STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675862	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Park Bend	2122 Park Bend Dr Austin, TX 78758

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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
	675862	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Park Bend	2122 Park Bend Dr Austin, TX 78758

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 (Resident #1) of 5 residents had the right to be treated with respect and dignity.CNA A did not provide Resident #1 with a shower when he asked to be assisted with a one.This failure placed the residents at risk of not receiving the care and services to meet their needs, and therefore not respecting their dignity. Findings included:Review of an undated face sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included a nontraumatic cerebral hemorrhage in the cortical hemisphere (bleeding in the brain without external injury), chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe), heart failure, hyperlipidemia (elevated cholesterol in the blood) , atrial fibrillation (irregular heart rhythm), metabolic encephalopathy (brain's function that is affected by body's metabolism), convulsions, cerebral infarction (stroke), dysphagia (difficulty swallowing), presence of a cardiac pacemaker, presence of a prosthetic heart valve, dementia, and adjustment disorder with depressed mood.Record review of Resident #1's Quarterly Minimum Data Set Assessment, dated 09/05/25, reflected a BIMS score of 8, which indicated moderate cognitive impairment. Resident #1 used a manual wheelchair for mobility and was dependent on staff for all of his activities of daily living, including showers, incontinent care, and chair/bed-to-chair transfers (including a wheelchair). Record review of Resident #1's Care Plan, dated 08/07/25, reflected,Focus: Resident #1 has an ADL self-care performance deficit related to intracerebral hemorrhage, chronic obstructive pulmonary disease, hypertension, congestive heart failure, atrial fibrillation, encephalopathy, Transient ischemic attacks (stroke) and benign prostatic hypertrophy(enlarged prostate gland). Interventions: Resident #1 required limited to extensive assistance with one staff member with showers and provide a sponge bath when a full bath or shower cannot be tolerated.A telephone interview on 11/19/25 at 2:45 PM with Resident #1's RP revealed the facility was not providing his care, and Resident #1 smelled like urine when coming back from a doctor's appointment. The RP stated Resident #1 had not been taking showers which should be every other day or three times per week. She further stated Resident #1 told her facility staff did not shower him because he was too difficult to shower. The RP stated she did not have proof of this, but she had observed him being smelly. An observation on 11/20/25 at 10:30 AM of Resident #1 revealed him sitting up in his wheelchair in his room. Resident #1 was wearing a white T-shirt and blue shorts. There was a strong urine-type of odor near the resident and the bed. In an interview on 11/20/25 at 10:30 AM with Resident #1, he said the staff were not giving him a shower that day. He stated he had urine on the bed, and on his clothing. He stated they had changed the bed, but he had not been changed or showered. Resident #1 stated the lady in charge (couldn't recall her name) was mean and ugly as hell and treated other people the same way. Resident #1 stated he asked for a shower that morning, and CNA A told him it was not his day for a shower, and that he got showers on Mondays, Wednesdays, and Fridays. Resident #1 further stated CNA A told him he should have taken a shower on his scheduled day. Resident #1 stated he could not even go to the dining room without feeling dirty and smelling like urine. Resident #1 stated it made him feel like he was a nobody, and he felt neglected.Review of Resident #1's Shower Sheet dated 11/20/25, reflected he had received a shower on 11/16/25, 11/18/25, and 11/19/25.In an interview on 11/20/25 at 3:50 PM with the DON, she said Resident #1's shower should have been done, and that was unacceptable, especially since he had an odor. The DON said the policy for providing showers to the residents included three scheduled shower days, three times per week. She further stated if a resident was requesting a shower off cycle, they should be getting that done for the residents. The DON stated the CNAs, the charge nurse, and herself were responsible for ensuring residents were clean and groomed. She further stated it was important to assist the residents with getting their showers to keep their skin clean, for their dignity, hygiene, and health. She started the resident could feel uncared for, unworthy and unkempt, and these feelings could spark anger and depression. The DON stated she was ultimately responsible for monitoring to ensure that staff were providing ADL care to the residents, and stated she pulled reports and talked to the residents during rounds. She stated she did not know why a resident would have been left in dirty clothing and had an odor. She stated if a resident were asking for a shower off cycle, the staff should have brought it to her attention, and she could have provided the shower to Resident #1 herself. The DON stated that by the end of the day shift, CNA A had given Resident #1 a shower, but that should have been done in a timelier manner. Review of the facility's Policy & Procedure on Resident Rights, dated February 2021, which reflected, Policy StatementEmployees shall treat