STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675797	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Weston	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to ensure each resident was treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 5 (Resident #1 and Resident #2) residents reviewed for dignity. The facility failed to ensure CMA A did not feed Resident #1 her medications from a pudding cup, while standing over her in the dining room on 4/7/26. The facility failed to ensure CNA B used person-centered language when she described Resident #2 as a feeder on 4/7/26. These failures could place residents at risk of shame and embarrassment.Findings included:Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female who originally admitted to the facility on [DATE], with a re-entry date of 01/06/2026. Her diagnoses included pneumonia, hemiplegia or hemiparesis (paralysis or severe weakness affecting one side of the body), Traumatic Brain Injury, seizure disorder, respiratory failure, dysphagia (difficulty swallowing), cognitive communication deficit. Her functional ability of eating indicated she needed setup or clean-up assistance. Resident #1 had a BIMS score of 08, indicating moderately impaired cognition. Review of Resident #1's care plan revealed she had an ADL self-care performance deficit r/t TBI with hemiplegia and required supervision/setup assistance from staff, initiated 2/13/23. Her care plan also indicated she had a swallowing problem related to complaints of difficulty or pain with swallowing, coughing, or choking during meals or swallowing medications, difficulty with thin liquids initiated 5/5/23. Review of Resident #2's comprehensive MDS assessment dated [DATE] reflected an [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included non-traumatic brain dysfunction, heart failure, Alzheimer's disease and seizure disorder. Her functional ability of eating indicated she needed setup or clean-up assistance. Resident #2 had a BIMS score of 03, indicating severe cognitive impairment. Review of Resident #2's care plan revealed she had an ADL self-care performance deficit r/t dementia and required substantial/maximum assistance from staff to eat, initiated 2/28/26.In an observation on 4/7/26 at 5:11 PM, CMA A was observed giving medication, while standing, to Resident #1, who was seated at a dining table in the dining room. CMA A was administering the whole medication using pudding, feeding Resident #1 the pudding until the cup was empty. In an interview on 4/7/26 at 5:15 PM CMA A stated it was not a typical practice to administer medications to residents while standing, and in the dining room during mealtimes. She stated she had been unable to locate Resident #1, so when she saw Resident #1 in the dining room, she decided to administer the medication, but that she should have been seated next to Resident #1 out of respect, until the entirety of the medication/pudding was administered.In an interview on 4/7/26 at 5:25 PM, CNA B stated that Resident #2 had already been fed, and she had fed Resident #2 because she was a feeder. CNA B acknowledged that was not a term she should have used to describe a resident, and that she should have used a more respectful term because that was not a dignified way to talk about a resident. In an interview on 4/7/26 at 9:25 PM, RN D stated staff should not be standing up while administering a medication that was given by way of food (pudding cup) or standing while feeding a resident. She stated typically staff should not be passing medications during meals, unless ordered, but it could also be a resident preference. She stated that (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was a dignity issue to refer to residents as feeders because if residents, visitors, or family heard that it could upset them. In an interview on 4/8/26 at 2:20 PM, the ADM stated he began working at the facility on 2/9/26. He stated that staff should not be addressing residents by their diagnoses, and they should not be referring to residents as feeders, and it was important for dignity purposes, staff should not say personal information that others could hear. He stated that it could make someone feel ashamed, or embarrassed.Review of the facility's policy titled Dignity dated February 2021 reflected, .8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record reviews and interviews, the facility failed to ensure the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week and have a designated full time Registered Nurse to serve as the Director of Nursing on a full- time basis for 1 of 1 facility's reviewed for nurse staffing.1. The facility failed to have the services of an RN for 8 consecutive hours on 10/11/25, 10/12/25, 11/09/25, 11/22/25, 11/23/25, 11/27/25, 12/11/25, 12/14/25, 1/17/26, 1/18/26, 2/7/26, 2/8/26, 2/13/26, 3/1/26, 3/15/26, 3/24/26, 3/25/26, 3/27/26, 3/28/26, 3/29/26, 3/30/26, 3/31/26. 2. The facility failed to ensure they had a full-time DON licensed in Texas from 3/20/26-4/08/26.3. The facility failed to ensure a separate RN-serving as the charge nurse, was on duty for 8 consecutive hours on 1/2/26, 1/3/26, 1/4/26, 1/7/26, 1/8/26, 1/12/26, 1/13/26, 1/16/26, 1/20/26, 1/21/26, 1/22/26, 1/26/26, 1/27/26, 2/1/26, 2/9/26, 2/13/26, 2/16/26, 2/18/26, 2/20/26, 2/27/26, 3/4/26, 3/5/26, 3/16/26, 3/18/26, 3/20/26, when they utilized their DON as their RN on duty, and their census was above 60 residents. These failures could have placed residents at risk of not receiving adequate care or monitoring of staff that required the supervision or decision making of an RN. Findings included: Record review of the facility's FY Quarter 1 CASPER report revealed a trigger for No RN Hours for the following dates: 10/11/25, 10/12/25, 11/09/25, 11/22/25, 11/23/25, 11/27/25, 12/11/25, 12/14/25. Record review of the facility's timesheets for direct care staff payroll hours for the period from 10/11/25-12/14/25 revealed no evidence for the services of an RN for 8 consecutive hours on 10/11/25, 10/12/25, 11/09/25, 11/22/25, 11/23/25, 11/27/25, 12/11/25, 12/14/25. Record review of the facility's use of agency personnel revealed no RN's were utilized through an agency for shiftwork on 10/11/25, 11/09/25, 11/22/25, 11/23/25, 11/27/25, 12/11/25, 12/14/25.Record review of the facility's timesheets for direct care staff payroll hours for the period from 1/1/26 through 3/31/26 revealed no evidence for the services of an RN for 8 consecutive hours, on: 1/17/26, 1/18/26, 2/7/26, 2/8/26, 2/13/26, 3/1/26, 3/15/26, 3/24/26, 3/25/26, 3/27/26, 3/28/26, 3/29/26, 3/30/26, 3/31/26. Record review of a posted daily staffing sheet dated 3/27/26 with the facility name in the top right corner, revealed that for (RN) 6a-6p-0 Total Hours, 6p-6a-0 Total Hours indicated. In an interview on 4/7/26 at 6:59 PM with the ADM, he stated they had hired a DON who lasted for approximately 4 days, and they were currently in the process of interviewing for a new DON. He stated the CRN had been providing assistance to the facility, as well as serving as the infection preventionist, but was not serving as the DON, nor did they have an interim DON.In an interview on 4/7/26 at 8:36 PM the CRN stated that she was not serving as the facility's DON, rather she was overseeing the clinical systems to ensure things did not fall apart. She stated that she had physically been in the building on 3/20/26, 3/23-3/27/26, 3/30/26, 4/1-4/3/26, and 4/6/26. She stated prior to her being in the building there was a full-time DON employed. She stated that the only services she could think of that would not be provided because of no RN coverage onsite would be staging a wound. She stated that LVN's provided wound care at the facility and could administer IV medications.In an interview on 4/7/26 at 9:04 PM, LVN E stated she was an agency LVN, and she last worked at the facility about a month ago. She stated that not having an RN on duty did not affect her work, because she could call the RN. She stated she would be able to conduct assessments, and if it was something unusual, she would call the on-call NP. She stated if an RN was needed during her shift, she would just call them, and that it was just a nice comfort to have an RN there in person versus having to contact them. She stated she had not had any situations where she needed an RN or the DON onsite, they were always available by phone. In an interview on 4/7/26 at 9:25 PM RN D stated the RNs would do admission assessments and the LVN's were capable of doing other assessments. She stated initial education should be given by an RN, such as medication administration and then an LVN could do education after the initial RN education. She stated she reiterated to residents about using their call lights. She stated there had not been any new admits (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the shifts she has picked up at this facility. She stated that a lot of times residents feel more confident, respected, or heard when they could request an RN and the RN goes to their room and gets what they need or supports them. In an interview on 4/8/26 at 10:47 AM the SC stated that she had worked at the facility for about 5 years and had been the SC for 1 year. She stated her responsibilities included staffing the building. She said if the facility was short staffed, she would work a shift as a CNA, as she was also a CNA. She said she also ensured the daily staffing sheets were filled out, and posted, kept up with absences, monitored the floors, and provided some training and competency check offs with CNA's. She stated the RN coverage was for supervising LVN's, CNA's, medication administration, breaks, and making sure everyone were doing what they were supposed to do, and making sure everyone was safe. She stated that the LVN's could pass medications, administer g-tube and peg tube medications, conduct skin assessments, and did charting. She stated they had a DON, and on 3/27/26 and 3/28/26 the facility did not have a DON. She said there were only LVN's, who were serving as charge nurses. She stated no RN had filled in for the DON since her departure on about 3/20/26. She stated the CRN physically worked in the building after the DON quit. She stated that they had just started utilizing agency RNs about 2 weeks ago. She stated if there was not an RN in the building, they could call the CRN and let her know. She stated a negative impact to residents could be that they did not feel confident in reporting their concerns due to there not being an RN supervisor. She stated nursing concerns were reported to the CRN. In an interview on 4/8/26 at 2:20 PM, the ADM said he began working at the facility on 2/9/26. He stated that he would be made aware that the facility would not have an RN on duty for at least 8 consecutive hours a day in the morning meetings daily where they went over staffing with the SC. They had realized that they skipped a couple days of reviewing staff once the DON left, but since then they had made sure they were doing everything they could to get an RN scheduled through agency. He stated he did not know if the company had a policy on having an RN serve as the DON when the facility was without one. When asked how often there were days, they had no RN available to provide care for residents, He stated that he was aware of 3/27/26 and 3/28/26 of days they had no RN on duty to provide care to residents. However, they had identified days from 2025 as well. He stated that PASRR care plan meetings had to have an RN present, and that they had about 10 PASRR positive residents, and did not identify any delays in PASRR care plans at the time. He stated that none of the care currently being provided in the facility was only doable by an RN.Review of the facility assessment dated 2026 revealed their overall staffing needs included 1 RN providing direct care. 2 RN's available to provide direct care-including DON and RNs with administrative duties. A staff to resident ratio of 1 RN to 30 residents, a RN coverage of 8 hours.