STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676031	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Meadow Creek	4343 Oak Grove Blvd San Angelo, TX 76904

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop a baseline care plan within 48 hours of admission that included instructions needed to provide effective and person-centered care of the resident that met professional standards of quality of care for 1 of 5 residents (Resident #1) reviewed for baseline care plans. The facility failed to develop the baseline care plan for Resident #1 within 48 hours following his admission on [DATE]. This failure could place residents at risk for complications due to the potential for their immediate needs not being identified so interventions could be planned and initiated.Findings included: Record review of Resident #1's face sheet dated 5/28/2026 revealed a [AGE] year-old female, admitted on [DATE] with diagnoses which included: pneumonia (an infection that inflames the air sacs in the lungs), age related osteoporosis without current pathological fracture (natural, progressive loss of bone mass and density with age, however no broken bones have broken from the disease yet). A record review on 5/28/2026 of Resident #1's electronic clinical records revealed the facility had not completed an initial baseline care plan within 48 hours of Resident #1's admission. During an interview on 5/28/2026 at 3:50 p.m., the Director of Nursing (DON) confirmed that a baseline care plan had not been completed within the 48-hour timeframe. The DON stated she started the baseline care plan on 4/16/2026 but did not complete and close it until 4/24/2026. She said her expectation was for the baseline care plans to be completed within the first 48 hours after admission by an RN. The DON stated the risk of not completing the baseline care plan was staff not knowing how to care for the resident. During an interview on 5/28/2026 at 4:00 p.m. with the Administrator, she stated her expectation was for nursing to complete the baseline care plan upon admission. She stated the risk in not completing the baseline care plan timely could affect the residents' quality of care by staff not knowing how to care for the resident. Requested facility policy at this time for baseline care plans. A policy was not received prior to exit.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 resident (Resident # 1) reviewed for transfers.The facility failed to ensure LVN C utilized a gait belt to transfer Resident #1 while toileting which resulted in a right dislocated shoulder. This failure could place residents at risk for falls, injury and a diminished quality of life.The findings include:Record review of Resident #1's face sheet dated 5/28/2026 revealed a [AGE] year-old female, admitted on [DATE] with diagnoses which included: pneumonia (an infection that inflames the air sacs in the lungs), age related osteoporosis without current pathological fracture (natural, progressive loss of bone mass and density with age, however no broken bones have broken from the disease yet).Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMs score of 6 which indicated the resident was cognitively impaired. The assessment indicated Resident #1 required maximum assistance with transfers.Record review of Resident #1's Care Plan for ADL self-care initiated on 4/24/2026 revealed the resident required the maximum assistance by staff for transfers.Record review of Resident #1's progress notes dated 4/23/2026 at 4:28 p.m. written by LVN C revealed, Upon attempting to stand up resident cried out in pain, resident became dead weight so staff had to clean her the best they could and then set her in wheelchair. During an interview on 5/28/2026 at 9:25 a.m. with Resident #1's responsible party, she stated that on 4/23/2026 at approximately 4:30pm she was present when LVN C assisted her Resident #1 off the toilet. She stated LVN C did not use a gait belt. She stated during the transfer she witnessed Resident #1 slip and LVN C grabbed her right arm to keep her from falling. She stated after LVN C grabbed Resident #1's arm she hollered out in pain. Resident #1's responsible party stated she was told a portable x-ray would be done in the facility. She stated on 4/24/2026 around 11:30am she chose to have Resident #1 sent to the emergency room because the portable x-ray had not been completed. Resident #1's responsible party stated at the emergency room they determined the right shoulder was dislocated.During an interview on 5/28/2026 at 10:00 a. m. with LVN C, he stated on 4/23/2026 at approximately 4:30 p.m. he did transfer Resident #1 off the toilet to the wheelchair and did not use a gait belt. LVN C stated he put his arms under Resident #1's arms and transferred her. LVN C stated she did not slip but did become dead weight during the transfer and he was holding all her weight. LVN C stated when Resident #1 complained of pain he administered medication and notified the MD who ordered an x-ray. He stated the x-ray was not completed prior to his shift ending. LVN C stated Resident #1 normally did not complain of pain. LVN C stated he had been educated on gait belt use by the facility upon hire and annually. LVN C stated he did not use a gait belt because he was just trying to help the resident off the toilet and thought that she would assist more with the transfer than she did.During an interview on 5/28/2026 at 11:25 a.m. CNA M stated she was present on 4/23/2026 at approximately 4:30 p.m. when LVN C transferred Resident #1 off the toilet. CNA M stated LVN C did not use a gait belt for the transfer. CNA M stated Resident #1 did give out during transfer and LVN C had to support all of Resident #1's weight but he did not see LVN C grab Resident #1's arm. CNA M stated Resident #1 did not verbalize pain prior to the transfer, but she did seem tired. CNA M stated she has been trained in using gait belts for transfers. CNA M stated gait belts were available in resident rooms. CNA M stated the risk of not using a gait belt could be falls.During an interview on 5/28/2026 at 11:45 a.m. with the DOR, she stated Resident #1 required maximum assistance for transfers which meant the helper did 75% of the work. The DOR stated staff should have been using a gait belt when transferring Resident #1 because she was maximum assist. The DOR stated the risk of not using a gait belt would be falls and injury.During an interview on 5/28/2026 at 11:58 p.m. CNA C stated gait belts were supposed to be used for transfers. She stated she had received training in using gait belts. CNA C stated if a gait belt was not used it could result in (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	falls and injury.During an interview on 5/28/2026 at 1:23 p.m., the ADON stated she sent Resident #1 to the emergency room after talking with Resident #1's responsible party, the DON, and Administrator. The ADON stated Resident #1 did not appear to be in any pain at that time. The ADON stated she was not sure how often training on transfers with staff as completed. The ADON stated staff should have been using a gait belt for safety. The ADON stated the risk of not using a gait belt could be injury.During an interview on 5/28/2026 at 2:28 p.m., the DON stated Resident #1 did have a dislocated shoulder but was unsure if it was due to the transfer. The DON stated she was not aware of any other incidents that occurred around the same time. The DON stated Resident #1 had not complained of any pain until after the incident. The DON stated transfer training was done upon hire and annually. The DON stated upon admission the resident care profile was updated with transfer techniques for each resident. The DON stated a gait belt should be utilized for transfers for safety. The DON stated not using a gait belt for transfers could result in falls and injuries.During an interview on 5/28/2026 at 3:00 p.m. the Administrator stated a gait belts should be used for all assisted transfers that did not require a mechanical lift. The Administrator stated it was the DON and ADON's responsibility to ensure staff received education on transfers. The Administrator stated it was her expectation for staff to use gait belts for transfers. The Administrator stated they did not have a policy on gait belt use. The Administrator stated the risk of not using gait belts for transfers could be falls and injuries. During an interview on 5/29/2026 at 10:45 a.m. Resident #1 stated the young man was helping her off the toilet placed his arms under my arms. Resident #1 stated she started to fall and he grabbed her right arm and it hurt. During an interview on 5/29/2026 at 3:08pm the MD stated he did remember the incident being reported to him, but he was not sure if it was unavoidable because he was not present during the incident. The MD stated, I think the nurse should know what he needs to do and follow facility protocol.Record review of facilities policy titled Safe Lifting and Movement of Residents revised July 2017 revealed in part: In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents.2. Manual lifting of residents shall be eliminated when feasible.4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.