STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675858	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Heritage	5437 Eisenhauer Road San Antonio, TX 78218

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure, in accordance with accepted professional standards and practices, complete, accurately documented, readily accessible, and systemically organized medical records for 2 of 5 residents (Residents #1 and #2) reviewed for accurate records. 1. The facility failed to document wound care treatments for Resident #1 for two days - 05/22/2026 and 05/23/2026. 2. The facility failed to document wound care treatments for Resident #2 for one day - 05/31/2026. These failures placed residents at risk for untreated or unmanaged wound care by inaccurate and missing records documentation. Findings included: 1. Record review of Resident #1's face-sheet revealed the resident an 86year-old, Female; with an admission date to the facility of 05/21/2026. Record review of Resident #1's Orders for May 2026 revealed diagnoses which included: muscle weakness (A lack of muscle strength), unspecified dementia without behavioral disturbance (A Neuro Developmental disorder without physiological conditions), and hypertensive chronic kidney disease (The kidneys are not working properly and are beginning to lose their function). Further review revealed an order, Coccyx: Cleanse with wound cleanser, Wound care: Coccyx: Cleanse with wound cleanser, Verbal Active, with a start date of 05/22/2026. Record reviewed of Resident #1's TAR for May 2026 revealed wound care treatments were not documented as completed for the wound to the resident's coccyx on 05/22/2026 and 05/23/2026. Observation on 06/03/2026 at 2:55 p.m. revealed Resident #1 was awake and alert and lying in bed. During an interview with Nurse B (Wound Care Nurse) on 06/04/2026 at 6:53 p.m., regarding the missing wound care documentation dated 05/22/2026 revealed Nurse B (Wound Care Nurse) completed wound care for Resident #1's coccyx. Nurse B (Wound Care Nurse) stated, I do all my patients' wound care first and then I sign. I probably forgot or something. I don't remember. Nurse B (Wound Care Nurse) B stated if wound care was not completed, the resident's wound could worsen and the resident could be at risk for infection. Nurse B (Wound Care Nurse) further stated, I expect the nursing staff to complete wound care according to physician orders and accurately document completion of treatments provided. Nurse B (Wound Care Nurse) acknowledged failure to complete, and document wound care could negatively affect wound healing and increase the risk of infection. 2. Record review of Resident #2s face-sheet revealed the resident was admitted to the facility on [DATE]. The resident was an ([AGE] year-old) male. Record review of Resident #2's physician orders, dated 05/25/2026, revealed wound care treatments for multiple areas: coccyx, left heel, left lateral foot, left medical foot, and right rear thigh to be cared for daily.- Wound care: Coccyx: cleanse with wound cleanser, pat dry, apply zinc oxide and Iota. one time a day, with a start date of 05/26/2026.- Wound care: L heel: Cleanse with ns, pat dry, add calcium alginate, wrap with ker1ix and secure with tape. one time a day, with a start date of 05/29/2026. Record review of Resident #2's TAR for May 2026 revealed wound care treatments scheduled for 05/31/2026 were not documented as completed. Further review revealed there was no documentation of the resident refusing the wound care treatments. Observation conducted on 06/03/2026 at 2:18 p.m. revealed Resident #2 was lying on his bed sleeping with the covers pulled up to his chin. The resident appeared clean, the bed was clean and dry, and the call light was clipped to the resident's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blanket within reach. Resident #2's wounds were not observed, and the wound care nurse was not present at that time. During an interview with Nurse A on 06/03/2026 at 2:31 p.m., Nurse A revealed Resident #2 was receiving hospice services. Nurse A stated the resident slept frequently, experienced shaking and seizures when stimulated, and required extensive assistance with care. Nurse A stated the resident's spouse visited daily and was actively involved in his care. During an interview with the DON on 06/04/2026 at 4:54 p.m., the DON stated treatment refusals were expected to be documented and reported according to facility policy. The DON confirmed the absence of documentation prevented verification that physician-ordered wound care treatments were completed as ordered on the identified dates. During an interview with Nurse A on 06/04/2026 at 7:03 p.m. regarding the missing wound care document dated 05/31/2026, Nurse A stated hospice staff had performed the wound care treatment for Resident #1 on 05/31/2026. Nurse A stated, I should have documented that. Nurse A further stated failure to provide wound care could result in worsening wounds, infection, and deterioration of the resident's condition. Record review of the facility's policy titled, Charting and Documentation, dated 2001, revealed, all services provided to a resident and the resident's response to care were to be documented in the resident's medical record. The policy further directed documentation of procedures and treatments including the date and time the treatment was provided. The name and title of the individual providing the care, assessment findings, resident response to treatment, treatment refusals, notifications made as indicted, and the signature and title of the individual documenting the care. Record review of the facility's policy titled, Wound Care, dated 2001, revealed, wound care documentation was to include the date wound care was provided, the initials of the individual performing the wound care, any changes in the resident's condition, resident complaints related to the procedure, whether the resident refused the procedure, and the signature and title of the individual documenting the care.