STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675878	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Grand Saline	1638 Vz Cr 1803 Grand Saline, TX 75140

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 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 interview and record review, the facility failed to ensure 1 of 3 residents (Resident #3) and her representative were informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment alternatives or treatment options and to choose the alternative or option he or she prefers. The facility failed to inform Resident #3 and her responsible party in advance about changes made to the physician orders involving insulin dosing and monitoring of blood sugar levels. This failure could place residents at risk of not being informed of changes to their treatment plan and the opportunity to direct his or her own medical treatment. Findings included: Record review of a face sheet dated 10/28/2025 indicated Resident #3 was a [AGE] year-old female who re-admitted to the facility on [DATE] with diagnoses which included a diagnosis of diabetes mellitus (a chronic condition in which the body does not produce enough insulin to regulate blood sugar levels). The face sheet indicated the Resident's family member was her responsible party/representative. Resident #3 discharged from the facility 05/02/2025 Review of the MDS dated [DATE] revealed Resident #3 had a BIMS score of 10 indicating her cognition was moderately impaired. Review of Resident #3's hospital records and physician's orders dated 02/27/2025 indicated Resident #3 was discharged to the facility on [DATE] with physician's orders for blood glucose levels to be checked by glucometer 4 times daily (before meals and at bedtime) and to be given Humulog insulin per sliding scale (insulin dosing based on the patient's blood glucose level at the time of testing). Review of Resident #3's progress notes dated 02/27/2025 indicated the nurse practitioner was notified of Resident #3's admission and hospital discharge orders on 02/27/2025. Further review of the progress notes indicated the nurse practitioner discontinued the sliding scale insulin order and changed the frequency of blood glucose testing from 4 times daily before meals and at bedtime to 2 times daily (before breakfast and at bedtime) with instructions to notify the nurse practitioner if blood glucose levels were greater than 350. Review of Resident #3's progress notes in the medical records dated 02/27/2025 through 03/04/2025 indicated there was no documented evidence that Resident #3 and the responsible party were notified of the changes to the physician orders. During an interview on 10/27/2025 at 11:00 AM, Resident #3's responsible party said she was not notified about the changes made to Resident #3's insulin dosing and blood glucose testing orders that came from the hospital. She said that 4-5 days after Resident #3 was admitted to the facility, Resident #3 told her she had not been getting her insulin shots. She said she questioned the nurse in charge about her mother's insulin orders and blood glucose test results and learned the orders had been changed. She said the facility should have told her about the proposed changes at the time they were made. She said she would not have known about the changes had she not asked about the orders. She said she talked to the Nurse Practitioner and got the sliding scale insulin orders with 4 times a day testing reinstated. She said she would have disagreed with the changes made to the hospital discharge orders if she had been notified of the proposed change. During an interview on 10/28/2025 at 03:05 PM, Charge Nurse C said nurses should notify the resident and his or her responsible party of new physician's orders and changes in physician orders. She said there were times when the resident or responsible party did not agree to orders or changes. Charge Nurse C said it was the resident's right to disagree with the doctor. She said she would let the doctor or nurse practitioner know if a resident or responsible party had a concern or did not agree with any orders. During an interview on 10/29/2025 at 11:30 AM, the DON said the nurses were responsible for notifying residents and responsible parties of changes in care and treatment. She said it was important for the residents and responsible parties to be informed and given the opportunity to participate in the decision-making process. The DON said she and the ADON reviewed new physician's orders daily in the morning meeting. She said they missed seeing that Resident #3 and the responsible party were not notified of the changes to the insulin dosing and blood sugar testing. A record review of the facility's policy titled Change in a Resident's Condition or Status dated Revised April 2025 indicated the following: Policy StatementOur facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition or status (e.g., changes in level of care, billing/payments, resident rights, etc).5.Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.6. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident #3) and representative was informed of her right to participate in the development and implementation of a person-centered plan of care. The facility failed to facilitate the inclusion of Resident #3 and/or the representative in the care planning process. This failure could prevent residents from incorporating their personal and cultural preferences in developing goals of care. Findings included: Record review of a face sheet dated 10/28/2025 indicated Resident #3 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included a principal diagnosis of COPD (a condition involving constriction and destruction of the airways in the lungs), a co-existing diagnosis of emphysema (a type of COPD involving the air sacs in the lungs), and pre-existing diagnoses of dementia and diabetes mellitus (a chronic condition in which the body does not produce enough insulin to regulate blood sugar levels). Review of the MDS dated [DATE] noted Resident #3 had a BIMS score of 10 indicating her cognition was moderately impaired. She was ambulatory with a walker and was incontinent at times. Review of the MDS dated [DATE] indicated Resident #3 discharged from the facility on 05/02/2025. Record review of Resident #3's medical records indicated a care plan was developed during a previous facility stay from 08/19/2025 - 09/08/24 was revised for the plan of care for the most current stay from 02/27/2025 - 05/02/2025. Record review of scanned documents, progress notes and social worker notes for Resident #3 from 02/27/2025 - 05/02/2025 did not indicate Resident #3 and/or representative had been informed of or invited to participate in the development of a care plan. There was no documentation of a refusal to participate in the care planning process. During an interview on 10/27/2025 at 11:00 AM, Resident #3's representative said she had not been consulted about or included in the care planning process for Resident #3. She said she was never asked to attend a care plan meeting nor was she invited to participate in the development of Resident #3's plan of care during the entire time Resident #3 was at the facility nor was she ever given a copy of a care plan. During an interview on 10/28/2025 at 03:10 PM, the DON said she had been at the facility for about 4 months. She said she could not find any documentation of Resident # 3 or the representative having been invited to a care plan meeting, a care plan meeting being held, or a review of a plan of care for Resident #3. The DON said she, the MDS Coordinator, and Social Worker shared in the care planning process. She said neither she nor the Social Worker were employed at the facility during Resident #3's stay at the facility and could not explain why Resident #3 and the representative had not been invited to a care plan meeting or been given a copy of Resident #3's care plan. A record review of the facility's policy titled Care Plans-Baseline dated Revised March 20244 indicated the following:A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include.but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative;, .4. The resident and/or representative are provided a written summary of the baseline care plan .5. Provision of the summary to the resident and/or resident representative is documented in the medical record. A record review of the facility's policy titled Care Plans, Comprehensive Person-Centered indicated the following: Policy Interpretation and Implementation4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:a: participate in the planning process.h. see the care plan and sign it after significant changes are made.5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive assessment was completed, using the CMS-specified process, within the regulatory time frames for 1 of 3 residents (Resident #4) reviewed for comprehensive assessments. The facility failed to complete a comprehensive MDS assessment for Resident #4 within 14 days of admission to the facility. This failure could place new residents at risk of delays in assessments and the residents' care plans not accurately reflecting their current needs. Findings included: Record review of a face sheet dated 10/28/2025 indicated Resident #4 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included cerebral atherosclerosis (a build-up of plaque in the arteries of and leading to the brain which thickens and hardens the arteries of the brain), major depression, diabetes mellitus, anxiety, sleep apnea, atrial fibrillation (a heart rhythm disorder), dysphagia (difficulty swallowing), arthritis, ataxia (lack of muscle coordination), and repeated falls. Record review of an incomplete admission MDS with an ARD date of 10/20/2005 indicated Resident #4 had a BIMS score of 00 (zero-zero) indicating his cognition was severely impaired. Further review of the MDS indicated sections A (identification Information, F (Preferences for Routine & Activities), GG (Functional Abilities), J (Health Conditions), O (Special Treatments, Procedures, and Programs), Q (Participation in Assessment and Goal Setting) and V (Care Area Assessment Summary) were not completed. Record review of Section Z indicated the MDS had not been signed as completed as of 10/29/2025. Record review of Resident #4's MDS history indicated he was admitted to the facility on [DATE], had an admission assessment in progress and was 2 days overdue. During an interview on 10/29/2025 at 11:10 AM, the MDS Coordinator said she did not know why the MDS had not been completed. She said the facility used the RAI Version 3.0 Manual as the policy for completing MDS assessments. She said she had been the MDS Coordinator for less than a year and was still slow at completing the MDS assessments. She said the Regional MDS Consultant had been helping her, but the Consultant had other buildings to help also. The MDS Coordinator said Resident #4's admission MDS assessment should have been completed by 14 days after admission which was 10/27/2025. Record review of the RAI Version 3.0 Manual: Section 2.2 indicated the following: Policy Interpretation and Implementation1.Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.2.admission Assessment - The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:.c. the resident has been admitted to this facility and was discharged return not anticipated and did not return within 30 days of discharge.The admission Assessment (Comprehensive) must be completed by the 14th day of the resident's stay (admission date + 13 = completion date).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 3 of 4 residents (Residents #2, #3, #4) reviewed for baseline care plans. The facility failed to ensure Resident #2's and Resident #4's baseline care plans were implemented and made available to nursing staff within 48 hours of admission. The facility failed to ensure Resident #3's baseline care plan included instructions to address the principal diagnosis of COPD. The facility failed to ensure Resident #3's baseline care plan included instructions to address identified risks for hyperglycemia and hypoglycemia. These failures could affect newly admitted residents and place them at risk of receiving inadequate care and services and not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs are met. Findings included: 1.Record review of a face sheet dated 10/28/2025 indicated Resident #2 was an [AGE] year-old female who admitted to the facility 10/06/2025 with diagnoses which included Alzheimer's disease, dementia, aortic stenosis (a condition where the aortic valve in the heart becomes narrowed, restricting blood flow from the heart to the rest of the body), and osteoporosis. Review of Resident #2's MDS dated [DATE] noted resident #2 had a BIMS score of 6 indicating her cognition was severely impaired. Record review of Resident #2's medical records for a baseline care plan indicated the electronic care plan for Resident #2 was completed but not signed by the resident, resident's representative, and by the staff who completed the care plan. Section 5. B. Signature of Resident and Representative indicated LVN C had signed the document in the area designated for Resident #2's signature and dated it 10/22/2025. The spaces on the care plan form designated for the signatures of the resident, resident representative, and staff participating in the development of the care plan were blank. During an interview on 10/29/2025 at 11:10 AM, the DON said the nurses usually printed the baseline care plan from the electronic record, completed it manually, and then gave it to the social worker to get signed. She said sometimes, the nurses completed the baseline care plan in the electronic record, printed it, and give it to the social worker to get signed. The DON said it looked like Resident #2's electronic baseline care plan was completed but not signed by the resident, the resident's representative, nor the facility staff. 2. Record review of a face sheet dated 10/28/2025 indicated Resident #3 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included a principal diagnosis of COPD (a condition involving constriction and destruction of the airways in the lungs), a co-existing diagnosis of emphysema (a type of COPD involving the air sacs in the lungs), and pre-existing diagnoses of dementia and diabetes mellitus (a chronic condition in which the body does not produce enough insulin to regulate blood sugar levels). Record review of an MDS dated [DATE] noted Resident #3 had a BIMS score of 10 indicating her cognition was moderately impaired. Further review of the same MDS indicated Resident #3 was ambulatory with a walker and was incontinent at times. Record review of an MDS dated [DATE] indicated Resident #3 discharged from the facility on 05/02/2025. Record review of medical records indicated Resident #3 was initially admitted to the facility on [DATE]. A MDS dated [DATE] indicated Resident #3 was discharged on 09/08/2024 with return not anticipated. Further review of medical records indicated a care plan developed during a facility stay from 08/19/2025 - 09/08/24 was revised for the plan of care for the most current stay from 02/27/2025 - 05/02/2025. The revised care plan included a problem with a start date for 08/20/2024 and identified as a Baseline Care Plan for new admission to skilled nursing facility, edited 02/28/2025. The revised baseline care plan indicated Resident #3's principal diagnosis of COPD and co-existing diagnosis of emphysema were not addressed in the care plan. The revised care plan indicated there were no goals or interventions to address identified risks of hypoglycemia (low blood sugar levels) and hyperglycemia (high blood sugar levels). Record review of scanned documents, progress notes and social worker notes for Resident #3 from 02/27/2025 - 05/02/2025 did not indicate Resident #3 and/or representative had been informed of the development of a care plan. During an interview on 10/27/2025 at 11:25 AM, Resident #3's representative said she had not been consulted about or included in the care planning process for Resident #3. During an interview on 10/28/2025 at 03:10 PM, the DON said she had been at the facility for about 4 months. The DON said she, the MDS Coordinator, and Social Worker shared in the care planning process. She said neither she nor the Social Worker were employed at the facility during Resident #3's stay at the facility and could not explain why Resident #3's revised care plan did not address the principal diagnosis for

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan, for each resident, consistent with the resident rights set forth 483.10(c)(3, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment for 1 of 3 residents (Resident #2) reviewed for comprehensive assessments. The facility failed to ensure a comprehensive person-centered care plan was developed and completed within 21 days of admission to the facility for Resident #2. This failure could place residents at risk of a delay in receiving care and services to meet medical and nursing needs. The findings included: Record review of a face sheet dated 10/28/2025 indicated Resident #2 was an [AGE] year-old female who admitted to the facility 10/06/2025 with diagnoses which included Alzheimer's disease, dementia, aortic stenosis (a condition where the aortic valve in the heart becomes narrowed, restricting blood flow from the heart to the rest of the body), and osteoporosis. Review of an MDS dated [DATE] revealed Resident #2 had a BIMS score of 6 indicating her cognition was severely impaired. Record review of Resident #2's medical records indicated a comprehensive care plan had not been completed. During an interview on 10/29/2025 at 11:10 AM, the MDS Coordinator said she, the DON, and the ADON shared responsibility for developing and implementing the care plans. She said for new admissions, the comprehensive care plan was to be done within 7 days of the completion of the comprehensive assessment and no more than 21 days after admission. She said that since the comprehensive MDS had not been completed, the comprehensive care plan had not been completed. She said Resident #2's comprehensive care plan should have been completed no later than 10/27/2025. The MDS Coordinator said she was working on getting caught up. The MDS Coordinator said the facility used RAI Version 3.0 Manual as the guide for completing MDS assessments and care plans. During an interview on 10/29/2025 at 03:15 PM, the DON said she, the ADON, and the Social Worker were new to the facility and were working on processes to get caught up and organized. She said she was not aware Resident #2's comprehensive care plan had not been completed. Review of CMS's RAI Version 3.0 Manual Section 2.2 indicated the Care Plan Completion Date must be dated by the end of the 7th calendar day following the completion date of the admission Comprehensive Assessment and can be no later than day 21 (admission date +21 = Comprehensive Care Plan due date). A review of the facility's policy titled Care Plans, Comprehensive Person-Centered and dated 2001 with a revision date of March 2022 indicated the following: Policy StatementA comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. 1. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in status), and no more than 21 days after admission.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 8 residents reviewed for accidents. (Resident #1).The facility did not prevent Resident #1, who was wearing a Wanderguard bracelet, from leaving the facility unsupervised on 09/07/2025. Resident #1 was found at the intersection of the county road the facility resided on and a state farm to market road approximately 1.3 miles from the facility. The facility was not aware the resident was missing for approximately 1 hour. The noncompliance was identified as PNC. The IJ began on 09/07/2025 and ended on 09/09/2025. The facility had corrected the noncompliance before the survey began.This failure could place residents at risk of potential accidents, injuries, harm, or death. Findings included:Record review of a face sheet on 10/27/2025 indicated Resident #1 was a [AGE] year-old male who admitted on [DATE] with diagnoses including: schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and mood disorders, such as depression or mania), bipolar disorder (a chronic mental health condition characterized by extreme mood swings between mania and depression), psychosis (a mental health condition characterized by a loss of touch with reality), anxiety disorder a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), depression (a common and serious mental health condition that significantly impacts a person's mood, thoughts, and behavior) and cognitive communication deficit (a difficulty in communication caused by problems with underlying cognitive functions like memory, attention, and executive function, rather than a language or speech impairment).Record review of a quarterly MDS dated [DATE] indicated Resident #1 had clear speech, usually understood others and was usually understood, he had a BIMS score of 07 indicating severe cognitive impairment. He had disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). He exhibited no wandering or other behaviors. He required set-up or clean up assistance with ADLs and he could feed himself. He was occasionally incontinent of bladder and continent of bowel. He was independent with mobility and walking unassisted. Record review of care plans for Resident #1 indicated he had a care plan initiated on 06/21/2025 and revised on 09/08/2025 indicating he was at risk for wandering. Goals included: ensure staff awareness of resident's risk, monitor for expressions of wanting to go home and assess quarterly and as needed for wandering/elopement risk. He had another care plan initiated on 09/08/2025 which indicated he was at risk for elopement and required a secured unit as evidence by impaired safety awareness and at risk for injury from others while residing in secure/ memory unit due to altered cognition and history of elopement. Care plan goals included: Will remain safe within the facility through the next review date. Interventions included: monitor for early warning signs of any behaviors and anticipate behavior(s) and redirect when in close proximity to others that might invoke aggression.Record Review of Resident #1's admission Elopement Risk assessment dated [DATE] indicated the resident had a score of 9. The assessment tool indicated a score of 10 or higher indicated a high risk for elopement. The interdisciplinary team had determined a Wanderguard (a wearable device used in senior living facilities to prevent residents at risk of wandering from leaving a protected area) was not indicated at that time as the resident was not actively exit seeking.Record Review of Resident #1's Elopement Risk assessment dated [DATE] indicated the resident had a score of 4. The interdisciplinary team had determined a Wanderguard was indicated at this time as the resident did leave the facility without notifying anyone.Record Review of Resident #1's Elopement Risk assessment dated [DATE] indicated the resident had a score of 7. The interdisciplinary team had determined the resident needed to be in the secure unit as he had eloped from the facility without staff knowledge and was found by the police approximately 1.3 miles from the facility.Review of Resident #1's Progress Notes in the electronic record indicated on 06/21/2025 he was seen on the driveway of the facility by facility staff. A visitor turning into the facility driveway stopped and gave the resident a ride back to the front door where he was brought inside. He was assessed with no injuries and said he was going to see his brother. A Wanderguard was placed on the resident to alert staff if he left the facility again.Review of Resident #1's Progress Notes in the electronic record indicated the resident did not exhibit any exit seeking behavior from 06/21/2025 until 09/07/2025.A review of the facility investigation report indicated the incident occurred on 09/07/2025 and was reported to the state agency on 09/08/2025 with no times indicated. Resident #1 was last seen at 8:20 AM on 09/07/2025 going towards his room. He was found by the sheriff and police departments about a mile away