STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675948	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Belton	810 E 13th Ave Belton, TX 76513

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and observations, the facility failed to ensure 1 of 6 residents (Resident #1) received services in the facility with reasonable accommodation of resident needs and preferences.Resident #1 had to wait 30 minutes for the call light to be answered, and according to Resident #1 had not received a shower in almost 2 weeks.This failure could place residents at risk of harm and/or isolation.Findings included:RR of Resident #1 face sheet revealed a [AGE] year-old male resident who admitted to the facility on [DATE] with diagnoses of multiple fracture of the pelvis (severe injuries, often resulting from high-energy trauma, that create unstable rings, causing intense pain, bleeding, and potential damage to internal organs), insomnia (inability to sleep), unstable burst fracture of T9-T10 vertebrae (a severe, high-energy injury where the bone shatters in multiple directions, potentially compromising the spinal canal and causing neurological damage), fracture of rib, dislocation of left wrist and hand, and displaced trimalleolar fracture of both legs (a severe, highly unstable injury involving fractures of the medial malleolus, lateral malleolus (fibula), and posterior malleolus (tibia), usually requiring urgent bilateral surgical reduction).RR of Resident #1 MDS record dated 02/15/2026 revealed that Resident #1 had a BIMS of 12, which indicate minimal cognitive impairment. The MDS also revealed that Resident #1 required maximum assist for toileting and showering needs. Maximum assist meant helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort of the task. An observation conducted on 04/07/2026 at 11:00AM revealed Resident call light was lit above their door.An observation and interview was conducted on 04/07/2026 at 11:01AM with Resident #1 who was laying in their bed. Resident #1 appeared disheveled and unkempt. Resident #1 stated he hated the being at the facility. Resident #1 stated he felt like that because he had to wait multiple hours, approximately 3 hours, before he got assistance. Resident #1 stated often the staff would respond to his call light but would tell him someone will come and help you but staff do not return. Resident #1 stated he had pushed his call light about 10 minutes before INV conducted the interview.An observation was conducted on 04/07/2026 at 11:18AM of Resident #1's call light lit above his door. Further observation revealed there were two staff members that sat at the nurse's station whom were a nurse and respiratory therapistAn observation was conducted on 04/07/2026 at 11:25AM of two staff still at the nurse's station located in the middle of the facility. At the nurse's station was a equipment box attached to the wall, which had lights, room numbers and was beeping. This box was revealed to be a call light alert system.An interview was conducted on 04/07/2026 at 11:28AM with Resident #1 revealed that the staff had not responded to his call light at that time.An observation conducted on 04/07/2026 at 11:30AM revealed the same 2 staff members at the nurse's station, and the same 4 lights binging including Resident #1's on the call light alert system. An interview was conducted on 04/07/2026 at 11:32AM, INV requested assistance from the ADM regarding Resident #1 call light which had been on for approximately 45 minutes at that point.An interview was conducted on 04/07/2026 at 1:17PM with CNA A revealed they had received training on call light systems which included all floor staff are responsible to answer the call lights. CNA A stated she knows when a call light was on by a light that triggered on the hallway above the resident's doors as well as the nurse's station would alert staff as (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	well. CNA A stated residents should not wait a long time to have their call lights answered. She stated that if the call light was not answered timely the resident could be in a hurting situation. An interview was conducted on 04/07/2026 at 1:23PM with CNA B revealed they had received training on call lights which included that call lights should be answered in a timely manner, and every staff would be responsible for answering the call lights. CNA B stated she knows when a call light was on because above the resident's doors was a light that is lit whenever the call light had been pushed. CNA B stated there was also a call light monitoring system at the nurse's station that would beep and light up. CNA B stated that a resident should wait no more than 10 minutes if you are able to get to it right then and there, then you should. She stated if a call light was not answered timely, it could affect a resident due to the resident could have fallen. An interview was conducted on 04/07/2026 at 1:30PM with RN C which revealed they had received training on call lights which included that the call lights should be answered in a timely manner and to notify the residents that help was on the way. She stated that everyone was responsible, as far as staff, to respond to call lights that are on. RN C stated outside the door there was a light that was turned on. She stated the front panel by the nurse station will let you know when there is a call light on as well. RN C stated that residents should only wait a couple of minutes for a response after they set off their call lights. RN C stated if staff did not answer call lights in a timely manner, the resident could be in an emergency situation, fall risk situation or even a fatal situation. An interview was conducted on 04/07/2026 at 1:36PM with the ADM which revealed she had received training on resident rights which included the residents had the right to be treated with dignity and respect. The ADM stated she had also received training on call lights which had included that everyone can answer the call lights however, type of direct care should be given by nursing staff. Call lights should be answered in a timely manner and assist the residents. The ADM stated the training covered the same information in the facility's policy. The ADM stated that staff would know that a call light was on because a light above the room will be lit, as well as the board near the nurse station will beep for the call light that is on. The ADM stated that the resident would not receive the care that they need, and there may be an incident if they are trying to assist themselves due to not getting the assistance in a timely manner. An interview was conducted on 04/07/2026 at 1:51PM with the DON who stated she had received training on resident rights which had included residents have the right to proper care, be treated with dignity and the right to be clean. The DON stated she had received training on call lights which included her expectation was that staff in the building should respond to the call lights. She stated staff would be aware of a call light that was on because a light would be lit above the resident's door, as well as notification at the call light system located at the nurse's station. The DON said that the residents should not wait 30-45 minutes to have their call light answered, and that it should be answered in a timely manner such as 10-15 minutes. She stated that if staff do not answer the call lights, the residents would not have their needs met. 03/17/2026 Call light grievance: Call light not answered in a timely manner. Family member noticed multiple call lights on but nobody assisting. RR indicated the facility had conducted inservice training on the following care areas in January:Resident RightsRR indicated the facility had conducted inservice training on the following care areas in March:Call lights - all staff is to answer the call lights but only direct care staff can provide care.Call lights - it is the responsibility of all staff, not just nursing department. Call light response time should not be 30+ minutes.RR of the facility provided policy titled Call System, Residents Policy dated January 2025 revealed the following:Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station.Each resident is provided with a means to call staff directly for assistance from his/ her bed, from toileting/bathing facilities and from the floor. Calls for assistance are answered timely.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and observations, the facility failed to ensure residents had the right to a dignified existence, self-determination, and communication for 2 of 6 (Resident #1 and Resident #2) residents reviewed for resident rights; in that:The facility failed to ensure that Resident #1 and Resident #2 received their showers as scheduled.This failure could place residents at risk for decreased quality of life, isolation, and skin breakdown.Findings Included: Resident #1RR of Resident #1 face sheet revealed a [AGE] year-old male resident who admitted to the facility on [DATE] with diagnoses of multiple fracture of the pelvis (severe injuries, often resulting from high-energy trauma, that create unstable rings, causing intense pain, bleeding, and potential damage to internal organs), insomnia (inability to sleep), unstable burst fracture of T9-T10 vertebrae (a severe, high-energy injury where the bone shatters in multiple directions, potentially compromising the spinal canal and causing neurological damage), fracture of rib, dislocation of left wrist and hand, and displaced trimalleolar fracture of both legs (a severe, highly unstable injury involving fractures of the medial malleolus, lateral malleolus (fibula), and posterior malleolus (tibia), usually requiring urgent bilateral surgical reduction).RR of Resident #1 MDS record dated 02/15/2026 revealed that Resident #1 had a BIMS of 12, which indicate minimal cognitive impairment. The MDS also revealed that Resident #1 required maximum assist for toileting and showering needs. Maximum assist meant helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort of the task. An observation and interview was conducted on 04/07/2026 at 11:01AM with Resident #1 who was laying in their bed. Resident #1 appeared disheveled and unkempt. Resident #1 stated he hated the being at the facility. Resident #1 stated the staff do not offer showers or bed baths for him. He stated he had not received a shower in almost 2 weeks. Resident #1 stated that the care he received regarding lack of showers made him feel dirty and want to leave the facility.Resident #2RR of Resident #2 face sheet revealed a [AGE] year-old woman who admitted to the facility on [DATE] with diagnoses of anxiety disorder, muscle weakness, wedge compression fracture of lumbar vertebrae (a common spinal injury where the front (anterior) part of a vertebra collapses, forming a wedge shape due to excessive pressure, often caused by osteoporosis, trauma, or tumors), and reduced mobility.RR of Resident #2 MDS record dated 03/29/2026 revealed that Resident #2 had a BIMS of 08, which indicate moderate cognitive impairment. The MDS also revealed that Resident #2 required maximum assistance for toileting and showering needs. Maximum assist meant helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort of the task. RR of daily shower list provided by the facility revealed:It is reported in the report that Resident #1 and Resident #2 is to shower on the evening shift on MWFThis document states all refusals are to be reported to the nurse and documented in POC/PCC. Nobody is allowed to make changes other than the DON or ADON.An interview was conducted on 04/07/2026 at 11:20AM with Resident #2 who was laying in bed. Resident #2 stated she does not often receive showers. Resident #2 stated her last shower had been more than 5 days prior. Resident #2 stated she did not know how it made her feel to not receive her showers.An interview was conducted on 04/07/2026 at 1:17PM with CNA A revealed they had received training on ADL care which included CNA's are responsible for providing a shower to residents. CNA A stated residents are offered a shower every other day, and if the resident refused a shower, it would be documented. CNA A also stated there would be no reason a resident did not receive a shower in almost 2 weeks unless they refused the shower. CNA A stated if a resident was not offered showers, it could impact them negatively by getting sores.An interview was conducted on 04/07/2026 at 1:23PM with CNA B revealed they had received training on ADL care which included CNA's are responsible for providing the showers to the residents. CNA B stated that residents are offered a shower 3 times a week, and if the resident refuses, it should be documented somewhere. She stated that a resident should not have been unshowered in almost 2 weeks. She (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it could negatively impact the residents hygiene and health concerns.An interview was conducted on 04/07/2026 at 1:30PM with RN C which revealed they had received training on ADL care which included that the CNA and hospice are responsible for the showers at the facility. She stated that residents are offered a shower 3 days a week. It should pop up in the Kardex for the aids to shower the residents. RN C stated if residents did not receive their showers in almost 2 week it could be the result of the resident refusing the shower and/or staffing levels were low. She said that it should be documented if residents had refused. She stated that residents may feel unsocial as well as their health and skin are at risk they had not received showers.An interview was conducted on 04/07/2026 at 1:36PM with the ADM which revealed she had received training on resident rights which included the residents had the right to be treated with dignity and respect. The ADM stated her policy regarding showers was that resident should receive their shower. They have a shower schedule that should be followed by 3 times a week. The ADM stated the nursing care team was responsible for providing showers to the residents. She stated that residents should be offered a shower 3-4 times a week, or at their leisure. She stated there would be no reason for a resident to not have received a shower in about 2 weeks. She stated that the resident could get bed sores and basic hygiene not being met. She stated they could get sick.An interview was conducted on 04/07/2026 at 1:51PM with the DON who stated she had received training on resident rights which had included residents have the right to proper care, be treated with dignity and the right to be clean. The DON stated she had received training on ADL care which included her expectation for showers were that staff provide showers 3 times a week or PRN. The DON stated that the CNA are mainly responsible for providing the showers to the residents. She stated that the resident could be affected mentally, their dignity as well and affect them in a negative way if they had not received their showers.RR of grievances filed provided by the facility revealed:03/17/2026 Resident care grievance: resident not being changed timely, soaking in urine.03/17/2026 resident care grievance: resident said she is not getting care timely as she should because short staffed. RR indicated the facility had conducted inservice training on the following care areas in January:Resident RightsRR of the facility provided policy titled Shower/Tub Policy undated revealed the following:The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.