers were completed by reviewing the shower sheets daily. The ADON stated she monitored by daily observations and any concerns with care were addressed immediately. The ADON stated she was not aware Resident #40 was not receiving her bed baths/showers as scheduled. The ADON stated she had not spoken with Resident #40 since Saturday. The ADON stated it was important to ensure showers/bed baths were given to help with skin integrity, reduce infections, and overall help the residents to feel clean. During an interview on 02/12/26 at 4:17 p.m., the Administrator stated he expected bed baths/showers to be given at minimum every other day and upon resident request. The Administrator stated CNAs were supposed to complete bed bath/showers according to their schedule. The Administrator stated the nurses should be holding the CNAs accountable by reviewing the shower sheets daily. The Administrator stated it was important to ensure showers/bed baths were given because good hygiene equates to good health. Record review of the facility's policy titled Activities of Daily Living (ADL), Supporting revised 02/2025 reflected, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the residents and in accordance with the plan of care, including appropriate support and assistance with. a. hygiene (bathing, dressing, grooming, and oral care) .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 18 residents (Resident #3) reviewed for accidents hazards. The facility did not ensure acetone was not stored on Resident #3's dresser on 02/10/26. This failure could place residents at risk for injury. Findings included: Record review of Resident #3's face sheet, dated 02/12/26, reflected Resident #3 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included chronic systolic heart failure (occurred when the left ventricle weakens and cannot pump blood effectively, causing blood to back up in the body). Record review of Resident #3's quarterly MDS assessment, dated 01/18/26, reflected Resident #3 made herself understood and understood others. Resident #3's BIMS score was 15, which reflected her cognition was intact. Resident #3 required set-up or clean up assistance with personal hygiene. Record review of Resident #3's comprehensive care plan, revised 12/15/25 reflected Resident #3 had an ADL self-care performance deficit. The care plan interventions included: the resident required set up staff participation with personal hygiene. During an interview and observation on 02/10/26 at 8:50 a.m., the state surveyor observed a small clear bottle that was labeled 100% pure acetone nail polish remover on Resident #3's dresser. Resident #3 stated a family member brought it to her and she was unsure if staff knew she had it. During an interview on 02/12/26 at 8:55 a.m., CNA B stated all staff should be aware and observant of items that did not belong at residents' bedside. CNA B stated she did not recall seeing the acetone on Resident #3's dresser but Resident #3 told her the state surveyor had asked about it. CNA B stated acetone cannot be in the building. CNA B stated there were residents that wandered the hall and this failure could potentially put them and other residents at risk for harm. During an interview on 02/12/26 at 9:01 a.m., LVN A stated all staff were responsible for ensuring items were stored properly and securely. LVN A stated Resident #3 could not have acetone at her bedside. LVN A stated Resident #3 stated a family member had brought it to her. LVN A stated it was important to ensure items were not left at bedside for residents' safety. During an interview on 02/12/26 at 3:27 p.m. the ADON stated all staff should be monitoring for things that could possibly harm a resident. The ADON stated acetone should be taken out of the resident room immediately and not be brought into the facility. The ADON stated she monitored by random rounds and making observations. The ADON stated it was important acetone was not left at bedside for resident's safety. During an interview on 02/12/26 at 4:17 p.m., the Administrator stated acetone should not be in a residents' room. The Administrator stated he was not aware Resident #3 had acetone at her bedside. The Administrator stated all staff should be monitoring and observant of what was at the residents' bedside. The Administrator stated it was important to ensure items were not left at bedside for residents' safety. Record review of the Safety and Supervision of Residents .revised on 07/2017 reflected. Our community strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are community-wide priorities. Individualized, Resident-Centered approach to Safety.1. Our individualized, resident-centered approach to safety addressed safety and accident hazards for individual residents. Resident Risks and Environmental Hazards.f. poison control.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 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 of 1 resident (Resident #23) reviewed for treatment and services related to indwelling catheters. The facility failed to ensure Resident #23's foley catheter (tube inserted into bladder) was secured on 02/10/26, 02/11/26, and 02/12/26. This failure could place residents at risk for urinary tract infections and a decreased quality of life. Findings included: Record review of Resident #23's face sheet, dated 02/12/26, reflected Resident #23 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of bladder (lack bladder control due to brain, spinal cord or nerve problems). Record review of Resident #23's annual MDS assessment dated [DATE], reflected Resident #23 made herself understood and understood others. Resident #23 had a BIMS score of 15, which reflected her cognition was intact. Resident #23 had an indwelling catheter. Record review of Resident #23's comprehensive care plan, revised 12/10/25, reflected Resident #23 had a foley catheter due to obstructive uropathy (urine flow is obstructed). The care plan interventions included: ensure staff aware of correct placement of catheter gravity drainage bag and tubing, keep tubing/bag below the bladder and do not kink tubing. Record review of Resident #23's nurse's note dated 02/10/26 completed by LVN D reflected she had changed Resident #23's catheter due to leakage. Record review of Resident #23's physician order summary report dated 02/12/26 reflected an active physician's order for foley catheter 26 French/30 ml every shift related to neuromuscular dysfunction of bladder with a start date 12/09/25. The order summary did not address catheter securement. During an observation and interview on 02/10/26 at 8:53 a.m., Resident #23 stated LVN D changed her catheter last night but did not secure her tubing. The state surveyor asked if she could bring an aide in to see the catheter, Resident #23 stated, yes. CNA B came in, pulled the sheet back and showed the state surveyor the catheter. The catheter tubing was under Resident #23's left thigh unsecured. CNA B never addressed catheter tubing, not being secured. During an observation and interview on 02/11/26 at 8:40 a.m., Resident #23 was lying in bed and stated her catheter tubing was not secured. During an observation and interview on 02/12/26 at 8:55 a.m., the state surveyor asked CNA B if she could see Resident #23's catheter again. CNA B pulled the sheet back and showed the state surveyor the catheter. Resident #23's catheter was not secured. The state surveyor asked CNA B if her catheter should be secured. CNA B stated it was supposed to be anchored to her leg to prevent trauma. CNA B stated the CNAs should report to the nurse if they noticed the tubing was not secured when providing care. CNA B stated she had reported it to LVN A on 02/10/26 after she had shown the state surveyor Resident #23's catheter and noticed it was not secured. CNA B stated it was important to ensure Resident #23's foley catheter was secured to prevent trauma. During an interview on 02/12/26 at 9:01 a.m., LVN A stated Resident #23's catheter should always be secured. LVN A stated initially the nurse that placed the catheter should have made sure the catheter tubing was secured but if the device comes off the nurse should replace it, or the aide should report it to the nurse. LVN A stated she could not recall CNA B telling her the tubing was not secured. LVN A stated to be honest she did not pay attention Tuesday or Wednesday to ensure the catheter was secured. LVN A stated this morning (02/12/26) she noticed it was not secured. LVN A stated this failure could potentially cause trauma to the perineum. An attempted telephone interview on 02/12/26 at 2:40 p.m., with LVN D, the nurse that changed Resident #23's catheter on 02/10/26. A message was left for a return phone call. During an interview on 02/12/26 at 3:27 p.m., the ADON stated she expected catheters to be always secured. The ADON stated LVN D should have ensured the catheter was secured when she changed her catheter on 02/10/26 but if the CNAs noticed it was not secured, she should have reported it to the nurse, and the nurse should have gone (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and secured the tubing. The ADON stated she monitored catheter securement by random rounds. The ADON stated it was important to ensure the catheter was secured to prevent the catheter being pulled and caused severe pain/bleeding or trauma to the perineal area. During an interview on 02/12/26 at 4:17 p.m., the Administrator stated he expected catheters to be secured upon the resident's request. The Administrator stated the nurse who inserted the catheter was responsible for ensuring the tubing was secured. The Administrator stated the ADON was responsible for monitoring and overseeing catheter securement. The Administrator stated it was important to ensure the catheter was secured to prevent any harm to the perineal area. Record review of the facility's policy titled, Catheter Care, Urinary, revised 07/2024 reflected. The purpose of this procedure is to prevent catheter-associated urinary tract infections. Maintaining Unobstructed Urine Flow. 1. 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. Changing Catheters.2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. Steps in the Procedure. 18. Secure catheter utilizing a leg band.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences for 1 of 2 residents (Resident #40) reviewed for oxygen therapy. The facility failed to have Resident #40's oxygen sign outside the door on 02/09/26, 02/10/26, 02/11/26, and 02/12/26. This failure could place residents who receive respiratory care at risk for respiratory infections including pneumonia, shortness of breath and even death. Findings included: Record review of Resident #40's face sheet, dated 02/12/26, reflected Resident #40 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Asthma (condition that causes airways to swell, narrow and fill with mucus), and wheezing (whistling sound made when air flows through narrowed airways in the lungs). Record review of Resident #40's quarterly MDS assessment, dated 12/17/25 reflected Resident #40 usually made herself understood and usually understood others. Resident #40 had a BIMS score of 11, which reflected her cognition was moderately impaired. During the 7-day look-back period the assessment did not indicate Resident #40 was receiving oxygen. Record review of Resident #40's physician order summary report, dated 02/12/26 reflected an active order for oxygen at 2L via N/C every 8 hours as needed for SOB with a start date 01/22/26. Record review of Resident #40's comprehensive care plan, revised on 02/09/26, reflected Resident #40 was on oxygen therapy related to decreased oxygen saturations and diagnoses of asthma and wheezing. The care plan interventions included oxygen settings at 2L/ml via NC and monitor oxygen saturations. During an observation and interview on 02/09/26 at 10:50 a.m., Resident #40 was lying in her bed wearing O2 at 2L/min via NC. Resident #40 stated she wore oxygen due to SOB. No oxygen sign was noted outside her door. During an observation on 02/10/26 at 8:44 a.m., Resident #40 was lying in her bed wearing O2 at 2L/min via NC. No oxygen sign was noted outside her door. During an observation on 02/11/26 at 9:05 a.m., Resident #40 was lying in her bed wearing O2 at 2L/min via NC. No oxygen sign was noted outside her door. During an observation and interview on 02/12/26 at 9:01 a.m., LVN A stated Resident #40 wore oxygen related to SOB. LVN A stated an oxygen sign should be on the outside of Resident #40's door. LVN A and the state surveyor went to Resident #40's door and saw there was no oxygen sign. LVN A stated she thought she had one at one time. LVN A stated all staff were responsible for ensuring an oxygen sign was outside Resident #40's door to let visitors/staff know that they should not smoke in the room because Resident #40 was on oxygen. LVN A stated the oxygen was not combustible, but it could potentially feed the fire. During an interview on 02/12/26 at 3:27 p.m., the ADON stated her expectation was an oxygen sign should be on Resident #40's door facing the hall. The ADON stated the nurses were responsible for ensuring an oxygen sign was always on the door. The ADON stated she monitored by random rounds, and she had not noticed there was no sign on Resident #40's door until state surveyor intervention. The ADON stated it was important to let everyone know that Resident #40 wore oxygen and if they smoked in her room, it could cause fire and to let staff know if power went out Resident #40's oxygen concentrator would need to be plugged into a red outlet (indicates an emergency backup power). During an interview on 02/12/26 at 4:17 p.m., the Administrator stated his expectation was an oxygen sign to be outside Resident #40's door. The Administrator stated nursing and maintenance were responsible for ensuring the sign was on the door. The Administrator stated he monitored by random rounds. The Administrator stated he did not notice the sign was not on her door until state surveyor intervention. The Administrator stated the facility was currently out of signs, but he will be placing an order. The Administrator stated it was important to notify everyone entering the room there was a combustible gas that could potentially cause a fire. Record review of the facility's undated policy titled Oxygen Storage, reflected, It is the policy of this center to maintain appropriate and safe storage of oxygen. 5. No smoking signage will be posted to prohibit smoking within fifty feet of the storage area.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food and drink that accommodated the residents' preferences for 1 of 23 residents (Resident #16) reviewed for preferences. The facility did not honor Resident #16's preference for no lima beans on 02/09/26. This failure could place residents at risk for a decrease in residents' choices and weight loss. Findings included: Record review of Resident #16's face sheet, dated 02/12/26, indicated a 54 -year-old female, admitted [DATE] and re-admitted on [DATE], with diagnoses including diabetes, high blood pressure, and cerebral palsy (a group of conditions that affect movement and posture). Record review of Resident #16's quarterly MDS assessment, dated 01/26/26, indicated Resident #16 understood and was understood by others. Her BIMS score was 15, which indicated she was cognitively intact. The MDS indicated she was independent in eating and oral hygiene. Record review of Resident #16's physician orders, dated 11/05/25, indicated regular diet, regular texture, regular consistency. Record review of Resident #16's comprehensive care plan, dated/revised 10/20/25, indicated Resident #16 was on a regular diet with a potential for malnutrition (undernutrition) related to diagnosis of cerebral palsy and diabetes. Record review of the lunch meal ticket, dated 02/09/26, for Resident #16 indicated regular diet, and under the note section indicated dislikes lima beans. Record review of Resident #16's medical records did not indicate she had a weight loss. During an observation and interview on 02/09/26 at 12:21 p.m., Resident #16 was in the main dining room eating her lunch. She said, I guess I will just pick the lima beans out of the vegetables, although I should not have to. She said she did not like lima beans, but she received them. During an observation and interview on 02/09/26 at 12:23 p.m., the ADON was in the dining room assisting staff pass out lunch trays. The surveyor and the ADON read Resident #16's meal ticket indicating Resident #16 disliked lima beans. The ADON said it should have been caught when the nurse passed the tray to Resident #16. During an interview on 02/10/26 at 10:00 a.m., the Dietary Manager said she expected Resident #16 not to receive her dislikes of lima beans. She said Resident #16 told her about two weeks ago about her dislike of lima beans and she added it to the tray card. She said the kitchen staff were responsible for ensuring they were reading the tray card and not serving anything a resident disliked. The Dietary Manager said it was important for all residents to receive their preference of food choices so they would eat. During an interview on 02/10/26 at 10:14 a.m., Dietary [NAME] M said she was the person who fixed Resident #16's lunch tray. She said she did not notice Resident #16's dislike of lima beans. She said she did not think about the Italian blend having lima beans in them. She said the risk of serving a resident something they did not like could cause them not to eat. During an interview on 02/12/26 at 3:56 p.m., the ADON said if Resident #16 did not like lima beans, then she should never have been served them. She said the process started in the kitchen with the cook and then to the staff who served the tray. She said dietary and nursing staff were responsible for ensuring they followed Resident #16's meal ticket. She said it was important to serve the correct diet and preference to prevent weight loss. During an interview on 02/12/26 at 4:15 p.m., the Administrator said he wanted Resident #16's' preferences to be known. The Administrator said he expected the kitchen staff to look at the tray cards and not serve something to the Resident #16 she disliked. He said the CNAs should ensure it was not on the tray, and the nurses were responsible for ensuring staff followed the tray card directions. The Administrator said it was important for their food preferences to be honored to prevent the residents from not eating. Record review of the facility's policy titled, Food and Nutrition Services , undated, indicated, Policy Statement: Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Policy Interpretation and Implementation: #1. The multidisciplinary staff, including nursing staff, the attending physician (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. #4. Reasonable efforts will be made to accommodate resident choices and preferences.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 1 resident (Resident #14) reviewed for hospice services. The facility did not ensure Resident #14's hospice records were a part of their records in the facility. This deficient practice could place residents at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record review of Resident #14's face sheet, dated 02/12/26, reflected Resident #14 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of the order summary report dated 02/12/26 reflected Resident #14 had an order to admit to hospice with an order date 12/23/25. Record review of Resident #14's significant change in status MDS assessment, 01/01/26, reflected Resident #14 usually made herself understood and usually understood others. Resident #14's BIMS score was 5, which reflected her condition was severely impaired. The assessment reflected Resident #14 had a life expectancy of less than 6 months and received hospice services. Record review of Resident #14's comprehensive care plan, revised on 12/24/25, reflected Resident #14 had a terminal prognosis related to Alzheimer's, end stage. The care plan interventions included work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physician and social needs were met. Record review of Resident #14's hospice binder, accessed by the state surveyor on 02/11/26 at 12:30 p.m. revealed no updated CTI, POC, medication list, nurses and aides note since the last IDT meeting (12/23/25). During an attempted interview on 02/09/26 at 11:15 with Resident #14, revealed she was non-interview able. During a telephone interview on 02/11/26 at 12:41 p.m., the RN Case Manager stated Resident #14 was admitted to hospice on 12/23/25 for Alzheimer's. The RN Case Manager stated the last visit was on 02/04/26. The RN Case Manager stated every other week either she or the aide would bring the IDT meetings notes which included the medication profile, and POC from all disciplines. The RN Case Manager stated the last IDT meeting was on 12/23/25. The RN Case Manager stated the process for coordinating with the facility was in person. During an interview and record review on 02/12/26 at 3:27 p.m., the ADON stated she was unaware Resident #14's hospice binder was not updated. The ADON stated honestly, she could not state who was responsible for ensuring the hospice book was updated with all required information before she became the ADON on 01/21/26. The ADON stated here on out it will be herself. The ADON stated the updated POC, aides, nurses and IDT meeting notes should be included in the binder. After reviewing the hospice binder with the state surveyor, the ADON stated the binder was not updated to include all information that was needed. The ADON stated the nurses communicated verbally one on one with the hospice staff. The ADON stated it was important to ensure recent hospice documentation was in the facility to keep communication between the facility and hospice for continuation of care. During an interview on 02/12/26 at 4:17 p.m., the Administrator stated he would expect the documents that were mutual agreed between the facility and hospice to be placed in the binder. The Administrator stated he had only been in this position since 01/28/26 therefore he did not know what documents were required. The Administrator stated the nurses at the facility/hospices including the nurse management were responsible for ensuring the binder was updated. The Administrator stated it was important to ensure recent hospice documentation was in the facility for continuity of care. Record review of the facility's policy titled Hospice Program, revised on 07/2017, reflected, . Hospice services are available to residents at the end of life.12. Our facility has designated (blank) to coordinate care provided to the (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents by our facility staff and the hospice staff. Obtaining the following information from the hospice: The most recent hospice plan of care specific to each resident; Hospice election form; Physician certification and recertification of the terminal illness specific to each resident; Names and contact information for hospice personnel involved in hospice care of each resident; Instructions on how to access the hospice's 24-hour on-call system; Hospice medication information specific to each resident; and Hospice physician and attending physician (if any) orders specific to each resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #6) reviewed for infection control. The facility failed to ensure CNA B and CNA H followed EBP and put on gown and gloves while providing incontinent care to Resident #6 on 02/11/26. This failure could place residents at risk for cross-contamination and the spread of infection. Findings Included: Record review of face sheet, dated 02/11/26, indicated Resident #6 was a [AGE] year-old male, admitted [DATE] and readmitted on [DATE], with diagnoses of Alzheimer's disease with late onset (progressive memory loss and cognitive decline), benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland) and chronic kidney disease stage 3A (moderate kidney damage and moderate decreased kidney functioning). Record review of comprehensive MDS, dated [DATE], indicated Resident #6 admitted following a short-term hospital stay with an indwelling catheter. This MDS indicated Resident #6 was always incontinent of bowel. This MDS indicated Resident #6 was diagnosed with benign prostatic hyperplasia and obstructive uropathy (blocking urine flow). Record review of Resident #6's care plan, dated 11/23/25, for EBP with intervention listed of staff must wear gowns and gloves during high-contact resident care activities. Record review of Resident #6 order summary report, dated 02/12/26, indicated an order for EBP including a gown and gloves were required for high contact activities started on 12/10/25. During an observation on 02/11/26 at 1:35 p.m., CNA B and CNA H entered Resident #6's room, performed hand hygiene, put on gloves, and began catheter care without gowns on. Observation of the door on the outside of Resident #6's room was a posted sign indicating EBP of gown and gloves required for high contact care with a box storing all needed supplies for care. During an interview on 02/12/26 at 8:46 a.m., CNA H stated she was not trained to wear PPE (personal protective equipment) when providing care to Resident #6. CNA H stated Resident #6 had a catheter and, to her knowledge, only residents with a wound were on EBP. CNA H stated that EBP was to be worn to protect them (the staff and the residents) from being splashed (particles coming in contact with their clothes and face) and spread infection. During an interview on 02/12/26 at 9:05 a.m., CNA B stated she forgot to wear PPE when providing care to Resident #6. CNA B stated she was not trained on PPE recently but she could not recall the exact date. CNA B stated residents with a wound and catheter required PPE when providing care to them. CNA B stated PPE was used to protect staff and residents from the spread of infection. CNA B stated it was CNA B's and CNA H's responsibility to put on PPE when providing care to Resident #6 who was on EBP. During an interview on 02/12/26 at 9:27 a.m., LVN G stated Resident #6 was on EBP and all staff were responsible for wearing PPE who provided direct contact care. LVN G stated that PPE was to prevent the spread of multidrug-resistant organisms. During an interview on 02/12/26 at 3:45 p.m., the ADON stated she expected all staff who provided direct care to Resident #6 to wear PPE when they provided direct contact care. The ADON stated that EBP was defined by gown and gloves. The ADON stated EBP was to be worn for residents with a catheter, wound, communicable disease or infection. The ADON stated that EBP was worn to protect them from being sprayed (particles coming in contact with their clothes and face) and to prevent the spread of infection. The ADON stated that she had not conducted an EBP training during the three weeks she was in the position. The ADON stated Resident #6 was at risk of infection and UTI when PPE was not worn during care. During an interview on 02/12/2026 at 4:45 p.m., the Administrator stated he expects his staff to wear EBP PPE when providing care to Resident #6 because he had an indwelling catheter. The Administrator stated his staff should put on and take off gowns and gloves when providing direct patient care. The Administrator stated EBP was for protection and preventing the spread of infection of communicable diseases. The Administrator stated (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing administration was responsible for ensuring EBP PPE was used during direct patient care. The Administrator stated EBP was a mandatory annual training but since he had taken on this role, 2 weeks ago, he had not done an in-service. Record review of the facility policy titled, Enhanced Barrier Precautions, dated February 2025, revealed, 'Enhance barrier precautions' refer to an infection control interventions designed to reduce transmission of multidrug-resistant organisms to residents. EBPs employs targeted gown and glove use in addition to standard precautions during high contact resident care activities.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 12 resident rooms (Resident #16) reviewed for physical environment. The facility failed to ensure Resident #16's windowsill was in good repair without exposed and splintered wood. This failure could place residents at risk for further deterioration, uncomfortable temperatures, the inability to properly clean, and possible pest infestation. Findings included: During an observation and interview on 02/10/2026, at 5:30 p.m., Resident #16's room windowsill had a visible hole and separated wood along the lower interior portion beneath the window. The opening measured approximately 10-12 inches in length and approximately 1-2 inches in width. The area contained cracked, splintered, and deteriorated wood with exposed inner material. The damaged section of the windowsill was located at resident height and was accessible to the resident. The surface was not smooth, intact, or cleanable. The windowsill had no protective covering, or repair was in place at the time of observation. Resident #16 stated the broken windowsill was there when she moved into the room. Resident #16 stated she did not remember the exact date she moved in, but she stated it was several months ago. Resident #16 stated she reported the broken windowsill via the TELS (Technology Enabled Life Safety) application but did not remember the date. Resident #16 stated it was several months ago. Resident #16 was not aware of any attempts to repair the window since she had moved into the room. During an interview on 02/10/2026 at 5:35 p.m., the Maintenance Supervisor stated he knew about the window for a while but just had not done the repairs. The Maintenance Supervisor stated, I just let it slip. The Maintenance Supervisor stated he finally got the approval to fix the windowsill this week. The Maintenance Supervisor did not have any documentation showing when a request for supplies to fix the window was submitted. The Maintenance Supervisor stated it was important for the windowsill to be fixed because the splintered wood could hurt someone, the temperature could be hard to control in the room, and it was not homelike. During an interview on 02/10/2026 at 6:20 p.m., the Maintenance Supervisor stated he learned about maintenance requests via the TELS (The Environmental Log System) platform used to track repairs. The Maintenance Supervisor stated again he had known about the issue for a long time but never had the budgeted money to fix the windowsill due to the facility changing owners. The Maintenance Supervisor said his budget was recently approved and the windowsill would be fixed. The Maintenance Supervisor said he used a bonding agent to patch it and that worked for a while, but then the windowsill got hit by a bed again and the windowsill broke again. The Maintenance Supervisor said he did not remember when he used the bonding agent to repair the windowsill, and he was not able to repair it since. During an interview on 02/10/2026 at 3:00 p.m., LVN G, assigned to Resident #16's hall, said it was her third day working at the facility. LVN G stated Resident #16 had not said anything to her about the broken windowsill. LVN G stated if she saw something that needed repair, she would report it to the ADON or the administrator. LVN G also stated she would put a ticket in TELS and the Maintenance Supervisor would see it. LVN G said it was important to repair broken items for the residents' safety. LVN G said insects could get in a hole or there could be a draft which could make a resident sick. During an interview on 02/12/2026 at 3:27 p.m., the ADON stated she was not aware of a hole in Resident 16's windowsill. The ADON stated if she saw something that needed attention, in the past she would tell the Maintenance Supervisor, but now the needed repair must be documented in the computer and put in a work order on the TELS application. The ADON said her expectation was an identified issue was fixed within three days, unless materials had to be ordered, then as soon as possible. The ADON said the Maintenance Supervisor was responsible for ensuring repairs were made. The ADON said she and the facility administrator were responsible for making rounds and monitoring for repairs. The ADON said repairing broken items was important because this was the residents' home. The ADON said it was important to fix because there could be a draft, or (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675788	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commerce		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 Sterling Hart Dr Commerce, TX 75428	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bugs could get in the room from the opening. During an interview on 02/12/2026 at 4:18 p.m., the facility Administrator said he was not aware of a broken windowsill in Resident 16's room, but when he learned of it this week, he bought the tools to fix it. The Administrator said everyone was responsible for reporting needed repairs using a facility wide system called TELS app. The Administrator said that this system notified the Maintenance Supervisor something needed repairing. The Administrator said he expected broken items to be fixed. The Administrator said repairs were triaged based on the concern and gave an example of a gas leak or a light out, the Maintenance Supervisor would address the gas leak first. The Administrator said it was important to fix broken items because residents deserve a nice home. Record review of policy and procedure, Maintenance Service dated 12/2009, indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. Functions of maintenance personnel include but are not limited to: maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines; and, maintaining the building in good repair and free of hazards.		