STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675931	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Camp Wood	710 Hwy 55 Camp Wood, TX 78833

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 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 observation, interview and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed medical records. The facility failed to ensure Resident #1's treatment administration record noted wound care treatments on 7/4/2025, 7/14/2025 and 8/3/2025 as required by the orders noted on the electronic medical record. This failure could place residents at risk of not receiving necessary care and services daily as ordered by the physician to promote proper healing of active wounds.Findings include:Record review of Resident #1's admission record, printed on 12/5/2025, reflected a [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #1 had diagnoses which included type 2 diabetes (a chronic condition that affects the way the body metabolizes sugar leading to high blood sugar levels) with unspecified complications, encounter for orthopedic (dealing with bones and/or muscles) aftercare following surgical amputation (removal o a limb or other body part), and anemia (lack of red blood cells to carry oxygen to body tissue).Record review of Resident #1's quarterly MDS assessment, completed on 12/4/2025, reflected a BIMS score of 10, which indicated moderate cognitive impairment. Resident #1 was coded as being at risk for pressure ulcers. Resident #1 was coded as having a limited range of motion of the lower extremity (hip, knee, ankle, foot) and using a manual wheelchair to ambulate. He required substantial/Maximal (helper does more than half the work) assistance with toileting, showering, dressing, and personal hygiene. He was dependent (helper did all the work) on transferring in and out of bed.Record review of Resident #1's treatment administration record for July of 2025 and August of 2025 reflected wound care to the left plantar (sole) medial (middle) foot was to be performed once a day with an order start date of 5/6/2025 until resolved.Record review of Resident #1's treatment administration record for the month of July and August of 2025 reflected staff failed to mark completion of wound care treatment on 7/4/2025, 7/14/2025 and 8/3/2025 as required by the orders noted on the electronic medical record.During an observation and interview on 12/4/2025 at 4:20 PM, Resident #1 was observed lying in bed with an above the knee amputation of the left leg. The leg was wrapped with gauze. He stated he was receiving treatment for wounds on his foot, but his toes got black, and his knee got so bad they took it off. During an interview on 12/8/25 at 1:32 PM, the DON revealed the TAR records for Residents #1 were not marked as completed on 7/4/2025, 7/14/2025 and 8/3/2025. He revealed a blank meant the nurse did not document a resident's refusal and he would have to interview the nurse to determine if the treatment was provided. He said not marking the treatment did not allow staff to know if treatment had been performed.Record review of the facility's policy reflected the following Policy StatementAll services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition andresponse to care.Policy Interpretation and Implementation2. The following information is to be documented in the resident medical record:a. Objective observations;b. Medications administered;c. Treatments or services performed;d. Changes in the resident's condition;e. Events, incidents or accidents involving the resident; andf. Progress toward or changes in the care plan goals and objectives.