STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675902	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Pilot Point	208 N Prairie St Pilot Point, TX 76258

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #1) of five residents reviewed for infection control. The facility failed to ensure Resident #1's catheter tubing remained off the floor. This failure placed residents at risk for healthcare associated cross contamination and infections.Findings included: Review of Resident #1's Face Sheet, dated 03/03/26, reflected she was a [AGE] year-old female who most recently admitted to the facility on [DATE], with diagnoses including retention of urine (the inability to completely or partially empty the bladder). Review of Resident #1's MDS Assessment, dated 02/21/26, reflected she was identified as having an indwelling urinary catheter. Review of Resident #1's Care Plan, dated 11/24/25, reflected Resident #1 was identified as having an indwelling urinary catheter. An intervention included, .ensure privacy bag and leg strap or anchor are in place. Review of Resident #1's Physician's Orders, dated 03/03/26, reflected she had active orders including: .Check Foley catheter tubing secure device placement every shift. Every shift. May use leg strap to secure Foley in place. Observation of Resident #1 on 03/03/26 at 10:00 AM revealed she was sitting in her wheelchair in the hallway. Resident #1 had a catheter in place; the catheter tubing was observed touching the floor. During an interview with LVN A on 03/03/26 at 10:15 AM, he confirmed Resident #1's catheter tubing was touching the floor. He stated the catheter tubing should have been attached to a clip under Resident #1's wheelchair, which would prevent it from touching the floor. LVN A attempted to locate the clip under Resident #1's wheelchair but was unable to do so. He stated he did not know why the clip was not present. LVN A stated the risk of catheter tubing being on the floor included potential infection control issues. During an interview with the Director of Nursing on 03/03/26 at 12:26 PM, she stated she had been made aware, by LVN A, that Resident #1's catheter tubing was touching the floor. She said the catheter tubing should have been attached to a clip under Resident #1's wheelchair, which would prevent it from touching the floor. The Director of Nursing stated the risk of catheter tubing being on the floor included potential infection control issues. Review of the facility's Catheter Care, Urinary policy, dated 07/2024, reflected, Infection Control. b. Be sure the catheter tubing and drainage bag are kept off the floor.

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