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	01/15/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, that were complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for documentation. The facility failed to ensure Resident #1 had an accurately documented personal items inventory sheet for admission and discharge.This failure could place residents at risk of missing personal items at admissions, during stay, and at discharge.The findings include: Record review of Resident #1's face sheet, dated 1/15/26 reflected an 83 -year-old female who was admitted to the facility on [DATE] and discharged [DATE]. Resident #1 had diagnoses which included: Alzheimer's disease (a progressive brain disorder), Major Depressive Disorder, and anxiety. The RP was listed as: family member.Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 99 (zero), indicative of severe impairment in cognition.Record review of Resident #1's Nurse Note dated 12/31/25 authored by the DON reflected the resident was discharged AMA per the RP's request. [The note provided no information on whether the resident's personal items were inventoried and sent home with the family.] Record review of facility's discharge list for the last 90 days, 10/1/25-1/15/26, reflected Resident #1 was discharged AMA on 12/31/25. Record review of R#1's D/C summary authored by LVN C dated 12/31/25 at 11:30 AM revealed: Resident family decided to take resident home against medical advice. MD notified and stated he did not feel resident was a safe discharge home. family decided to take her home against MD advice.[Timeline: From interview on 1/15/26 at 11:05 AM with the Administrator: 12/20/25 family informed of resident to move to a semi-private room (Family intended to take resident home AMA but relented). On the 12/31/25-resident discharged AMA, per RP request.] During an interview on 1/15/26 at 11:05 AM, the Administrator stated no residents had been given 30-day notice and no residents were discharged on an emergency basis. The Administrator stated Resident #1 was discharged AMA per request of the RP. The Administrator stated she was not certain whether an inventory sheet of the resident's personal items had been inventoried at admissions or discharge; but the family took all the resident's personal items home. During an interview on 1/15/26 at 1:20 PM, LVN A stated on 12/20/25 the RP was informed that Resident #1 needed to move to a semi-private room based on Medicaid payments, but the family refused and intended on executing an AMA. LVN A stated the RP delayed the AMA because they (RP) wanted to prepare another family for the resident going home and arranging medical care. LVN A stated on 12/31/25 Resident #1 was discharged home with community support. LVN A could not recall whether discharge arrangements involved an inventory of the resident's personal items. During an interview on 1/15/26 at 1:26 PM, CNA B stated she provided ADLs services to Resident #1 who was totally dependent for all ADLs (was bed bound). CNA B stated the RP agreed around 12/20/25 for a transfer to a semi-private room with someone compatible but a family member objected and wanted the resident discharged home. CNA B stated on 12/31/25 that the family member came with the approval of the (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RP and discharged the resident AMA. CNA B stated the family left with all the resident's possessions and an inventory sheet was not completed. During an interview on 1/15/26 at 1:50 PM, LVN C stated the timeline was as follows: she was a witness with the Administrator on 12/20/25, informing the RP that Resident #1 had to be relocated to a non-private room. LVN C stated the Administrator informed the RP and the RP agreed with the room change if the resident was placed with a quiet, compatible resident. LVN C stated the resident remained in the facility until 12/31/25 when the family member with the approval of the RP discharged the resident home AMA. LVN C stated the resident left with her medication list. LVN C stated she was not certain as to whether an inventory sheet was completed or mailed to the RP. During an interview with the DON on 1/15/26 at 2:15 PM, the DON stated on 12/20/25 the RP was informed the resident needed to move to a semi-private room and the RP agreed, but a family member objected. The DON stated the family member with the resident's RP approval took the resident home AMA on 12/31/25. The DON stated there was no plan for the resident's discharge and the physician felt it was unsafe for the facility to do a discharge plan. The DON stated he could not locate the initial, updated, or discharge inventory sheet for Resident #1. The DON stated nursing practice required that the resident personal items be inventoried at admission and surely at discharge. The DON stated he was quite certain the facility did not have a policy on inventory sheets of resident personal items. During a telephone call on 1/15/26 at 3:07 PM, the RP stated she agreed with the AMA discharged on 12/31/25. The RP stated she told the facility Discharge [Resident #1] now. The RP stated the resident was being followed in the community by a physician who had and made visits to the resident's home. The RP stated the family took all the resident's personal items and nothing was missing; but did not remember signing any inventory sheet at admissions, during stay, or at discharge. During an interview on 1/15/26 at 3:31 PM, the Administrator stated on 12/20/25 that she informed the RP and family the resident needed to move from a private room to a semi-private room and the facility had a private resident in a semi-private room and had to correct the situation. The Administrator stated the RP agreed with the move, but a family member objected and almost resulted in an AMA discharge on [DATE]. The RP agreed to allow the family member to pursue an AMA when arrangements were made for the resident's transfer home. The Administrator stated the AMA occurred on 12/31/25 persistence of the RP. The Administrator stated the family provided the transportation of resident home and the family was given a list of medications and encouraged to seek out a physician in the community and arrange for home health. The Administrator stated the resident could return to the facility. The Administrator stated there was no written AMA form because the RP demanded the AMA and the physician agreed. Regarding inventory sheets for any resident, the standard practice was for an inventory at admissions, during care if any items came from the outside, and at discharge. The Administrator stated she had no explanation why the standard practice was not done for Resident #1. The Administrator stated she would check whether the facility had a policy on inventory sheets or resident personal items; but at time of exit on 1/15/26 at 5:00 PM, the facility did not provide a policy on inventory of resident's personal items.Record review of facility's Transfer or Discharge, Facility-Initiated policy dated October 2022 read: .When a resident is transferred or discharged from the facility, the following information is documented in the medical record.Disposition of personal effects.