

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Avir at Knox City		STREET ADDRESS, CITY, STATE, ZIP CODE 605 S Ave F Knox City, TX 79529	
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to respect the resident's right to personal privacy in 1 of 3 common hallways reviewed for privacy in that: A list of residents that received incontinence care services was posted on the wall in a hallway at a nurse charting station which was visible to potential passersby. This failure could place residents at risk of having medical information personal, or care instructions exposed to others and misuse of personal information. During an observation on 12/16/25 at 4:05 PM revealed a list of 14 residents names that received incontinence care services was posted on the wall in a hallway on the secured unit at the nurse charting station which was located across from the doorway of a dining room. During an interview on 12/18/25 at 11:30 AM, the ADON stated she posted the incontinence care list on the wall in the hallway at the charting station. She stated she posted it on the wall but did not think about how it affected resident's privacy when she did that. She stated she did not remember when she posted it there. She stated she now realized that may have caused residents to feel embarrassed. She stated she had received training about a month ago on privacy. She stated the DON also provided training to staff on privacy periodically. She stated everyone was responsible for ensuring residents had privacy. She stated privacy was important to residents because this was their home and they wanted to ensure residents felt safe and comfortable. She stated a potential negative outcome was embarrassment, that it could cause residents to feel unhappy and not want to live here, or it could cause others to make fun of residents. During an interview on 12/18/25 at 12:55 PM, the DON stated residents should feel protected and in a safe environment and not feel exposed. She stated residents had the right to have their personal care needs private. She stated she was not aware of the incontinence care list posted on the wall in a hallway. The DON stated the list was not appropriate because it gave information that residents may not want to be known because it was a dignity issue. She stated staff were also trained on privacy when they were hired. She stated herself and their Human Resources department provided ongoing training to staff regarding privacy. She stated she expected staff to ensure residents have their rights to privacy. She stated a potential negative outcome was that it could cause depression. During an interview on 12/18/25 at 2:15 PM, the ADM stated residents have a right to privacy. The ADM stated she was not aware of the incontinence list posted in the hallway. She stated this was a privacy and dignity issue. She stated she trained all staff in the residents' privacy, and she also provided ongoing in-services to staff. She stated she expected residents' privacy to be respected so they felt safe and comfortable. She stated a potential negative outcome was that residents would not feel safe and comfortable and not feel like they were at home. Record review of the facility policy, Resident Rights, revised February 2021, revealed the following in part: Policy Statement Employees should treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:a. a dignified existence.b. be treated with respect, kindness, and dignity.t. privacy and confidentiality.dd. communicates in person and by mail, email, and telephone with privacy.4. Unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA compliance officer.		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident had a right to a safe, clean, comfortable, and homelike environment in the facility and failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior in 1 of 2 common dining rooms and 10 of 33 resident rooms (24, 25, 26, 28, 30, 31, 32, 33, 34, and 35) reviewed for environment. The facility failed to ensure residents that used common areas and rooms were clean, safe, and did not need repair. These failures could place residents at risk of living in an unsafe, unclean, uncomfortable, and unhomelike environment which could cause a decline in resident psychosocial well-being. The findings included: During an observation on 12/16/25 at 11:42 AM in room [ROOM NUMBER] revealed, the vertical blinds in the bedroom window were missing 1 slat. During an observation on 12/16/25 at 12:14 PM room [ROOM NUMBER] revealed 2 broken and/or cracked planks on the flooring in the room. The planks were also bowing upward and sticking up from the floor. Additionally, the window was broken and covered with two doubled up pieces of cardboard and duct taped to the framing. Also, the vertical blinds on the bedroom window were missing 1 slat. During an observation on 12/16/25 at 2:38 PM, room [ROOM NUMBER] revealed the vertical blinds on the bedroom window missing 1 slat. During an observation on 12/16/25 at 2:43 PM room [ROOM NUMBER] revealed the vertical blinds on the bedroom window missing 1 slat. During an observation on 12/16/25 at 2:49 PM in room [ROOM NUMBER] revealed, the vertical blinds on the bedroom window were missing 1 slat. During an observation on 12/16/25 at 3:01 PM in room [ROOM NUMBER] it was revealed the vertical blinds on the bedroom window were missing 2 slats. During an observation on 12/16/25 at 3:30 PM in room [ROOM NUMBER] it was revealed the vertical blinds on the bedroom window were missing 1 slat. During an observation on 12/16/25 at 4:03 PM room [ROOM NUMBER] revealed 22 broken and/or cracked flooring tiles in the room. Additionally, the vertical blinds on the bedroom window were missing 10 slats. During an observation on 12/17/25 at 12:11 PM in the dining room [ROOM NUMBER] broken and/or cracked tiles that went all the way across the middle of the dining room floor. The vertical blinds on a dining room window were missing 7 slats. Additionally, a white blanket was used as a window covering on that window. During an observation on 12/17/25 at 12:47 PM in room [ROOM NUMBER] it was revealed the vertical blinds on the bedroom window were missing 2 slats. During an observation on 12/17/25 at 1:05 PM in room [ROOM NUMBER] it revealed the vertical blinds on the bedroom window was missing 3 slats. Record review of a document titled, Work Orders for [facility name], undated, revealed an open work order for blinds torn that was not dated. There were no open or closed work orders for broken or cracked floor tiles or planks, or a broken window documented on the list of work orders. During an interview on 12/18/25 at 11:30 AM, the MS stated he walked the building several times daily to identify issues that needed repairs; he did not solely depend on residents and staff to submit work orders for repairs. He stated repairs needed were documented in an electronic system called Tels. He stated he could access the Tels system through an application on his cellular phone and it organized the maintenance work orders. He stated he was responsible for ensuring repairs were completed timely. He stated high priority repairs were completed immediately, and other repairs were completed when he could get to them. He stated he considered a broken window a high priority repair. He stated he was aware there were several rooms that were missing slats on the window vertical blinds. He stated the facility just switched owners a couple of months ago and there was an issue with the funding. He stated he had not followed up recently to check on the status of the funding since the switch. He stated he had been busy trying to get his classes, new training, and learning new ways of doing things that were required by the new owners. He stated he was aware of rooms with cracked and broken tiles and planks, and he changed them 2 years ago, but the building floor was pier and beam which caused flooring to move (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and break. He stated he was not aware of plank flooring that was broken in the resident's room. He stated he did not know why there was no work order for broken tiles and planks listed in the Tels system as they should have been submitted on the list of work orders. He stated he was aware of the room with the broken window, but there was no funding at the time to purchase materials needed to repair it and they also had no access to petty cash. He stated he cleaned out the broken pieces of glass and installed two layers of cardboard and duct taped it. He stated he did not know why there was no work order for broken window listed in the Tels system, however it should have been submitted as a work order. He stated the new owners monitored the work orders in the Tels system. He stated he had not received training on maintenance or the importance of residents having a comfortable homelike environment. He stated he did not know how missing slats from the blinds negatively affected the residents. He stated cracked and broken tiles, and broken plank flooring could be a tripping hazard for residents. The MS stated he could not determine a possible negative outcome of not repairing a window. During an interview on 12/18/25 at 11:30 AM, the ADON stated she was aware that the broken blinds and flooring had been like that for several months and had been reported to the corporate office as well as submitted in the Tels system. She stated she was aware of the broken window in room [ROOM NUMBER]. She stated she did not enter a work order for the broken window in the Tels system because she knew the MS was aware of the broken window. ADON stated she had been trained in the environmental requirements of the facility. She stated she was responsible for training staff in reporting maintenance needs. She stated it was important that residents lived in a homelike environment so they could be comfortable, just like she preferred at her home, because this was their home. She stated broken and cracked flooring was a potential trip hazard. She stated broken windows could have allowed animals to enter the building as well as not protect residents from weather conditions. The ADON stated missing slats on the blinds had not allowed residents to have privacy. She stated not making needed repairs could cause residents to have depression when they saw things that were broken. During an interview on 12/18/25 at 12:55 PM, the DON stated the MS and ADM were responsible to ensure needed repairs were completed. She stated all staff were responsible for reporting repairs needed. She stated they had a rounding system every week with staff where they could report repairs needed directly to the MS and they could also enter repairs needed in the Tels system. She stated the importance of reporting repairs was to prevent accidents or complications in the facility. She stated the broken blinds had been reported and were ordered but they were the wrong size and were sent back. She stated the facility was bought by a new company afterwards and there had been a delay with having access to money. She stated she was aware of broken tiles and plank flooring. She stated she was concerned because it could be an accident risk and could cause issues when staff tried to clean the floors. The DON stated she was not aware of the broken window in the resident's room. She stated the Tels system was documentation that someone reported to make the MS accountable to ensure repairs were completed. She stated she expected staff to document issues such as broken windows in the Tels system as well as verbally tell the MS. She stated she considered a broken window to be a priority. She stated she had received training on importance of maintenance with the previous company as well as the new company. She stated a potential negative outcome of a broken window was elopement or injury. She stated broken and cracked flooring could cause residents to trip or they cut could themselves on it. During an interview on 12/18/25 at 2:15 PM, the ADM stated the MS was responsible for assessing the building for repairs. She stated all staff were responsible for reporting repairs needed. She stated the Tels system was the main system used to submit and monitor repairs needed but serious things should have been directly reported to the MS. The ADM stated she was aware of the vertical blinds that were broken in several rooms. She stated the blinds had been broken for a while and they had been replacing them little by little. The ADM stated she had been aware of broken tiles and cracked tiles, and broken plank flooring in resident's rooms for a couple of months. She stated those issues should have been documented in the Tels system. She stated she was aware the broken and cracked tile (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	flooring in the dining room had been reported to the corporate office of the previous company that owned the facility, but they had to restart that process with the new company. She stated she was not aware if the broken flooring in the resident's room having been reported. She stated that it was a fall hazard. The ADM stated she was not aware of the broken window in the resident's room. She stated that there was an elopement risk and shard glass could've possibly caused injury and she considered that a serious repair that needed to be addressed. She stated the broken window should have been documented in the Tels system so they could track it and ensure it had been fixed. She stated she had received training on maintenance and environment. She stated herself and the MS were responsible for training staff. She stated staff had been trained in how to document repairs in the Tels system. She stated the Tels system was for tracking repairs, and it was important for the repairs to be documented there. She stated she expected a simple repair to be completed on the same day; however, she would have allowed 2-3 more days if additional materials were needed. She stated she expected a broken window to be repaired on the same day. The ADM stated a potential negative outcome of not addressing repairs needed in the facility would not allow the facility to provide a homelike environment for residents and this was important because it was their home. Record review of the facility policy, Maintenance Service, revised December 2009, revealed the following in part: Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. maintaining the building in good repair and free from hazards. f. establishing priorities in providing repair service. Record review of the facility policy, Homelike Environment, revised February 2021, revealed the following in part: Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation and interview, the facility failed to provide information to residents and their representatives on their rights related to filing grievances or concerns for 4 of 4 confidential residents. The facility failed to ensure 4 of 4 confidential residents were provided, per the facility policy through postings in prominent locations: the grievance procedure, access to grievance forms, information regarding who the facility grievance officer was with their contact information, and accommodations to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings included: Observation of prominent posting on 12/17/2025 at 9:44 AM revealed the facility did not have instructions regarding the grievance procedure with any of their prominent postings. Grievance forms were not readily available to residents in the facility, and there was no accommodation to submit grievance anonymously. During a confidential interview on 12/17/2025 at 10:00 AM with the resident council, 4 confidential residents stated they did not know how to file a formal grievance. The residents attending Resident Council stated they did not have access to grievance forms, and they did not know where grievance forms were kept. Additionally, residents in the Resident Council were not aware of who their grievance officer was, nor the process to resolve grievances. The residents stated they had not seen a posting in the facility pertaining to grievances. The residents in the Resident Council also stated they did not know how to file anonymous grievances, and they were not aware they had the option to file a formal complaint anonymously. During an interview on 12/18/2025 at 12:55 PM the DON stated there were grievances forms on her door. She stated everyone was responsible for taking grievances from residents. She stated residents could tell any staff member of their grievance and the staff member would fill out the grievance form for the resident. She stated she was not sure if information on grievances was posted on the bulletin board. She stated the grievance process should be posted for residents to see. She stated she would be involved in any grievance that involved the nursing department and then either she or the ADM would provide the resident with the outcome. She stated she had received training on the grievance policy. She stated supervisors, including herself, were responsible for ensuring their staff were trained in grievances. She stated they also discussed grievances that needed to be addressed during morning meetings. She stated she was not aware residents did not know who the grievance officer was and that residents did not know how to file a grievance. She stated residents could complain to anyone or call her as well. She stated she did not consider the grievance forms on her door to be accessible to residents because there was no prominent sign that indicated the forms were there. She was not aware residents could not access forms without staff assistance. She stated she was not aware residents must have the option to file an anonymous grievance. She stated anonymous grievances were important so residents could report their concerns without fear of retaliation. She stated it was possible there were grievances not filed due to lack of access to the forms. She stated she expected grievance postings to be in prominent areas so residents would not be afraid of retaliation and so they had easy access to file grievances. She stated a potential negative outcome was that residents could feel discontent and not file grievances due to feeling things would not get done or not feel comfortable complaining, which could cause them to be introverted. During an interview on 12/18/2025 at 2:15 PM the ADM stated she was the Grievance Officer for the facility. The ADM stated there were grievance forms on DON's door and residents could let staff know about grievance and staff could fill out the grievance form for them. The ADM stated the grievance policy was that she was to investigate grievances and ensure they were resolved. The ADM stated the grievance process information was posted on the bulletin board by the nurse station. She stated she was not aware residents did not know how to file a grievance or who the grievance officer was. The ADM stated she did not consider the grievance forms on the DON's door to be readily accessible to residents because of the height they were located at and (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because the forms were not prominent and blended in with other items on the door. The ADM stated there was no procedure in place currently that allowed residents to obtain a grievance form on their own or to submit it anonymously. The ADM stated it was important that residents had a way to submit an anonymous grievance and not be afraid of retaliation. She stated it was possible she may not be aware of some grievances. She stated she was concerned about this because there could have been issues that she was not aware of that were reportable to the State. The ADM stated she had been trained in grievances. She stated staff have also been trained in grievances. The ADM stated the grievance posting was important for residents so they could know where to get the form and know how to file a grievance. She stated she expected residents to feel comfortable with filing a grievance. She stated she believed residents should have a way to file an anonymous. She stated she expected grievances to be resolved as soon as possible. She stated a potential negative outcome of not having a grievance posting was that was that residents would not know to file a grievance so, then grievances would not be corrected. She stated a negative outcome of not having a way to submit an anonymous grievance could cause residents to not feel safe. The ADM stated the grievance posting was no longer on the bulletin board after she observed the bulletin board. Record review of the facility policy, Grievances/Complaints, Filing, revised April 2017, revealed the following in part: Policy Statement Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman). The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the residents and/or representatives. Policy Interpretation and Implementation2. Residents, family and resident representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal.3. All grievances, complaints or recommendations stemming from residents or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response.4. Upon admission, residents are provided with written information on how to file a grievance or complaint. A copy of our grievance/complaint procedure is posted on the resident bulletin board.5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously.6. The contact information for the individual(s) with whom a grievance may be filed is provided to the residents and/or representative upon admission.7. The administrator has delegated the responsibility of grievance and/or complaint investigation to the grievance officer who is _____ and can be contacted by _____.13. If the grievance is filed anonymously, the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance(s) and report the findings. The grievance officer will reiterate to the resident that it is against facility policy and federal regulations to discriminate or sanction a resident who has filed or verbalized a complaint against the facility, and that his or her rights to be free of discrimination or reprisal will be protected.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 1 of 2 medication carts (Medication Cart A) reviewed for medication storage. LVN B left Medication Cart A unlocked and unattended in the hallway by the nurse's station. The facility failed to ensure Medication Cart A's medications were stored separately by route. These failures could place residents at risk for drug diversion and an increased risk for medication errors. The findings included: During an observation on 12/16/25 at 11:31 AM, Medication Cart A was observed unlocked and unattended in the hallway by the nurse's station. No staff members or residents were observed in the area around Medication Cart A. During an interview on 12/16/25 at 11:33 AM, LVN B stated she knew she was supposed to lock the medication cart when she walked away from it. LVN B stated she forgot to lock it when she went to check on a resident. LVN B stated a potential negative outcome to the residents was they could get into it [the medication cart]. During an observation on 12/17/25 at 4:15 PM of Medication Cart A with LVN A and the DON revealed the following: -Fluticasone/Salmeterol inhaler for Resident #1 was stored next to Calcitonin Nasal Spray for Resident #12 in the same sectioned area in the third drawer, -Nitroglycerin sublingual tablets for Resident #41, Ondansetron injections for Resident #7, Cosopt eye drops for Resident #7, and Rhopressa eye drops for Resident #7 were stored next to each other in the same sectioned area in the first drawer, and-Latanoprost eye drops for Resident #7, Lantus flexpen for Resident #10, and Insulin Aspart flexpen for Resident #10 were stored next to each other in the same sectioned area in the first drawer. During an interview on 12/17/25 at 4:25 PM, LVN A stated she was not aware of the medications needing to be separated by route and the pharmacy consultant had never said anything when they had done their checks. LVN A stated a potential negative outcome to the residents was the staff could give the wrong med or wrong patient and there was also a risk for cross contamination. Attempted phone interview on 12/18/25 at 9:34 AM with the Pharmacist revealed no answer. The Surveyor left a voice mail with call back number. During an interview on 12/18/25 at 9:47 AM, the DON stated she expected the medications carts to be locked at all times. The DON stated she trained the nurses by doing in-services and watching to see if the carts were locked. The DON stated LVN B was checking on residents down the hall the other day and she just forgot to lock the medication cart. The DON stated a potential negative outcome with the medication cart being unlocked and unattended was someone could get into it who was not authorized. The DON stated she expected medications to be separated in the medication cart. The DON stated the pharmacy consultant went in and checked their medication carts and had not mentioned the storage of medications being an issue. The DON stated there used to be a divider in the medication cart to keep the medications separated but she did not know what happened to the dividers. The DON stated a risk to the residents was a nurse not looking at the label and a medication error occurring. During an interview on 12/18/25 at 11:03 AM, the ADM stated she expected the medication carts to be locked at all times. The ADM stated she did not know why LVN B did not lock the medication cart when she walked away from it. The ADM stated the nurses were trained in medication storage, but it was unknown when. The ADM stated the DON and herself were responsible for ensuring the nurses kept the medication carts locked at all times. The ADM stated a potential negative outcome was that a resident could get in [the medication cart] or an employee could also get in [the medication cart]. The ADM stated the medications stored in the medication carts should be separated and easily accessible. The ADM stated the DON was responsible for monitoring the storage of medications in the medication carts. The ADM stated the nurses were trained on medication storage, but she would have to go back and look at in-services for exact dates. The ADM stated a potential negative outcome was that the nurses could get the medications mixed up or give the wrong medication. Record review of the facility's document titled, (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Consultant Pharmacist Summary dated 11/17/2025, reflected the following: .4. Medication Carts:.All medications stored/labeled properly: No.The following suggestions are best practice guidelines: -always keep inhalers, eye drops, ear drops, oral liquids and topical labeled patient specific items and stored separately to help reduce the possibility of med [medication] errors. Record review of the facility's policy titled, Medication Labeling and Storage, dated 2001, reflected the following: Policy Statement - The facility stores al medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.Policy Interpretation and Implementation:Medication Storage: .4. Compartments (including, but not limited to, drawers.carts .) containing medications and biologicals are locked when not in use.5. Medications are stored in an orderly manner in cabinets, drawers, carts. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Avir at Knox City		STREET ADDRESS, CITY, STATE, ZIP CODE 605 S Ave F Knox City, TX 79529	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interviews, and record review, the facility failed to ensure that the menu met the nutritional needs of residents and was followed for the lunch meal on 12/16/25 reviewed for nutritional adequacy. The facility failed to: 1) Ensure lunch item served on 12/16/2025 reflected what was on the DM's menu. 2) Ensure residents on special diet (pureed bread) receive pureed bread for the 12/16/2025 lunch meal. These failures could affect all residents who ate food from the kitchen by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. The findings included: Review of the weekly menu week 3 Tuesday lunch revealed Beef goulash, Squash medley, tossed salad, Cornbread, Margarine, Dressing of choice, Fresh baked cookie and a Beverage. During an observation on 12/16/25 from 12:15 PM to 12:30 PM revealed a message written on a white board hanging on a wall in the secured unit dining room said that reflected, Lunch: goulash, green beans, bread slice, fruit. Three items of pureed food were observed to be included on four pureed meals that were served which included: pureed goulash, pureed green beans, and pureed mixed fruit. The pureed bread was not observed to be included with any of the four meals. In an interview on 12/18/2025 at 9:53 AM with the DM, he stated that I am responsible for making the pureed bread and residents on that meal type were supposed to get it. The DM further stated that he made the pureed bread and forgot it in the refrigerator. He stated, Sometimes I forget stuffs. The DM stated he did inform the ADM, RD and all the other residents that the menu was being substituted. [BR1] The DM stated he did inform the ADM, RD, and all the other residents that the menu was being substituted. He stated that it would cause residents' dissatisfaction resulting in weight loss. In an interview on 12/18/2025 at 10:39 AM with the RD, she stated that she was not aware that pureed bread was not served to some of the residents. The RD stated the DM was responsible to follow that, and such be documented. The RD stated that the potential negative outcome on such residents could be less calories. In an interview on 12/18/2025 at 11:47 AM with LVN A, she stated I was not here on that day, 12/16/2025; the dietary staff were responsible to serve resident with the correct meal. LVN A stated that residents would not get all the calories and nutrients needed which could result in malnutrition and breakdown. LVN A further stated, The facility doesn't provide nutritive meals for the residents, and I told my DON about it. She responded that she would take care of it. In an interview on 12/18/2025 at 12:18 PM with the DON, she stated I was not aware that pureed bread was not served on 12/16/2025; the DM was responsible for making sure that pureed bread was served to the resident for lunch on Tuesday, 12/16/2025. When asked about the menu not being followed, the Director of Nurses stated, It must have come up in one of our meetings. Usually, the Dietary Manager and Administrator will figure it out. She stated, within the nursing department, none of the staff members had complained about dietary services not following the menus. DON stated that residents could have less nutrition resulting in weight loss. In [BR2] an interview on 12/18/25 at 12:47 PM with the ADM, she stated I was not aware that pureed bread was not served on 12/16/2025. The DM [BR3] was responsible for making sure that pureed bread was served to the resident for lunch on Tuesday, 12/16/2025. She stated she had been notified before that menus were not followed by the DM and nursing staff. The ADM stated the potential negative outcomes to the residents without the pureed bread was, The residents are not getting enough portions leading to possible weight loss. Record review of the facility's undated policy and procedure manual titled, Menu Planning, reflected the following: Policy: Nutritional needs of individuals be provided in accordance with the established national standards adjusted for age, gender, activity level and disability, through nourishing, well balanced diets, unless contradicted by medical needs. Based on a facility's reasonable efforts, menu should reflect the religious, cultural, and ethnic needs of the population served, as well as input received from individuals and group. Procedure: 1. Menu planning will be completed by the facility at least two weeks in advance of service and menu kept on file for a reasonable period (check individual (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	state regulations to see if there are specific guidelines). All current menus will be posted in the kitchen area during the appropriate time. a. Regular and therapeutic menus will be written to provide a variety of foods served on different days of the week, adjusted for seasonal changes, and in adequate amounts at each meal to satisfy recommended daily allowances. If menus are written in circles, they are rotated. 4. Regular and therapeutic menus will be written by the facility's food and nutrition professionals in accordance with the facility's approved diet manual or purchased from an approved vendor. The registered dietitian nutritionist (RDN) or designee will approve all menus. 5. Menus will be posted in areas that are accessible to patients/residents at heights where all individuals can easily view them. 6. Temporary changes in the menu will be noted on the menu substitution sheet [BR4] and posted so that facility staff are aware of changes. (See Sample Menu Substitution Sheet later in this chapter.) The RDN or designee will approve all permanent menu changes.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety. 1) The facility failed to ensure food items in the freezers (4), were labeled and stored in accordance with the professional standards for food service. 2) The facility failed to protect foods from potential contamination. These failures could place residents at risk for food-borne illness and cross contamination. The findings included: The following observations were made during a kitchen tour on 12/16/25 that began at 11:01 AM and concluded at 11:38 AM: The facility failed to have vent hood located directly above the cooktop on the right side of the kitchen free from dust and cobwebs. Walk-in Freezer #1 revealed the following: What appeared to be chicken breasts, ground beef, and chicken wings in three different clear plastic bags with no label, no date on bag. Walk-in Freezer #2 revealed the following: What appeared to be sausage in a clear plastic bag with no label, no date on bag. Walk-in Freezer #3 revealed the following: What appeared to be Chinese rice, French fries, mixed vegetables, and okra in four different clear plastic bags with no label, no date on bag. Walk-in Freezer #4 revealed the following: What appeared to be chicken drumsticks, and egg rolls in two different clear plastic bags with no label, no date on bag. In an interview on 12/18/2025 at 9:53 AM with the DM, he stated I am responsible for dating and labeling of all food items in the freezers. The DM further stated that he was not sure why the food items were not labeled or dated, and that he must have forgotten. The DM stated he was trained and had seen the policy on food storage/labeling and dating. When asked about the unclean vent hood with cobwebs, the DM stated, I have spoken to the maintenance guy about it, but he is so busy, though promised to take care of it. The DM stated it was important for food items to be labeled and dated to ensure outdated food was not being served as that could cause residents to get sick. In an interview on 12/18/2025 at 10:39 AM with the RD, she stated that the dietary staff was responsible for dating and labelling of all food items in the freezers. She added that the DM should have the log of all in-services done on dating and labeling of all food items. The RD stated that food items not labeled or dated would potentially cause food borne illness to the residents. In interview on 12/18/2025 at 11:47 AM with the LVN A, she stated I don't know why the food items were not labeled or dated; that everything was supposed to be labeled and dated. She added that the DM was responsible for ensuring that food items were dated properly. LVN A stated that residents could get an infection from food items not labelled properly. In an interview on 12/18/25 at 12:47 PM with the ADM, she stated that the DM was responsible for dating and labelling all food items in the freezers and it was the facility's policy that all food items be properly labeled/dated and monitored. The ADM stated food items should be labeled and dated, but the kitchen staff must have forgotten to do that when the food items were received. The ADM stated the potential negative outcomes to the residents with unlabeled/undated food, was it could make the residents sick because we do not know how long the food items were in the freezers. The ADM stated she did not notice the dusty vent hood with cobwebs inside the kitchen. Record review of the facility policy and procedure titled, Food receiving and storage, revised date November 2022, reflected the following: Policy Statement: Food shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). 7. Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen, or discarded. Record review of the facility policy and procedure titled, Sanitation, revised date November 2022, reflected the following: Policy Statement: The Food service area is maintained in a clean and sanitary manner. Policy Interpretation and Implementation: 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to respect the resident's right to personal privacy in 10 of 33 resident rooms (24, 25, 26, 28, 30, 31, 32, 33, 34, and 35) reviewed for privacy in that: 1. Resident rooms [ROOM NUMBERS], beds B, didn't have privacy curtains that were designed or equipped to allow for full visual privacy. 2. Resident rooms 24, 25, 26, 28, 30, 31, 32, 33, 34, and 35 had slats missing from the window vertical blinds, which allowed potential passersby to see inside the rooms. These failures could also cause residents to feel uncomfortable, disrespected, and possible exposure to anyone passing by. Findings included: During an observation on 12/16/25 at 11:42 AM in room [ROOM NUMBER] revealed, the vertical blinds on the bedroom window were missing 1 slat which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered when the blinds were closed. During an observation on 12/16/25 at 12:14 PM in room [ROOM NUMBER] revealed the vertical blinds on the bedroom window missing 1 slat which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered when the blinds were closed. During an observation on 12/16/25 at 2:38 PM room [ROOM NUMBER] revealed the vertical blinds on the bedroom window missing 1 slat which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered when the blinds were closed. During an observation on 12/16/25 at 2:43 PM in room [ROOM NUMBER] revealed the vertical blinds on the bedroom window were missing 1 slat which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered when the blinds were closed. Additionally, there was no privacy curtain that allowed B to have full visual privacy. There was a privacy curtain hanging between bed A and bed B however, the curtain did not extend all the way to the wall, which left approximately a 4-foot gap between that privacy curtain and the wall. During an observation on 12/16/25 at 2:49 PM room [ROOM NUMBER] revealed the vertical blinds on the bedroom window missing 1 slat which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered when the blinds were closed. During an observation and interview on 12/16/25 at 3:01 PM resident # 3 room [ROOM NUMBER], bed B, said he changed clothes in the restroom in his bedroom because there was a surveillance camera in the hallway directly outside his bedroom door that was watching him. The resident said he did not have a privacy curtain on his side of the room to close for privacy from the surveillance camera or from his roommate. Observation of the room revealed the vertical blinds on the bedroom window were missing 2 slats which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered for each missing slat when the blinds were closed. There was a surveillance camera dome installed in the hallway ceiling outside of the bedroom. This camera was visible from bed B. Additionally, there was no private curtain between bed B and the restroom in the room. There was a privacy curtain hanging between bed A and bed B however, the curtain did not extend all the way to the wall, which left approximately a 4-foot gap between that privacy curtain and the wall. During an observation on 12/16/25 at 3:30 PM in room [ROOM NUMBER] revealed the vertical blinds on the bedroom window was missing 1 slat which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered when the blinds were closed. During an observation on 12/16/25 at 4:03 PM in room [ROOM NUMBER] it revealed the vertical blinds on the bedroom window were missing 10 slats which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered for each missing slat when the blinds were closed. During an observation on 12/17/25 at 12:47 PM in room [ROOM NUMBER] the vertical blinds on the bedroom window was missing slats which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered for each missing slat when the blinds were closed. During an observation on 12/17/25 at 1:05 PM, room [ROOM NUMBER] revealed the vertical blinds on the bedroom window missing 3 slats which left an opening of approximately 3 inches wide of the window from top to bottom to be uncovered for each (continued on next page)		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing slat when the blinds were closed. During an interview on 12/18/25 at 11:30 AM, the MS stated he walked the building several times daily to identify issues that needed repairs; he did not solely depend on residents and staff to submit work orders for repairs. He stated repairs needed were documented in an electronic system called Tels. He stated he could access the Tels system through an application on his cellular phone and it organized the maintenance work orders. He stated he was responsible for ensuring repairs were completed timely. He stated high priority repairs were completed immediately, and other repairs were completed when he could get to them. He stated housekeeping installed privacy curtains, but he did not know who was responsible for installing the privacy curtain tracks on the ceiling. He stated he was aware there were several rooms that were missing slats on the window vertical blinds. He stated the facility just switched owners a couple of months ago and there was an issue with the funding. He stated he had not followed up recently to check on the status of the funding since the switch. He stated he had been busy trying to get his classes, new training, and learning new ways of doing things that were required from the new owners. He stated there was no funding at the time to purchase materials needed and they also had no access to petty cash. He stated the new owners monitored the work orders in the Tels system. He stated he had not received training on maintenance or the importance of residents having a comfortable homelike environment. He stated he did not know how missing slats from the blinds negatively affected the residents. During an interview on 12/18/25 at 11:30 AM, the ADON stated she was aware that the broken blinds had been like that for several months and had been reported to the corporate office as well as submitted in the Tels system. ADON stated she had been trained in the environmental requirements of the facility. She stated she was responsible for training staff in reporting maintenance needs. She stated it was important that residents lived in a homelike environment so they could be comfortable, just like she preferred at her home, because this was their home. The ADON stated missing slats on the blinds did not allow residents to have privacy. She stated she was not aware of residents not having privacy curtains in their rooms that allowed them to have full visual privacy. She stated she was not aware there was a surveillance camera outside one of these rooms but realized how uncomfortable the resident felt. She stated residents should be able to be hidden from everyone except for others who were inside the privacy curtains with them. She stated she had received training about a month ago about privacy. She stated the DON also provided training to staff on privacy periodically. She stated everyone was responsible for ensuring residents had privacy. She stated privacy was important to residents because this was their home and they wanted to ensure residents felt safe and comfortable. She stated a potential negative outcome was embarrassment, that it could cause residents to feel unhappy and not want to live here, or it could cause others to make fun of residents. During an interview on 12/18/25 at 12:55 PM, the DON stated the MS and ADM were responsible to ensure needed repairs were completed. She stated all staff were responsible for reporting repairs needed. She stated they had a rounding system every week with staff where they could report repairs needed directly to the MS and they could also enter repairs needed in the Tels system. She stated the broken blinds had been reported and were ordered but they were the wrong size and were sent back. She stated the facility was bought by a new company afterwards and there had been a delay with having access to money. She stated the Tels system was documentation to make the MS accountable to ensure repairs were completed. She stated she had received training on importance of maintenance with the previous company as well as this new company. The DON stated residents should feel protected and in a safe environment and not feel exposed. She stated residents had the right to have their personal care needs private. She stated she was not aware of the bedrooms that did not allow residents to have full visual privacy. She believed privacy curtains should be able to provide a separation so residents would not be able to see their roommate. She stated another privacy curtain may be needed in rooms that have a bathroom to provide privacy to the residents whose room was in front of the restroom. She stated she was not aware residents should be able to have full visual privacy in rooms that did or did not have a (continued on next page)		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restroom. She stated she was concerned residents did not have total privacy when changing or receiving care. She stated the systems in place to monitor privacy were the in-services and rounding's they provided to staff on resident rights and HIPAA rights. She stated staff were also trained on privacy when they were hired. She stated herself and their Human Resources department provided ongoing training to staff regarding privacy. She stated she expected staff to ensure residents have their rights to privacy. She stated a potential negative outcome was that it could cause depression. During an interview on 12/18/25 at 2:15 PM, the ADM stated the MS was responsible for assessing the building for repairs. She stated all staff were responsible for reporting repairs needed. She stated the Tels system was the main system used to submit and monitor repairs needed but serious things should have been directly reported to the MS. The ADM stated she was aware of the vertical blinds that were broken in several rooms. She stated the blinds had been broken for a while and they had been replacing them little by little. She stated the broken blinds were a privacy issue. She stated she had received training on maintenance and environment. She stated herself and the MS were responsible for training staff. She stated staff had been trained in how to document repairs in the Tels system. She stated the Tels system was for tracking repairs, and it was important for the repairs to be documented there. She stated she expected a simple repair to be completed on the same day; however, she would have allowed 2-3 more days if additional materials were needed. She stated staff should shut the door and have the privacy curtain drawn when changing residents in their rooms. She stated residents have a right to privacy. The ADM stated she was not aware residents did not have full privacy in their bedrooms due to lack of privacy curtains. She stated it was important for them to have privacy, so they felt comfortable when changing and during peri-care. She stated she trained all staff in the residents' privacy, and she also provided ongoing in-services to staff. She stated she expected residents' privacy to be respected so they felt safe and comfortable. She stated a potential negative outcome was that residents would not feel safe and comfortable and not feel like they were at home. The ADM stated a potential negative outcome of not addressing repairs needed in the facility would not allow the facility to provide a homelike environment for residents and this was important because it was their home. Record review of the facility policy, Resident Rights, revised February 2021, revealed the following in part: Policy Statement Employees should treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:a. a dignified existence.b. be treated with respect, kindness, and dignity.t. privacy and confidentiality.dd. communicates in person and by mail, email, and telephone with privacy.4. Unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA compliance officer.		

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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 2 of 3 residents (Resident #5 and Resident #6) reviewed for infection control.-CNA A did not perform hand hygiene after touching a trash can, before touching wipes, and did not perform hand hygiene between all glove changes when providing incontinence care to Resident #6.-LVN A did not perform hand hygiene between all glove changes when providing wound care to Resident #5. These failures could place residents at risk for cross contamination and infection. The findings include: Resident #6 Record review of the admission record for Resident #6, dated 12/18/25 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: atherosclerotic heart disease (plaque buildup up in arterial walls), abnormal weight loss, and urinary incontinence. Record review of the quarterly MDS assessment for Resident #6, dated 11/12/25 revealed Resident #6 was dependent for toileting hygiene - the helper does all of the effort and the resident does none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity. Record review of the current care plan for Resident #6, last care conference dated 08/22/25, revealed there was a problem area: Urinary Incontinence: I am incontinent of bowel and bladder due to my cognitive status. I am at risk for skin breakdown if I am not cleaned properly and regularly. During an observation on 12/17/25 at 1:10 PM revealed CNA A provided incontinence care for Resident #6 with the help of CNA B. CNA A washed her hands with soap and water and then moved the trash can that was next to Resident #6's head of bed with her bare hands and her thumb went inside the trash can to pick it up. CNA A then began pulling out the wipes for Resident #6 and opened up the clean brief and set it aside. CNA A then used ABHR and put on clean gloves. CNA A then unfastened the brief and began wiping the groin area. CNA A then removed her gloves, used ABHR and put on clean gloves. CNA A then turned Resident #6 on her side and removed the old brief, placed a towel for a barrier and then wiped Resident #6's buttocks. CNA A then removed her gloves and put on clean gloves with no hand hygiene in between the glove change. CNA A then placed a clean brief under Resident #6 and turned her on her back and fastened the brief. CNA A then removed her gloves and used ABHR. During an interview on 12/17/25 at 1:21 PM, CNA A stated she had been trained on hand hygiene between all glove changes and to perform hand hygiene after touching a trash can. CNA A stated she thought it was ok to touch the trash can because it was clean from any other trash. CNA A stated she got nervous and that was why she messed up. CNA A stated she did not remember when she was last trained on hand hygiene during incontinence care. CNA A stated the risk to the residents was they could get infected. Resident #5 Record review of the admission record for Resident #5, dated 12/16/25 revealed an [AGE] year-old male who was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy (when your brain doesn't work right because of chemical imbalance or problem in your body), pressure ulcer of buttocks Stage 2 (wound from pressure) and depression (mood disorder). Record review of the comprehensive MDS assessment for Resident #5, dated 03/11/25, revealed Resident #5 was at risk for developing pressure ulcers/injuries. Record review of the order summary report for Resident #5, dated 12/16/25, revealed the following order: Clean area with Normal Saline or wound cleanser to right gluteus (buttock). Apply collagen dressing to manage exudate (drainage), cover with foam dressing, change every day and PRN with a start date of 11/11/25. Record review of the current care plan for Resident #5, last care conference 10/28/25, revealed there was a problem area: Resident has a pressure ulcer r/t right gluteus (buttock). During an observation on 12/17/25 at 3:34 PM, LVN A provided wound care to the pressure wound on Resident #5's right gluteus. LVN A put on a clean gown outside the room. LVN A washed her hands with soap and water and put on clean gloves. LVN A (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then cleansed Resident #5's wound with normal saline and 4x4 gauze. LVN A then removed her gloves and put on clean gloves and did not perform hand hygiene between the glove changes. LVN A then applied collagen to the wound bed and covered with a silicone border foam dressing. LVN A then removed her gloves and washed her hands with soap and water. During an interview on 12/17/25 at 4:32 PM, LVN A stated she had been trained to perform hand hygiene between glove changes but could not remember when. LVN A stated it just slipped her mind. LVN A stated the risk to the residents was possible infection. During an interview on 12/18/25 at 9:28 AM, the ADM stated she was unable to find a basic Infection Prevention and Control Program Policy for the facility and the policy provided was the most relevant. During an interview on 12/18/25 at 9:47 AM, the DON stated she expected staff to sanitize their hands between glove changes. The DON stated she expected the staff to sanitize their hands after touching a trash can. The DON stated CNA A and LVN A may have been rattled when providing care in front of a surveyor. The DON stated CNA A and LVN A made honest mistakes. The DON stated the staff were recently trained in hand hygiene and she would have to look up exactly when they were trained. The DON stated she was responsible for ensuring staff were following infection control policies. The DON stated the residents had a risk of infection. During an interview on 12/18/25 at 11:03 AM, the ADM stated she expected staff to hand sanitize between glove changes. The ADM stated she expected the staff to hand sanitize after touching a trash can. The ADM stated the staff have been trained on hand hygiene and the DON was responsible to monitoring. The ADM stated she did not know why CNA A or LVN A did not sanitize their hands between all glove changes. The ADM stated a possible negative outcome was it could lead to infections. Record review of the Relias training transcript for CNA A, undated, revealed Hand Hygiene Basics was completed on 12/09/25. Record review of the Relias training transcript for LVN A, undated, revealed Hand Hygiene Basics was completed on 11/22/25. Record review of the facility policy titled, Handwashing/Hand Hygiene, with a revised date of 01/2025 reflected the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare - associated infections. Administrative Practices to Promote Hand Hygiene:2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Indications for Hand Hygiene:1. Hand hygiene is indicated:.c. after contact with blood, body fluids, or contaminated surfaces;e. after touching the resident's environment;g. immediately after glove removal.5. The use of gloves does not replace hand washing/ hand hygiene.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Avir at Knox City		STREET ADDRESS, CITY, STATE, ZIP CODE 605 S Ave F Knox City, TX 79529	
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that facility was free of pests and rodents for the facility's only kitchen. The facility did not maintain an effective pest control program to ensure the facility was free of flies in the kitchen. These findings could place residents at risk for an unsanitary environment and a decreased quality of life. The findings included: Record review of the facility's pest control binder 2025 pest control visited the facility bi-weekly to treat pests and insects. The kitchen was last treated for rats on 06/11/2025 and there was no mention of flies. Observation of the facility's kitchen on 12/16/2025 at 11:16 AM, revealed approximately four flies flying around DM as he prepared meal before lunch was served. The flies were observed landing on food preparation stations that were not in use, on top of the plate warming station and on cooking utensils. No fly trap tapes observed. In an interview on 12/18/2025 at 9:53 AM with the DM, he stated It is the maintenance personnel that is responsible for pest control. The DM stated pest control was at the facility last month and had no reasons why the flies were there. When asked if anyone was notified regarding the flies in the kitchen, the DM stated, I have spoken to the maintenance guy, and he promised to get in touch with pest control. The DM stated having flies in the kitchen could get residents sick, but there is nothing I could do about it. In an interview on 12/18/2025 at 11:11 AM with the MS, he stated I am responsible for making sure that flies are controlled in the kitchen and environs. The MS stated that pest control was at the facility a week ago and had nothing written down on the pest control log. The MS stated flies in the kitchen were due to going in and out of the kitchen door all day. The MS further stated, I know what the policy on pest control is but haven't looked at it for a long time. The MS stated having flies in the kitchen could result in flies getting in food, which could spread diseases on food prepared in the kitchen. In an interview on 12/18/2025 at 11:47 AM with the LVN A, she stated No, I don't know if the facility sent any pest control to the kitchen for the flies, it is mild now because it is winter, you should come see it during summer. She further stated that I have reported to the MS, and he always says, am doing what I can. LVN A stated the flies could spread diseases on the food and then transferred to the residents, making them sick. In an interview on 12/18/25 at 12:47 PM with the ADM, she stated that she believed the opened back door was the reason flies kept getting into the kitchen, as they used the door to exit the kitchen to discard trash and accept deliveries. The ADM stated they had pest control out once a month and as needed for flies. She further stated, It is the responsibility of the MS to get pest control to the kitchen. The ADM stated having flies in the kitchen could be bad, as residents could get sick due to infections. The ADM stated she would continue to work with pest control to solve the problem in the kitchen and had ordered air curtains. Record review of the facility policy and procedure titled, Pest Control, revised date May 2008, reflected the following: Policy Statement: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services.		