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	04/29/2026

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 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 observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 3 residents (Resident #1) reviewed for privacy.The facility failed to ensure CNA A provided privacy by closing the door and drawing the privacy curtain during incontinent care for Resident #1.This failure could place residents at risk of lack of privacy and not having residents' rights acknowledged.The findings include:Record review of Resident #1's face sheet, dated 04/29/26, reflected Resident #1 was admitted on [DATE]. She was an [AGE] year-old female diagnosed with fracture of the right femur(thigh bone), dementia, adult failure to thrive and gastro-esophageal reflux .Record review of Resident #1's initial MDS dated [DATE] reflected a BIMS score of 03 indicating her cognition was severely impaired . Further review revealed she needed complete support with toilet hygiene.Record review of Resident #1's care plan dated 03/26/26 reflected that she had an ADL self-care performance deficit r/t Dementia, Impaired balance, Right femur fracture and failure to thrive. The relevant intervention was assistance by one staff member with personal hygiene.During an observation and interview on 04/29/26 at 1:50pm CNA A had provided incontinent care to Resident #1 in her room. CNA A did not close the door or draw the privacy curtain fully during the incontinent care. The incontinent care would have been fully visible to anyone who entered the room during the incontinent care.During an interview conducted on 04/29/26, at 2:00 p.m. Resident #1 said that she believed CNA A had performed the care satisfactorily and that she was pleased with the service. She further noted that she did not observe whether the privacy curtain was fully closed nor whether the door to her room was shut. Resident #1 was unable to comprehend and answer whether she will feel comfortable if an unidentified bystander observes her during personal care activities.In an interview on 04/29/26 at 2:20pm, CNA A reported having over one year of experience as a CNA. He said that incontinent care was a routine part of his responsibilities since the beginning of his career. CNA A stated that it was a mistake that the door and privacy curtain were not fully closed. He explained that he believed it was acceptable to keep the curtain partially closed since the peri care was not visible to Resident #1's roommate , but he recognized that leaving the door open was inappropriate. On further discussion, CNA A stated that the open door with the privacy curtain in partly opened position allow visibility of the peri care to anyone entering the room. He said that his neglect compromised Resident #1's right to privacy and dignity during the incontinent care.During an interview on 04/29/26, at 3:30p.m, the DON stated that it was mandatory to respect and uphold residents' privacy and dignity during nursing care, including incontinent care, by closing doors, windows, and privacy curtains. The DON stated that the door and privacy curtain of Resident #1 should have been fully closed prior to initiating care. He expressed the belief that Resident #1's privacy was not compromised since no unauthorized persons observed the procedure. He added, however, there was a possibility of violating privacy if anyone entered the room during the incontinent care. The DON also noted that resident rights were part of ongoing staff training and that all nursing staff were required to complete an annual evaluation to ensure their competence in respecting residents' rights and maintaining proper nursing practices.Record review facility policy Resident Rights revised in February 2021 reflected: Employees shall treat all residents with kindness, respect, (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	and dignity.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:A) dignified existence.t) privacy and confidentiality.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 4 residents (Resident #2 and Resident#3) reviewed for respiratory care.The facility failed to ensure the nebulizer masks and tubing of Resident #2 and Resident #3 were stored safely in protective bags.This failure placed residents at risk for respiratory infections through contamination. Findings included:Record review of Resident #2's face sheet dated 04/29/26 reflected Resident #2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. He was a [AGE] year-old male diagnosed with heart failure, dementia, acute and chronic respiratory failure, abscess of lung without pneumonia, chronic kidney disease and obesity.Record review of Resident #2's annual MDS dated [DATE] reflected a BIMS score of 13 indicating his cognition was intact. Further review revealed he was on oxygen therapy for respiratory issues.Record review of Resident #2's care plan dated 11/26/25 reflected that he had altered respiratory status/difficulty breathing r/t hyper capnic (elevated CO2 level in blood) respiratory failure. The relevant intervention was administering medication/puffers as ordered and monitoring for effectiveness and side effects.Record review of Resident #2's physician's order reflected : Arformoterol Tartrate Inhalation Nebulization Solution 15 MCG/2ML (Arformoterol Tartrate): 1 vial inhale orally via nebulizer two times a day for COPD. -Start Date-04/09/2026Record review of Resident #3's face sheet, dated 04/29/26, reflected Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. He was a [AGE] year-old male diagnosed with COPD(difficulty in breathing), heart failure, dementia, acute kidney failure and adult failure to thrive.Record review of Resident #3's annual MDS dated [DATE] reflected a BIMS score of 14 indicating his cognition was intact. Further review revealed he was on oxygen therapy for respiratory issues. Record review of Resident #3's care plan dated 04/02/25 reflected that he had COPD and relevant intervention was administering aerosol or bronchodilators as ordered and monitoring/documenting any side effects and effectiveness.Record review of Resident #3's physician's order reflected : Plastic tubing must be kept in a plastic bag attached to the concentrator or nebulizer. Check every shift for infection control. -Start Date- 07/10/2025During an observation and interview with RN B on 04/29/26 at 1:35 PM, it was noted that the nebulizers for Resident #2 and Resident #3 were placed on their side tables. The tubes and masks of the nebulizers were laid openly on the tables, not stored in protective bags, exposing them to the open atmosphere. Specifically, the mask and tubing for Resident #2 were among the resident's other belongings, and a urine bottle containing urine was positioned beside Resident #3's nebulizer mask. RN B, immediately removed the unprotected masks and tubes, stating that they should have been stored in protective bags. She explained that if the equipment was not protected from external environmental factors, there was a risk of cross-contamination and microorganism colonization, which could lead to serious respiratory and other infections. RN B emphasized that it was the nurses' responsibility to ensure proper storage of respiratory equipment in protective bags. She stated , as the charge nurse on that day, she acknowledged that she should have identified this noncompliance and corrected it immediately.In an interview conducted on 04/29/26 at 3:30 p.m., the DON stated that nebulizer masks, tubing, and oxygen nasal cannulas should be cleaned and stored in a clean protective bag after use. He explained that this practice was intended to minimize the risk of respiratory infections caused by contaminated equipment. The DON further clarified that it was the nurses' responsibility to ensure this process was completed after medication administration. He noted that residents sometimes remove their equipment and forget to replace it in the protective bags, highlighting the importance of regular rounds by nursing staff to verify proper storage of respiratory devices.Record review of the in-service since [DATE] revealed there were no in services on safe handling of respiratory equipment.Review of the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policies on 04/29/26 revealed there were no policies available on safe storage of nebulizer mask and tubes after medication administration.