

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675878	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2026
NAME OF PROVIDER OR SUPPLIER Avir at Grand Saline		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview and record review the facility failed to report to state agency emergency situations that pose a threat to resident health and safety immediately, but not later than 24 hours after the incident occurs or is suspected for 1 of 1 kitchen reviewed for environmental safety. The facility failed to report an emergency situation involving a suspected gas leak/propane odor and fire department intervention to the State Agency within 24 hours of occurrence or discovery on 06/01/26. The fire department responded to the facility, investigated the reported propane odor, and shut off the propane supply to the oven. This failure could affect the health and safety of residents, staff, and visitors due to exposure to a hazardous environmental condition within the facility. Record review of the local fire department's Public Disclosure Report dated 06/01/26 documented a response to a reported propane odor in the kitchen. Fire personnel assessed the area using a carbon monoxide monitor and detected no traces of CO. The report noted a faint propane odor associated with the oven. As an immediate corrective action, the propane supply to the oven was shut off. The report indicated no fire, explosion, injuries, or hazardous material release occurred. The key narrative stated: Smells propane in kitchen very bad [name of fire department] was dispatched [facility's address] in reference to a propane smell in the kitchen. [Unknown personnel] arrived on scene and [name of local fire department] personnel walked the kitchen with a CO monitor. The monitor did not detect any traces of CO. The oven had a faint smell of propane. The propane was shut off to the oven. The worker advised she would have maintenance check it out. Record review of a work order repair invoice dated 6/2/26 indicated the following: Job Details: Oven has a small gas leak on a valve - oven is shut down by the fire department. Completion notes: checked in with maintenance, he showed me the area that the leaks were in. I found one of the connections to the baso valve was very loose. Removed fitting and reapplied sealant. Placed fitting in and tightened it down. No further leaks noted at this time. Relit all pilots and checked functionality. Unit operating properly at this time. During an observation of the kitchen oven and interview with the DM on 6/13/26 at 12:24pm, the DM pointed to the oven area where the leak was coming from and was repaired. No gas smell was observed during the noon meal preparation. The DM said she was notified on the night of 6/1/26 by the DON that she smelled gas and the fire department was notified and came on-site to do a gas test. The DM said the following day on 6/2/26 a repair company came and repaired the oven and turned the gas back on. She said while the oven was temporarily out of use the kitchen staff served sandwiches, chip, and cereal until the oven was repaired. Record review of the Administrator's emailed statement received on 6/13/26 at 12:54pm regarding the incident stated the following: [On June 1st] I [Administrator] was called about 8 PM. I [Administrator] was informed the kitchen smelled like it had gas in it. Facility was unable to get a hold of the maintenance man. I [Administrator] instructed them to call the fire department. The fire department came out and verified the facility had a gas leak. I [Administrator] told the [DM] to not cook anything on the stove or oven. I [Administrator] then asked her what she needed to do for breakfast in the morning because the residents usually have sausage and eggs or bacon. She told me [Administrator] what cereal to purchase and to purchase several gallons of milk as well as bowls for the cereal. The next morning, I (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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Administrator] went to Walmart and purchased cereal, milk and bowels. As I [Administrator] recall, one plumber came out that day. He verified we had a problem. Because he could not repair the problem, a second plumber was called and he did fix the problem. The maintenance man told me [Administrator] the problem was a fitting or hose that may have been disconnected from the oven/stove while the staff were trying to clean behind it. Record review of the DON emailed statement received on 6/13/26 at 2:22pm, regarding the incident stated the following: On the night of 6/1/26 at approximately 8 pm. I [DON] was up at the facility working late and when the staff and smokers came from outside, they reported to me [DON] that the dining room smelled strong of propane. I [DON] was in my [DON] office at the time. I [DON] went to the kitchen to investigate with a CNA. We both agreed that we smelled it as well when walking into the dining room. It wasn't super strong but warranted investigation. I [DON] was unable to open the kitchen doors as the dietary staff had already left for the evening. I [DON] then called dietary manager to let me [DON] into the kitchen and let her know about smell. She [DM] came up within 5 minutes, and we both went in to investigate. All the knobs were turned off to all appliances we could not tell where anything could've caused the smell other than it was strongest by the oven. I [DON] called [Administrator] and [Maintenance Supervisor]. We all agreed to have fire department come out and investigate to see if they could find cause. I [DON] called 911 about need for clearance of possible gas leak, 3 firemen came out to investigate. They checked all the knobs again and they were all off. No dangerous levels of gas are noted with their device. They also noticed smell from the oven. They opened oven doors and noted that left oven was still hot although dietary had stopped cooking hours before. They stated that kitchen appeared safe now but as a safety measure they wanted to shut off the gas lines. They shut off gas lines behind the stove and suggested not using the stove until maintenance could get someone out to service. I [DON] then called [Administrator, Maintenance Supervisor, and DM] to let them know situation and that breakfast would need to be figured out for the morning. During an interview on 6/13/26 at 5:40 pm, the Maintenance Director stated he had served in that role for approximately one year. He reported that on 6/1/26, the Director of Nursing contacted him after smelling gas in the kitchen. The DON also contacted the fire department. Prior to leaving the facility on 6/1/26, the fire department turned off the oven as a precautionary measure. The Maintenance Director stated that on 6/2/26 he contacted a licensed plumber to conduct a gas pressure test; however, the test could not be completed at that time due to weather conditions, as access to the facility roof was required. He further stated that a repair company responded on 6/2/26 and identified a pilot light line leak (occurs when gas escapes from the piping or fittings that supply the pilot burner in a gas furnace or heater. The pilot light is a small, continuously burning flame that ignites the main burners when the thermostat calls for heat. In many systems, the pilot gas is fed through a dedicated line from the main gas supply to the pilot valve. If this line is damaged, corroded, or has a loose connection, gas can leak even when the pilot is off). The company completed the necessary repairs that same day and restored the gas supply to the oven. According to the Maintenance Director, a gas pressure test was subsequently completed on 6/9/26 to verify that the repairs were effective and that no additional leaks were present. The Maintenance Director stated that a suspected gas leak was considered an emergency due to the potential risk of explosion and the possible health effects associated with gas exposure. He further stated that he was unaware whether the incident had been reported to the State, as reporting responsibilities would fall under the Administrator's authority. During an interview on 6/13/26 at 8:50 pm, the DON stated she had served in that role for approximately one year. The DON stated that a gas leak could be considered an emergency; however, she was unaware that the incident may have been reportable to the State. The DON stated that because the fire department was contacted and the necessary repairs were completed promptly, she believed all appropriate actions had been taken. The DON declined to provide examples of potential outcomes that could result from gas leak exposure. Record review of Disaster and emergency policy dated June 2025 indicated the following: Policy: To maintain and continue staff awareness of the actions to be taken in a disaster (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situation. Responsible Person: The Administrator will be responsible for the Internal Disaster Plan Policies and Procedures. The DON or Director of Maintenance may serve as backup as assigned by the Administrator. Procedures: To define the proper actions to be taken by the in the event of a disaster situation. Disaster and emergency situations include the following: . Loss of Cooking Capabilities. The Administrator or designated representative will notify the Texas Health and Human Services of the disaster conditions at 800-458-985.Any time in which the disaster plans are implemented HHSC will be notified no later than by the next business day.		