

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Avir at Weston		STREET ADDRESS, CITY, STATE, ZIP CODE 2505 S 37th St Temple, TX 76504	
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on, interview and record review, the facility failed to ensure residents are offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet for 1 of 1 (Resident # 1) reviewed for nutrition and hydration: The facility failed to follow Resident #1's physician orders for enteral feeding. This failure could affect residents receiving enteral nutrition/hydration and place them at risk of health complications and decline in health. Findings include: Record review of Resident #1's face sheet dated, reflected an initial admission date of 6/02/2023 and a readmission date of 11/05/2024 with diagnosis that include UNSPECIFIED SEVERE PROTEIN-CALORIE MALNUTRITION (Deficiency of protein and energy intake), DYSPHAGIA (difficulty swallowing), GASTRITIS, UNSPECIFIED, WITHOUT BLEEDING (Inflammation of the stomach lining), CEREBRAL PALSY (Abnormal brain development or injury), VITAMIN D DEFICIENCY, IRON DEFICIENCY. Record Review of Resident # 1's MDS assessment dated [DATE], reflected a BIMS of 99. The assessment reflected Resident # 1 required extensive assistance with ADLs. Resident # 1's weight was 161 pounds, and the resident's nutritional approach was feeding tube and mechanically altered diet. Record review of Resident #1's Order summary report dated 01/29/2026 reflected a physician order to administer at bedtime Nutren 2.0 @65ML/HR Continuously for 10 hours (8P-6A), providing 1300 kcal, 55 gm protein, and 1650ml free water. The physical order had a start date of 11/26/2025 and no end date. Record review of Resident #1's weights from October 2025 to current reflected there was no weight loss for Resident # 1. Record review of progress note dated 1/28/2026 at 9:38am revealed the NP was notified that Resident #1's tube feeding was not done by night shift nurse. She ordered staff to encourage him to eat all his breakfast and to monitor any change in condition throughout day. Record review of meal intake dated 1/28/2026 reflected Resident #1 had eaten 75-100% of breakfast. In an Interview on 01/29/2026 at 1:15pm, the DON stated Resident #1 missed his nighttime tube feeding 1/27/2026 from 8pm-6am. She stated the night nurse did not give Resident # 1 his feeding. She stated the NP was notified and ordered staff to encourage Resident #1 to eat all his breakfast and monitor for any changes in his condition throughout the day. She stated her expectation was that the night nurse should have followed physician orders and given Resident #1 his nighttime tube feeding of Nutren 2.0 @65ML/HR continuously for 10 hours (8P-6A). She stated the potential risk of not following physician orders and not providing enteral feeding to a resident is weight loss or malnutrition. In an interview on 01/29/2026 at 3:20p.m., LVN A stated she did not follow physician orders for Resident #1 and failed to provide Resident #1's tube feeding of Nutren 2.0 @65ML/HR continuously for 10 hours (8P-6A) on 01/27/2026. She stated she got confused and thought Resident #1's feeding was to be done during the day shift. She stated that she should have double checked the physician orders. She stated that the potential risk of not following physician orders and not providing enteral feeding to a resident is the risk of malnutrition. She stated she has not worked in the facility since 01/27/2026 and had not received the in-service training yet. In an interview on 01/29/2026 at 5:23 p.m., the DON stated she</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675797
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was currently providing in-service training to staff over PEG tube, following physician orders and documentation. She stated to ensure Resident #1 did not miss anymore tube feedings, she was calling Resident #1's night nurse to ensure the tube feeding was done. She stated during the morning stand-up talks with staff she would remind them of tube feeding. In an Interview on 01/29/2026 at 5:42 p.m., LVN B stated he received in -service training over peg tube feeding, following physician orders, and documentation. He stated the negative outcome of not following physician orders and not providing tube feeding is the potential of weight loss. In an interview on 01/29/2026 at 6:00 p.m., LVN C she stated she received in -service training over PEG tube feeding, following physician orders, and documentation. She stated a negative outcome of not following physician orders and not providing tube feeding is the potential for weight loss and malnutrition. Record review of in-service records titled PEG tube, orders and documentation dated 01/29/2026 revealed LVN B, LVN #3 and DON completed the training. Record review of nutrition Risk assessment dated [DATE] at 10:02am reflected most recent weight of 168 pounds, Height of 64inches and BMI of 28.8. Record review of facility's current Enteral Nutrition policy and procedure dated November 2018 reflected Adequate nutritional support through enteral nutrition is provided to residents as ordered.</p>		