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	02/11/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure 1 (Resident #2) of 4 residents reviewed for Resident Rights was treated with respect and dignity. Resident #2 stated she felt that she was being labeled here for being bipolar. Resident #2 stated she had been getting high anxiety all over her body, had a lot of crying, and she had been picking at a place on her chin to [NAME] come and could not stop. Resident #2 said she felt as if it was her responsibility to speak in Spanish to MA E to show her respect since that was MA E's preferred language. These failures can lead to residents feeling like their rights were not being respected. Findings included: Record review of Resident #2's undated face sheet reflected a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses of dementia, insomnia, anxiety disorder, hyperlipidemia (high blood fats), difficulty in walking, post-traumatic stress disorder, cognitive communication deficit, bipolar disorder, and hypertensive heart disease. Further review revealed Resident #2's primary language was English. Record review of Resident #2's Quarterly MDS Assessment, dated 11/26/2025, reflected a BIMS Score of 15, which indicated the resident had a mild cognitive impairment. Resident #2 required two people to assist with her activities of daily living (ADLs), and she required transfer from bed to chair to bed with one person assist and her mechanical wheelchair. An observation and interview on 02/05/26 at 12:13 PM of Resident #2 revealed her hands trembling while she was stating, I feel that I am being labeled here for being bipolar. Resident #2 stated she had been getting high anxiety all over her body, a lot of crying, and she had been picking at a place on her chin to [NAME] come and cannot stop. She stated she was peeling layers off the skin on her chin. Resident #2 stated her anxiety levels were high due to issues with her medication changes, and all the confrontation between her RP and the facility. Resident #2 stated MA E only spoke to her in Spanish. Resident #2 felt she had to speak in Spanish to MA E to get her medications. Resident #2 said she felt as if it was her responsibility to speak in Spanish to MA E to show her respect since that was MA E's preferred language. Resident #2 stated did not know that one of her resident rights was to be spoken to in her primary language. Resident #2 further stated she does not want to upset anyone and will continue to speak to MA E in her preferred language so that she can have her pain medications when she asked for them. Resident #2 stated she had spoken to the Administrator and the DON about her concerns, but she did not remember when she had talked to them. An interview on 02/05/2026 at 11:30 AM with MA E revealed the residents had a right to be spoken to in their preferred language. MA E further stated she would not talk to a resident in a language they were not comfortable speaking. An interview on 02/10/26 at 3:40 PM the ADON stated Resident #2 came to visit her often and to confide in her. The ADON stated she had not witnessed anyone in the facility yelling at or mistreating Resident #2. She stated the other day Resident #2 came to her and stated she thought nobody in the facility liked her. The ADON stated she told Resident #2 she had a right to her feelings and perceptions, and that she liked Resident (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2. ADON stated the residents had the right to exercise their rights while they were in the facility, and that speaking to residents in their preferred language was one of their rights. A review of the facility's Policy and Procedure on Notice of Resident Rights and Responsibilities, dated 03/2017 reflected, Policy StatementOur facility shall inform the resident both orally and in writing of his or her rights as a resident, and the rules andregulations governing the resident's conduct and responsibilities during his or her stay in the facility.Policy Interpretation and Implementation5. Our facility will inform the resident of his or her rights and responsibilities in a language that is understandable to the resident. If the resident has limited English proficiency, his/her rights and responsibilities will be presented in the resident's primary language.6. For foreign languages commonly encountered in our community the facility will provide the resident with written translations of his or her rights and responsibilities. If the foreign language is not common to our community, such rights may be communicated orally through a competent interpreter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #1) reviewed for infection control. Facility staff failed to recognize infection control protocol for EBP and Contact precautions for Resident #1. The facility failed to ensure CNA C disinfected the mechanical lift before taking it out of Resident #1's room. The facility failed to ensure CNA C put on a gown and conduct handwashing/hand hygiene between glove changes when providing peri-care to Resident #1 These failures could place the residents at risk of infection transmission, poor wound healing, and hospitalization.Findings included: Record review of Resident #1's undated face sheet dated 2/5/26 at 10:41 am reflected a [AGE] year-old male who admitted to the facility on [DATE] and was re-admitted on [DATE]. He had diagnoses of intracranial injury with loss of consciousness of unspecified duration (traumatic brain injury), abdominal hernia without obstruction or gangrene, chronic pain syndrome, presence of cardiac pacemaker, hemiplegia affecting left nondominant side, major depressive disorder, hypothyroidism, chronic kidney disease, dysphagia (difficulty swallowing), bacterial infection, and schizophreniform disorder. Record review of Resident #1's Quarterly MDS Assessment, dated 12/31/2025, reflected the resident had a BIMS Score of 11, which indicated the resident had a mild to moderate cognitive impairment. Resident #1 required two people to assist with all of his activities of daily living (ADLs), and he required transfer from bed to chair to bed with two people and a mechanical lift. Resident #1 had a diagnosis of bacterial infection. Resident #1's MDS further reflected he did had an open lesion other than ulcer, rashes or cuts. Record review of Resident #1's undated Care Plan reflected a focus area of actual impairment to skin integrity of the right breast related to cellulitis, infection of soft tissue. The goals reflected Resident #1 will have no further complications related to open wound of the right breast/axilla area through the review date. The interventions included:*Monitor for side effects of the antibiotics and over-the-counter pain medications such as gastric distress, rash, or allergic reactions which could exacerbate skin injury*Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to MD.Resident #1's Care Plan also reflected a focus area of ADL self-care performance deficit related to dementia, hemiplegia, impaired balance and traumatic brain injury. The goal reflected Resident #1 would maintain current level of function through the review date. The interventions reflected Resident #1 required total assistance of two people for all of his ADL care. Record review of wound culture order dated 08/27/2025 revealed a culture was ordered to wound but did not specify location of wound. Record review of wound culture resulted 09/02/2025 at 8:30 AM revealed report contains critical results site: right flank/ Organism Escherichia coli and methicillin resistant staphylococcus aureus. Record review of Resident #1's contact precaution order dated 09/02/2025-09/07/2025 revealed that all services including treatments, activities, showers, and meals, have been received in the resident's private room d/t strict isolation/contact precautions ordered by DR Record review of Resident #1's contact precaution order dated 10/28/2025 revealed contact isolation precautions due to MRSA infection to wound in right flank area. ordered by DR. Record review of Resident #1's EBP Order dated 10/28/2025 Order end date: Indefinite, revealed ENHANCED BARRIER PRECAUTIONS every shift. ordered by DR. Record review of Resident #1's EBP Order dated 11/11/2025 Order end date: Indefinite, revealed EBP: Staff must use gown and gloves during high- contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Enhanced barrier precautions are (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommended for residents known to colonize or are infected with a MDRO as well as those who are not confirmed to have MDRO. ordered by DR Record review of Resident #1's physician order start date 11/11/2025 revealed EBP precautions to include gloves and gown during high-contact resident care with an end date of indefinite. ordered by DR Observation of video dated 08/18/2025 at 9:27 AM Staff member wiped Resident #1's fungal area (that was later diagnosed as MRSA) then used same wipe to clean the rest of Resident #1's body. Observation of video dated 09/03/2025 at 7:14 PM unidentified staff members applied cream to both sides of Resident #1's face. Wound to right side checked bandage intact. Staff were wearing gloves and masks, not a gown. Observation of video dated 09/04/2025 at 10:08 AM unidentified staff members wore gloves for Resident #1's incontinent care and applies patch without changing gloves. Observation of video dated 09/05/2025 at 3:31 PM an unidentified staff member took the trash can from floor and sat it on Resident #1's sheets during incontinence care. The same gloves were used to make bed after incontinence care. The mechanical lift was taken outside of the room without being cleaned. This staff member did not wear a gown and wore gloves outside of room after incontinence care provided. Observation of video dated 09/05/2025 at 8:43 AM No gowns during Resident #1's incontinence care. Observation of video dated 09/06/2025 at 9:18 AM revealed no gowns are worn while changing resident's clothes. Observation of video dated 09/06/2025 at 11:44 AM revealed unidentified staff wore no gowns during Resident #1's wound care to right side. Male nurse carried tray with wound care supplies out of room wearing same gloves used for wound care. Observation of video dated 09/10/2025, nurse provided wound care used marker from pants and replaced the marker back to pants after using on Resident #1's wound bandage without cleaning marker. He did not change gloves and walked out of room with trash in his hand from wound care and a tray. He did not change gloves, wipe down tray or the marker used. Observation of video dated 10/29/2025 at 9:33 AM nurse provided Resident #1's wound care on bedside table and does not wipe down table prior to leaving the room. DR touches remote to bed, bedside table, and drinking glass with gloves that she used to examine the wound. Observation of video dated 10/29/2025 at 7:48 AM revealed unidentified staff provided Resident #1's incontinence care without a gown. Observation of video dated 10/30/2025, at 3:53 PM revealed unidentified staff provided Resident #1's incontinence care provided with gloves only. Observation of video dated 10/31/2025 at10:08 AM revealed unidentified staff provided Resident #1's incontinence care with gloves then applies pain patch with same gloves. Observation of video dated 11/01 2025 at10:32 AM an unidentified staff member wore no gowns during Resident #1's wound care and did not take off gloves before leaving the room after wound care. She also did not clean down the bedside table used during wound care. In an observation on 02/05/2026 at 10:53 AM Resident #1's door and area next to door was without an EBP sign. An observation on 02/05/2026 at 2:25 of peri-care for Resident #1 revealed CNA C did not conduct handwashing/hand hygiene and did not put on a gown prior to providing peri-care. After cleansing the peri-area, CNA C removed soiled gloves and did not conduct hand hygiene before putting on clean gloves. She proceeded to cleanse Resident #1's bottom, removed the soiled brief and placed it in the trash can. CNA C removed soiled gloves and did not conduct hand hygiene before putting on clean gloves. She then applied skin barrier to Resident #1's bottom. CNA C removed soiled gloves and did not conduct hand hygiene before putting on clean gloves. She then put a clean brief on Resident #1, provided repositioning with pillows, reapplied his left foot/lower leg boot and put a clean blanket over him. Interview on 02/10/26 at 2:57 PM the DR stated Resident #1 had developed an abscess on his right flank that was treated with doxycycline until closed and healed. She stated on healing the wound had sealed on the outside, but there was some infection on the inside, so it had re-opened. The DR stated Resident #1 had been seen by wound care physician and was treated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Bactrim, and to date the wound has not returned or opened up. The DR stated there had not been any other wounds. The DR stated Resident #1 was not colonized with MRSA and did not require Enhanced Barrier Precautions at this time, since his wound had healed. The DR then gave the DON verbal orders to discontinue Enhanced Barrier Precaution orders, dated 02/10/26. An observation on 02/05/2026 at 3:01 PM of Resident #1's transfer to bed with a mechanical lift revealed CNA C did not disinfect the mechanical lift before taking it out of the room. An interview on 02/05/2026 at 3:14 PM CNA C revealed she knew she should have washed her hands and used sanitizer between glove changes, but she did not have hand sanitizer with her during the care. She stated she did not have the hand sanitizer because she had been trying to get Resident #1's weight when he was in the mechanical lift and stated LVN B was trying to leave after his shift. CNA C stated she had forgotten to disinfect the mechanical lift before removing it from Resident #1's room. CNA C stated she did not think she needed to put on a gown when providing care to Resident #1 at this time. She stated she had received training on Infection Control, wearing a gown with precautions, and handwashing/hand hygiene each month. CNA C stated not conducting hand hygiene when providing resident care and between glove changes and not wearing a gown when there were precautions could lead to the spread of infection between residents. An interview on 02/10/26 at 3:40 PM with ADON who stated when Resident #1 had first developed the wound to his right flank, it was treated as an abscess. We did not have contract with [company], so he went to outside wound care, which is when we received communication for MRSA. His PCP started him on an antibiotic and wound care. The wound re-opened and we started another ABT and isolations. Then we had [company], and once the wound healed he should have been taken off isolation. The ADON stated all staff should conduct handwashing/hand hygiene when gloves were changed. She stated the policy on Hand Hygiene was to always conduct handwashing/hand hygiene when providing care for residents, and when changing from soiled to clean gloves. She stated she had conducted an in-service on EBP and hand hygiene in January 2026. The ADON stated a consequence of staff not following all infection control precautions and handwashing/hand hygiene was transferring infection from one resident to another, resident to another staff member or to yourself. An interview on 02/11/2026 at 11:30 AM with the ADM revealed he had been trained on Infection Control. He stated the training included the importance of conducting hand hygiene/handwashing when providing care to residents, when changing gloves, and to strict handwashing when suspected Norovirus, as hand sanitizer did not kill this virus. The ADM stated he took this training in April 2025, the CDC Infection Preventionist training. He stated the policy for hand washing when providing care included when staff should wash their hands, such as when picking up food trays, when entering and leaving a resident room, high contact touch areas, and when changing their clothing. He stated all staff, residents, and visitors should be washing their hands to help prevent the spread of infection. He further stated a negative outcome of staff not doing proper hand hygiene could be an outbreak of an infection. He stated the DON and the ICPC nurse monitor to ensure all staff were washing their hands, along with monthly in-services on Infection Control and hand hygiene. A record review of policy Handwashing/Hand Hygiene dated 01/2025, revealed the following relevant information: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Administrative Practices to Promote Hand Hygiene1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand-hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policies. Alcohol-based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility.Indications for Hand Hygiene1. Hand hygiene is indicated:a. immediately before touching a resident;b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device);c. after contact with blood, body fluids, or contaminated surfaces;d. after touching a resident;e. after touching the resident's environment;f. before moving from work on a soiled body site to a clean body site on the same resident; andg. immediately after glove removal.2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations.4. Single-use disposable gloves should be used:a. before aseptic procedures;b. when anticipating contact with blood or body fluids; andc. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions.5. The use of gloves does not replace hand washing/hand hygiene.A record review of the facility's policy titled Isolation - Initiating Transmission-Based Precautions dated 03/28/2025 reflected, Policy Statement - Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents.Transmission-based precautions may include contact precautions, droplet precautions, or airborne precautions.The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. A record review of the facility's policy titled Infection Control - Surveillance for Infections dated 01/2025 reflected, To maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public and To prevent, detect, investigate, and control infections in the facility.