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	06/12/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to formulate an advance directive for 1 of 4 residents (Resident #1) reviewed, in that:The facility failed to ensure Resident #1's OOH DNR was accurately reflected in her medical record and in her plan of care.This deficient practice could result in residents' end of life wishes being unknown or dishonored.The findings were: Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: dementia with behavioral disturbance, type 2 diabetes mellitus and malignant neoplasm of left kidney (cancer of the kidney). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 which indicated a severe cognitive impairment. Record review of Resident #1's signed OOH DNR dated [DATE] was located in a three-ring binder at the nurses station but was not uploaded into the resident's medical record. The OOH DNR indicated Resident #1 should not have CPR in the case of a medical emergency. Record review of Resident #1's dashboard for her electronic medical record revealed she was full code status. Record review of Resident #1's physician order summary revealed she had an order for full code status dated [DATE]. Record review of Resident #1's Care Plan dated [DATE] revealed the resident desired full code status.During an interview on [DATE] at 5:33 p.m., Resident #1's family stated the family did not want CPR for Resident #1 and had signed an OOH DNR to honor their request. The family member stated the facility ADON had helped coordinate obtaining and signing the OOH DNR. During an interview on [DATE] at 7:26 p.m., the ADON stated Resident #1 had an OOH DNR signed at the facility which was kept at the nurses station in a binder. The ADON stated once a OOH DNR is obtained medical records was responsible for ensuring it was uploaded into the medical record. The ADON stated right now the facility did not have anyone staffed to do medical records since February 2026. She stated the Administrator had been doing the uploading. During an interview on [DATE] at 1:47 p.m., the ADON stated the facility did not have a social worker. The ADON stated she was doing her best to ensure the residents were still getting their needs met. She stated the DNR's were falling on her shoulders, and she had to make sure it was all done, scanned, and code status changed. The ADON stated Resident #1's medical record physician orders, dashboard and care plan did not accurately reflect the resident's family's desire for DNR status. The ADON stated she should have consulted with Resident #1's physician to change code status with orders to ensure the facility was honoring the residents' rights. The ADON stated the care plan would follow the physicians order but they did not have a MDS Coordinator right now to revise care plans. She stated she was not sure who was responsible now because the MDS Coordinator had been responsible. The ADON stated the facility did not currently have a DON. Record review of the facility policy titled Advanced Directives dated [DATE] revealed: If The Resident Has An Advanced Directive: 1. if the resident or the resident's representative has executed one or more advance directive .copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. 2. The Director of Nursing Services or designee notifies the attending physician of advanced directives (or changes in advance directives) so that appropriate orders can be documented int he residents medical record and plan of care.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 4 residents (Resident #1 and #2) reviewed for care plans.1. The facility failed to ensure Resident #1's comprehensive care plan included information accurate DNR status. 2. The facility failed to ensure Resident #2's care plan included mouth pain and ulcers and the need to continue to follow up with medical care and interventions. These failures could place residents at risk for not having their needs and preferences met.The findings include:1. Record review of Resident #1's face sheet dated 6/11/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: dementia with behavioral disturbance, type 2 diabetes mellitus and malignant neoplasm of left kidney (cancer of the kidney). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 which indicated a severe cognitive impairment. Record review of Resident #1's signed OOH DNR dated 1/10/2026 was located in a three-ring binder at the nurses station but was not uploaded into the resident's medical record. The OOH DNR indicated Resident #1 should not have CPR in the case of a medical emergency. Record review of Resident #1's dashboard for her electronic medical record revealed she was full code status. Record review of Resident #1's physician order summary revealed she had an order for full code status dated 1/11/2026. Record review of Resident #1's Care Plan dated 6/11/2026 revealed the resident desired full code status.During an interview on 6/11/2026 at 5:33 p.m., Resident #1's RP stated the family did not want CPR for Resident #1 and had signed an OOH DNR to honor their request. The RP stated the facility ADON had helped coordinate obtaining and signing the OOH DNR. During an interview on 6/11/2026 at 7:26 p.m., the ADON stated Resident #1 care plan did not reflect the residents wishes for DNR status. She stated the MDS Coordinator was responsible for ensuring accuracy of the residents care plans. She stated the facility did not have a MDS Coordinator currently. The ADON stated the facility also did not have a DON. She stated she did not know who was ensuring care plans were complete and accurate as she had the same question. During an interview on 6/12/2026 at 2:36 p.m., the HR Director stated the facility did not have an MDS Coordinator and the RCN was doing that work. She stated the DON left the faciity on 6/01/2026 and had not yet been replaced. 2. Record review of Resident #2's face sheet dated 6/11/2026 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: dementia, type 2 diabetes mellitus without complications, and cellulitis and abscess of mouth. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact. The assessment indicated the resident required supervision for all care and movement. Record review of Resident #2's Physician Visit Request dated 1/16/2026 revealed the resident had a sore under the left side of his tongue and missing teeth with diagnoses of cellulitis of the mouth and orders to refer to dental ASAP for oral cellulitis. Record review of Resident #2's progress notes dated 5/12/2026 revealed the resident had an appointment with an oral maxillofacial surgeon on June 2nd at 8:30 a.m. Record review of Resident #2's comprehensive care plan initialed 10/16/2025 revealed no plan of care for cellulitis and abscess of mouth, mouth sores or mouth pain, or dental care for follow up. During an observation and interview on 6/12/2026 at approximately 11:10 a.m., Resident #2 was observed in his room holding a washcloth under his chin and spitting into the washcloth repeatedly. Resident #2 was unable to speak without drooling. He stated he had an appointment for dental care withing the last two weeks but missed the appointment because the person who was supposed to take him did not show up. He stated he missed the appointment and did not know when he was going. He stated he wanted to go to the appointment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He stated he did not currently have pain but did sometimes have pain in his mouth and from his teeth. During an interview on 6/12/2026 at 11:15 a.m. CNA A stated Resident #2 had sores in his mouth and had been to the dentist and doctor multiple times and had even received antibiotics. She stated for a while he was not talking. She stated he is talking more now, but still not like he used to. She stated he is eating soft foods and was not complaining of pain. During an interview on 6/12/1026 at approx. 1:00 p.m. Resident #2's physician stated he tried to treat Resident #2s dental issues with anti-virals and antibiotics empirically which was not successful. He stated he then made a dental referral which had been completed. He stated the dentist made a referral to an oral surgeon. He stated the appointment was scheduled 6/02/2026. He stated he did not know the details on why Resident #2 did not go to the appointment. He stated the staff did communicate with him that they rescheduled the appointment for June 23, 2026. During an interview on 6/12/2026 at 1:47 p.m., the ADON stated Resident #2's care plan did not include a plan of care for his mouth or dental issues. She stated this should be included in his care plan. She stated it was important to include because the care plan was the plan of action on how the facility was taking care of the residents. The ADON stated the facility did not have a DON. During an interview on 6/12/2026 at 4:57 p.m., the RCN stated he had not been doing care plans until today (6/12/2026). He stated it should have been the charge nurses, ADON, DON and MDS nurse who was responsible. The RCN stated he will be filling in 3-4 days a week since the DON left the facility. Record review of the facility policy titled Care Planning-Interdisciplinary Team dated 12/2024 revealed: 1.Resident care plans are developed according to the timeframes and criteria established by S483.21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered by the State for 1 of 1 Activity Directors reviewed for qualifications of activity professionals.The facility failed to have a qualified Activities Professional to direct their activities program.This deficient practice could place residents at risk of not receiving activities that were individualized to match the skills, abilities, and interests/preferences of each resident. The findings include: Record review of the facility assessment dated [DATE] revealed the facility staffing needs required an Activities Director. During an interview on 6/11/2026 at 6:41 p.m. the Activities Director stated she had been a housekeeper and worked as a cashier at a local grocery store before applying for the job as Activities Director. When asked about her previous experience working with activities or as an Activities Director she stated, none what-so-ever. She stated she was still learning the job and her duties. She stated she did not have an assistant. She stated she had not had any training on how to be an Activity Director; she had not completed any shadow work and did not have another Activity Director to consult. She stated she had not taken any training courses, and was not currently enrolled in any training courses, although a course had been discussed with the Administrator who was her supervisor. She stated the Administrator stated she would have to pay for the training herself. She stated the course was expensive at approximately $500, and she could not afford it. She stated she had discussed having the company pay for the training with the Administrator, but the request had been denied. During an interview on 6/12/20206 at 2:36 p.m. the HR Director stated she was new to the facility as of 5/18/2026 and was still adjusting to the role. She stated she had not hired, nor participated in the hiring of the Activity Director. During an interview on 6/12/2026 at 4:11 p.m., the Administrator stated the Activities Director was not certified. The Administrator stated to her knowledge the requirement for the Activity Director was only having a high school diploma. The Administrator stated she hired the current Activities Director but was not aware of the requirements. She stated they had discussed her certification but had not enrolled her in any certification class. The Administrator stated she knew the Activities Director needed to be certified. She stated she had not enrolled the Activities Director in the course because staffing, safety, and care of the residents had been her focal point. Record Review of The Activities Director Job Description dated 2/09/2026 revealed the qualifications for the position were listed as: previous office experience, nursing home experience and supervisory experience preferred. The job description did not list educational requirements. During an interview on 6/12/2026 at 4:57 p.m. the RCN stated the facility did not have a policy for Activities Director. A policy for activities program was provided via a link via email was unable to be opened. The RCN did not respond or resend the policy in a readable format.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to assist residents in obtaining routine dental services and emergency dental services including arranging for the transportation to and from the dental services locations to meet the needs for 1 of 2 (Resident #2) residents reviewed for dental services. The facility did not ensure Resident #2 was provided transportation to a dental specialist to address his ongoing mouth infection and ulcers. This failure could place residents at risk of oral complications, dental pain, and diminished quality of life. The findings were: Record review of Resident #2's face sheet dated 6/11/2026 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: dementia, type 2 diabetes mellitus without complications, and cellulitis and abscess of mouth. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated the resident was cognitively intact. The assessment indicated the resident required supervision for all care and movement. Record review of Resident #2's progress notes dated 5/12/2026 revealed the resident had an appointment with an oral maxillofacial surgeon on June 2nd at 8:30 a.m. Record review of Resident #2's comprehensive care plan initialed 10/16/2025 revealed no plan of care for cellulitis and abscess of mouth, mouth sores or mouth pain, or dental care for follow up. During an observation and interview on 6/12/2026 at approximately 11:10 a.m., Resident #2 was observed in his room holding a washcloth under his chin and spitting into the washcloth repeatedly. Resident #2 was unable to speak without drooling. He stated he had an appointment for dental care withing the last two weeks but missed the appointment because the person who was supposed to take him did not show up. He stated he missed the appointment and did not know when he was going. He stated he wanted to go to the appointment. He stated he did not currently have pain but did sometimes have pain in his mouth and from his teeth. During an interview on 6/12/2026 at 11:15 p.m. CNA A stated Resident #2 had sores in his mouth and had been to the dentist and doctor multiple times and had even received antibiotics. She stated for a while he was not talking. She stated he is talking more now, but still not like he used to. She stated he is eating soft foods and was not complaining of pain. During an interview on 6/12/1026 at approx. 1:00 p.m. Resident #1's physician stated he tried to treat Resident #1's dental issues with anti-virals and antibiotics empirically which was not successful. He stated he then made a dental referral which had been completed. He stated the dentist made a referral to an oral surgeon. He stated the appointment was scheduled 6/02/2026. He stated he did not know the details on why Resident #2 did not go to the appointment. He stated the staff did communicate with him that they rescheduled the appointment for June 23, 2026. During an interview on 6/12/2026 at 1:13 p.m. CNA B stated she was supposed to transport Resident #2 on 6/02/2026 to his dental appointment. She stated the regular facility transporter was out on leave. She stated she told the facility she could help out. She stated on the day of the appointment, she was unable to show up to work on time because she had personal family issues and did not have a babysitter. She stated she called the ADON and the Administrator know and they said they would reschedule the appointment. She stated she did not give very much notice, she stated it was the same morning as the appointment when she gave notice. CNA B stated she was aware prior to the date of the call-in that she was the facility transporter and was responsible for Resident #2's transportation to his dental appointment. She stated she had no other transports scheduled on that day. During an interview on 6/12/2026 at 1:47 p.m., the ADON stated the facility transporter was on medical leave. The ADON stated she and a CNA had provided transportation services to appointments in his absence. She stated on 6/02/2026 the date of Resident #2's appointment she was working as a charge nurse on the floor, the other CNA was working on the floor and the transporter was on leave. The ADON stated in the past they have tried to coordinate transportation with Resident #2's family, but they do not live locally. She stated Resident #2 does not meet medical necessity for a transport company. She stated in that case they have a facility van to (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take residents to appointments. The ADON stated the physician was notified of the missed appointment, and it was rescheduled. The ADON stated the facility did not have a DON. During an interview on 6/12/2026 at 4:11 p.m., the Administrator stated transportation for appointments was handled by the DON. The Administrator stated she was second backup for transportation after the DON for coordination. The Administrator stated on 6/02/2026 Resident #2's transportation to the appointment would have fallen on the ADON and herself for coordination. She stated there was no way for either of them to have gone. She stated at the time she was not aware of the appointment and was not aware he had missed the appointment because she would have taken him herself. She stated transportation to appointments was important to ensure the residents are receiving adequate care. Record review of the facility policy titled Transportation Policy undated, revealed: Responsibilities: A. Facility: 1. Arrange/provide transport as needed. 3. Schedule appointments according to the recommendations of medical providers 4. Schedule transportation to meet appointments scheduled by facility/or resident/family based on availability of vehicle and/or transportation services. 5. Reschedule appointments as needed based on clinical significance as determined by medical director and the interdisciplinary team.:

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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 ensure medical records were maintained in accordance with accepted professional standards and practices for each resident, that were complete and accurately documented for 1 of 4 residents (Residents #1) reviewed for accuracy of medical records. The facility failed to ensure Resident #1's signed and executed OOH DNR was uploaded as part of the resident's medical record. This deficient practice could place residents at risk for errors in care and treatment and inaccuracies in documentation. The findings include:Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: dementia with behavioral disturbance, type 2 diabetes mellitus and malignant neoplasm of left kidney (cancer of the kidney). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 2 which indicated a severe cognitive impairment. Record review of Resident #1's signed OOH DNR dated [DATE] was located in a three-ring binder at the nurses station but was not uploaded into the resident's medical record. During an interview on [DATE] at 5:33 p.m., Resident #1's RP stated the family did not want CPR for Resident #1 and had signed an OOH DNR to honor their request. The RP stated the facility ADON had helped coordinate obtaining and signing the OOH DNR. During an interview on [DATE] at 7:26 p.m., the ADON stated Resident #1 had an OOH DNR signed at the facility which was kept at the nurses station in a binder. The ADON stated once a OOH DNR is obtained medical records was responsible for ensuring it was uploaded into the medical record. The ADON stated right now the facility did not have anyone staffed to do medical records since February 2026. She stated the Administrator had been doing the uploading. During an interview on 6/ 12/2026 at 4:11 p.m., the Administrator stated the charge nurses and medical records were primarily responsible for ensuring scanning and uploading of documents into the residents' medical records. The Administrator stated since the facility did not have anyone currently in the position of medical records the responsibly fell on her. She stated it was important to ensure residents received adequate care. Record review of the facility policy titled Advanced Directives dated [DATE] revealed: If The Resident Has An Advanced Directive: 1. if the resident or the resident's representative has executed one or more advance directive .copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.