

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/06/2026
NAME OF PROVIDER OR SUPPLIER  Avir at Pecos		STREET ADDRESS, CITY, STATE, ZIP CODE  1819 Memorial Dr Pecos, TX 79772	
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents were provided with reasonable accommodation of needs and preferences, including ensuring the call light was within reach to request assistance, for one (Resident #1) of four residents reviewed for resident rights. The facility failed to ensure Resident # 1 had the call light within reach. This failure placed Resident #1 at risk for unmet needs, delayed assistance, increased fall risk, and potential injury. Findings included: Record review of Resident #1's admission record dated 01/06/2026 revealed an [AGE] year-old male admitted [DATE]. Record review of Resident #1's History and Physical dated 02/27/2025 revealed an [AGE] year-old male diagnosed with severe cognitive impairment (serious problems with memory and thinking), metabolic encephalopathy (brain dysfunction caused by illness or chemical imbalance), subclinical hypothyroidism (mild underactive thyroid), hypertension (high blood pressure), hyperlipidemia (high cholesterol), orthostatic hypotension (drop in blood pressure when standing), urinary tract infection (infection of the bladder or urinary system), benign prostatic hyperplasia (enlarged prostate causing difficulty urinating), unsteadiness on feet (balance problems), repeated falls (history of falling), dysphagia (difficulty swallowing), and malnutrition (not getting enough nutrition). Record review of Resident #1's MDS Quarterly assessment dated [DATE] revealed a BIMS score of 04, indicating severe cognitive impairment (significant problems with memory and thinking). The assessment further revealed impaired communication and the need for extensive assistance with transfers, toileting, and mobility. Section GG for Functional Abilities revealed Resident #1 required substantial to maximal assistance with bed mobility, transfers, toileting hygiene, dressing, and personal hygiene. The assessment further revealed Resident #1 had impaired balance and was a high fall risk. Record review of Resident #1's care plan dated 12/19/2025 revealed problem areas including fall risk, acute pain related to right femoral neck fracture, impaired communication, incontinence, risk for dehydration, benign prostatic hyperplasia (a common condition in older men where the prostate grows bigger and presses on the urethra, the tube that carries urine out of the body), and nutritional risk. Interventions included reminding Resident #1 to use the call device and ensuring the call light was within reach, keeping the bed in the lowest position, locking wheelchair brakes, monitoring for pain, and providing a safe environment. In an observation and interview on 01/06/2026 at 11:10 AM, Resident #1 was lying in bed, groomed and clean, with the room free of odors. The call light was observed hanging from the privacy curtain toward the foot of the bed about six feet away from the resident, and was not within his reach. A fall mat was present on the right side of the bed, and the bed was in the lowest position. Resident #1 stated that if he needed assistance, he would press the call light to get help. The investigator asked if he could reach the call light since it was hanging away from him, and he said he could not. Resident #1 said that if he needed help and couldn't reach his call light, he would yell until a staff member went to see him and help him. An interview on 01/06/2026 at 11:15 AM with CNA A revealed that call lights were</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675881
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>supposed to be within reach of all residents while in bed. CNA A stated that Resident #1's call light was not within reach and was hanging from the privacy curtain. CNA A stated that if the resident could not reach the call light, he could attempt to get up without assistance and sustain a fall which could result in injuries. An interview on 01/06/2026 at 1:29 PM with the Administrator revealed that the call light should be placed within reach of residents so they could request assistance. The Administrator stated that the call light placement observed in Resident #1's room was not acceptable because Resident #1 would not be able to reach it if he needed assistance, which could result in him getting up on his own, which could result in fall related injuries. The Administrator stated that all staff were responsible for checking for call light placement when they conducted their rounds every two hours. An interview on 01/06/2026 at 1:56 PM with Hospitality Aide B revealed that call lights should be clipped to residents' clothing or bed sheets to ensure accessibility. Hospitality Aide B stated that the call light in Resident #1's room was not accessible since it was clipped on the privacy curtain away from the resident's reach, and stated that in case of an emergency or if the resident needed assistance, he would not be able to call for help which could result in the resident falling and getting injured. An interview on 01/06/2026 at 1:59 PM, with RN C revealed that the resident was a high fall risk and required significant assistance with transfers. RN C confirmed that the call light was expected to always be within reach, and stated that the call light placement observed on 01/06/2026 was not acceptable since the resident would not be able to reach it to ask for help. RN C stated this could result in delays of care for the resident, and if he sustained a fall, he would not be able to call for help. In an interview on 01/06/2026 at 2:24 PM with the DON, she stated that the resident previously fell on [DATE], and that fall precautions were implemented, including placing the call light within reach of the resident, a low bed, and fall mat. The DON confirmed that it was not acceptable for the call light to be hanging from the privacy curtain and out of reach. The DON stated that if Resident #1 attempted to get up without assistance, he could sustain a fall and injury. An interview on 01/06/2026 at 2:43 PM with CNA D revealed that call lights needed to always be within reach of the residents. CNA D stated that improper placement could result in the resident not being able to request assistance and could lead to accidents if the resident got up from bed on his own and sustained a fall by not being able to call for help. Review of the facility's policies and procedures provided, included the policy titled Call System, Resident, revised in September 2022, did not reveal any specific policy language addressing the use, placement, or requirement of call lights.</p>		