STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676035	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kingsland	3727 W Ranch Rd 1431 Kingsland, TX 78639

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident /Resident Representative had the right to be informed of, and participate in, his or her treatment for one (Resident #1) of six residents reviewed for resident rights. The facility failed to notify Resident #1's family when he had a fall on 01/17/2026 during the night shift. This failure could place the residents at risk of not being informed of their health status, in order to make informed decisions regarding their care. Findings included:Review of Resident #1's face sheet printed 01/27/2026 reflected a [AGE] year-old male who was admitted on [DATE] with the following dx. Type 1 Diabetes Mellitus with other diabetic kidney complications (a chronic autoimmune condition where the pancreas produces little to no insulin, causing high blood glucose (sugar) levels.), Sepsis, unspecified organism,(a life-threatening, emergency response to infection where the immune system damages the body's own tissues and organs) nontraumatic subarachnoid hemorrhage (is a life-threatening, often fatal emergency involving bleeding between the brain and surrounding membranes, typically caused by a ruptured intracranial aneurysm), hemiplegia (paralysis affecting one side of the body, resulting from brain or spinal cord damage, often from stroke, traumatic injury, or cerebral palsy, causing weakness, stiffness (spasticity), and impaired movement in the face, arm, and leg on that side) and hemiparesis(a neurological condition causing weakness or partial paralysis on one side of the body) following cerebral infarction (a critical medical condition where restricted blood flow causes tissue death (necrosis) in the brain.), Acute Bronchiolitis(a common, self-limiting lower respiratory tract viral infection) due to respiratory syncytial virus, Orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down.). Resident #1's face sheet also reflected an RP. Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 09, indicated moderate cognitive impairment. Section GG Functional Abilities reflected Resident #1 was 06. Independent - Resident completes the activity by themself with no assistance from a helper 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity with transfers and toileting. Section J-Falls 0. Review of Resident #1's care plan initiated 12/31/2025 reflected Resident #1 had an ADL selfcare performance deficit related to confusion, moderate risk for falls related to confusion. Review of Resident #1's incident report dated 01/17/2026 at 09:00 p.m. completed by LVN A reflected: Res found on floor near Nurses station. he slipped. vitals, Neuro checks, blood sugar check, given glucose. Bg at 118 post treatment. Ambulatory without assistance.Agencies/people Notified_ No Notifications found. Review of Resident #1's progress notes dated 01/17/2026 reflected no evidence of Resident #1's family being notified of his fall on 01/17/2026. During an interview on 01/27/2026 at 10:40 a.m., Resident #1's family stated they were not notified of Resident #1's fall on 01/17/2026. Family stated they found out about Resident #1's fall the following day when family was visiting. During an interview on (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/27/2026 at 1:09 p.m., the ADON stated, If a resident fell or there was a change in a resident's condition, the nurse on duty would evaluate the resident, depending on the outcome, send the resident to the hospital. The ADON stated the nurse would notify the MD, family, DON, the on-call staff and the resident's family. The ADON stated it was important to notify the resident's family of every change of condition for the coordination of care. The ADON stated, unless the family does not want to be notified. The ADON also stated the nurse should document everything that was done including notification of the family. During an interview on 01/28/2026 at 1:32 p.m., the Regional Nurse stated she had been filling in as the DON since the facility did not have a DON at the time. The Regional Nurse stated if there was a fall or change of condition, she expected the nurse on duty to notify the RP and the MD. The Regional Nurse looked at Resident #1's incident report dated 01/17/2026 at 09:00 p.m. and stated, according to this incident report, Resident #1's family was not notified along with the MD. The Regional Nurse stated that it did not matter the time of the day that the fall occurred, the nurse should have notified the RP/Family and the MD.During an interview on 1/28/2026 at 3:30 p.m., the Administrator stated when a resident falls, the nurses should notify the RP and communicate with the NP/MD, that was the facility's protocol to notify the family and physician. During an interview on 01/29/2026 at 09:14 a.m., LVN A stated she was the nurse on duty for Resident #1 on 01/17/2026. LVN A stated that it was her first night working at the facility and with Resident #1. LVN A stated Resident #1 was found on the floor next to the nurse's station. LVN A said she called the staff for directions because she was not familiar with the protocols. LVN A said she was not told by the on-call staff to call Resident #1's RP/Family so she did not call the family. LVN A stated most facility would want the family to notify after a fall that is why she called the on-call for direction, but she was not told to notify Resident #1's family. Review of facility's policy titled Change in a Resident's Condition or Status revised April 2025 reflected: Policy Statement ---Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).Policy Interpretation and Implementation-- I. The nurse will notify the resident's attending physician or physician on call when there has been a(an):a. accident or incident involving the resident.b. discovery of injuries of an unknown source.c. adverse reaction to medication.d. significant change in the resident's physical/emotional/mental condition.e. needs to alter the residents' medical treatment significantly.f. refusal of treatment or medications three (3) or more consecutive times);g. needs to transfer the resident to a hospital/treatment center.h. discharge without proper medical authority; and/or i. specific instructions to notify the physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the residents' status that:a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting);b. impacts more than one area of the president's health status.c. requires interdisciplinary review and/or revision to the care plan; andultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.b. there is a significant change in the residents' physical, mental, or psychosocial status.c. there is a need to change the resident's room assignment.d. a decision has been made to discharge the resident from the facility; and/ore. it is necessary to transfer the resident to a hospital/treatment center. Review of facility's policy titled Resident Rights dated February 2021 reflected: Policy StatementEmployees shall (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treat all residents with kindness, respect, and dignity.Policy Interpretation and Implementation--appoint a legal representative of his or her choice, in accordance with state law.--be notified of his or her medical condition and of any changes in his or her condition.--be informed of, and participate in, his or her care planning and treatment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a person-centered comprehensive care plan to meet the preferences and goals of each resident and address the resident's medical, physical, mental and psychosocial needs for one (Resident #1) of six residents reviewed for care plans. The facility failed to include in Resident #1's care plan that he had Type 1 Diabetes Mellitus and needed insulin for blood glucose management. The facility failed to update Resident #1's care plan after a fall on 01/10/2026 and was sent to the ER for further evaluation and diagnosed with Right sided zygomaticomaxillary complex fracture (often high-impact facial injury involving the cheekbone (zygoma) and its articulations with surrounding bones, causing significant facial asymmetry, flattening, swelling, and numbness.) These deficient practices placed residents at risk for not receiving care and services. Findings included: Review of Resident #1's face sheet printed 01/27/2026 reflected a [AGE] year-old male who was admitted on [DATE] with the following dx. Type 1 Diabetes Mellitus with other diabetic kidney complications (a chronic autoimmune condition where the pancreas produces little to no insulin, causing high blood glucose (sugar) levels.), Sepsis, unspecified organism,(a life-threatening, emergency response to infection where the immune system damages the body's own tissues and organs) nontraumatic subarachnoid hemorrhage (is a life-threatening, often fatal emergency involving bleeding between the brain and surrounding membranes, typically caused by a ruptured intracranial aneurysm), hemiplegia (paralysis affecting one side of the body, resulting from brain or spinal cord damage, often from stroke, traumatic injury, or cerebral palsy, causing weakness, stiffness (spasticity), and impaired movement in the face, arm, and leg on that side) and hemiparesis(a neurological condition causing weakness or partial paralysis on one side of the body) following cerebral infarction (a critical medical condition where restricted blood flow causes tissue death (necrosis) in the brain.), Acute Bronchiolitis(a common, self-limiting lower respiratory tract viral infection) due to respiratory syncytial virus, Orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down.). Review of Resident#1's admission MDS assessment dated [DATE] reflected a BIMS score of 09, indicating moderate cognitive impairment. Section I -Active Diagnoses reflected Diabetes Mellitus. Section N-Medication reflected Resident #1 received insulin injection 5 days a week. Review of Resident #1's care plan initiated 12/31/2025 reflected Resident #1 had an ADL selfcare performance deficit related to confusion, moderate risk for falls related to confusion. Resident #1's care plan did not address Type 1 diabetes and the use of insulin. Resident #1's care plan did not address facial fracture as well. Review of Resident #1's physician orders reflected the following:Lantus SoloStar Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Glargine) Inject 15 unit subcutaneously one time a day for DM -Start Date- 12/28/2025 at 0600 am. HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if151 - 200 = 2u;201 - 250 = 4u;251 - 300 = 6u;301 - 350 = 8u;351 - 400 = 10u,subcutaneouslybefore meals for DM -Start Date- 12/29/2025 at 4:30 pm. Review of Resident #1's ER visit record dated 01/10/2026 reflected:Exam: CT (Computed Tomography is a non-invasive medical imaging test that combines specialized X-ray equipment with computers to produce detailed, cross-sectional, 3D images of bones, blood vessels, and soft tissues inside the body) Maxillofacial (relating to the jaw and face) without contrast.Impression: Right sided zygomaticomaxillary complex fracture. (often high-impact facial injury involving the cheekbone (zygoma) and its articulations with surrounding bones, causing significant facial asymmetry, flattening, swelling, and numbness.) Review of Resident #1's progress note dated 01/10/2026 at 09:25 p.m. written by LVN B reflected: Patient return from ER at this time with Dx: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facial Fractures. No new orders at this time. Will continue to monitor. During an interview on 01/27/2026 at 10:51 a.m., the MDS nurse stated she had just taken over the MDS position and was not sure who completed Resident #1's care plan. The MDS nurse stated she had just started working on care plans, she was only doing MDSs. The MDS nurse stated there is a section in the MDS that triggers the comprehensive care plan, and she just learned that. The MDS Nurse stated care plan was supposed to be done continuously as events occur to a Resident. The MDS Nurse stated Resident #1's facial fracture should have been care planned. The MDS nurse stated Resident #1's diagnosis of Type 1 Diabetes should have been care planned so that everyone was aware to monitor his blood sugars. The MDS Nurse stated the Regional Nurse was the one completing care plans. During an interview on 01/28/2026 at 1:32 p.m., the Regional Nurse stated baseline care plans were done on admission and when there was unique things, they keep adding until day 21 when the comprehensive care plan is ready. The Regional Nurse stated comprehensive care is usually trigger from the MDS on day 21, that is when a comprehensive care plan is to be completed. The Regional Nurse stated Resident #1 was in the facility for more than 12 days so his comprehensive care plan should have been completed. The Regional Nurse stated she would expect Resident #1's diagnoses of Diabetes Mellitus to be on the care plan, monitoring Resident #1's blood sugar, and making sure the appropriate care was given. The Regional Nurse stated, if Resident #1's diabetes was not care planned, there would have been adverse outcome of not getting his blood glucose. The Regional Nurse stated after she looked at Resident #1's care plan, she realized Resident #1 had 6 things care planned. The Regional Nurse stated Resident #1's comprehensive care plan should have been completed and it was not done. The Regional Nurse stated usually the DON, ADON, Dietary all work together, IDT approach. The Regional Nurse also stated Resident #1's facial fracture should have been added on the comprehensive care plan. Review of facility's policy titled Care Plans' Comprehensive Person-Centered dated 2001 reflected: Policy Statement-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation--1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required M DS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including:(1) services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.i2e any specialized services to be provided as a result of PASARR recommendations; and(3) which professional services are responsible for each element of care.c. includes the resident's stated goals upon admission and desired outcomes.d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem areas and conditions. 12. The interdisciplinary team reviews and updates the care plan:a. when there has been a significant change in the residents' condition.b. when the desired outcome is not met.c. when the resident has been readmitted to the facility from a hospital stay; andd. at least quarterly, in conjunction with the required quarterly MDS assessment.13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical record in accordance with established policies.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to give each resident a special diet to help when there was a nutritional problem for one (Resident #1) of four residents reviewed for therapeutic diet. The facility failed to administer therapeutic diet for Resident #1 from 12/27/2025 through 12/31/2025 as was recommended by the hospital upon discharge. The failure place residents at risk for aspiration, choking and hospitalization.Findings included: Review of Resident #1's face sheet printed 01/27/2026 reflected a [AGE] year-old male who was admitted on [DATE] with the following dx. Type 1 Diabetes Mellitus with other diabetic kidney complications (a chronic autoimmune condition where the pancreas produces little to no insulin, causing high blood glucose (sugar) levels.), Sepsis, unspecified organism,(a life-threatening, emergency response to infection where the immune system damages the body's own tissues and organs) nontraumatic subarachnoid hemorrhage (is a life-threatening, often fatal emergency involving bleeding between the brain and surrounding membranes, typically caused by a ruptured intracranial aneurysm), hemiplegia (paralysis affecting one side of the body, resulting from brain or spinal cord damage, often from stroke, traumatic injury, or cerebral palsy, causing weakness, stiffness (spasticity), and impaired movement in the face, arm, and leg on that side) and hemiparesis(a neurological condition causing weakness or partial paralysis on one side of the body) following cerebral infarction (a critical medical condition where restricted blood flow causes tissue death (necrosis) in the brain.), Acute Bronchiolitis(a common, self-limiting lower respiratory tract viral infection) due to respiratory syncytial virus, Orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down.). Review of Resident#1's admission MDS assessment dated [DATE] reflected a BIMS score of 09, indicating moderate cognitive impairment Review of Resident #1's care plan initiated 12/31/2025 reflected Resident #1 had an ADL selfcare performance deficit related to confusion, moderate risk for falls related to confusion. Initiated 01/05/2026 Dietary- resident's nutritional needs willbe met through next review with intervention of a NCS diet with puree texture and thin liquids. Review of Resident #1's physician order dated 12/31/2025 reflected: Regular diet, Pureed texture, Regular liquid consistency. Review of Resident #1's discharged Hospital records dated 12/22/2026 reflected: During the course of patient treatment these goals or recommendations may change, depending on functional progress, and further recommendations will be made. The interdisciplinary care team will collaboratively determine final discharge plans considering the overall care needs of the patient.If patient discharges from acute care before next treatment, please let this document serve as a discharge status.Speech-Language Pathology-Dysphagia (difficulty swallowing) Intervention. Recommendations:Diet Consistency: thin liquids, pureed. Review of Resident #1's dietary communication slip to the kitchen dated 12/27/2026 completed by LVN B reflected: New admission, Regular /Liberalized, NCS, Regular texture and thin liquid. Review of Resident #1's dietary note completed by the Dietary Manager on 12/29/2026 reflected pureed consistency.Review of Resident #1's dietary communication slip to the kitchen dated 12/31/2026 completed by LVN C reflected pureed texture with thin liquids.During an interview on 01/28/2026 at 11:57 a.m., LVN C said she was the admitting nurse for Resident #1. LVN C stated she could not remember if she got nurse-to-nurse report that Resident #1 was on a pureed diet or if she got report at all. LVN C stated she would assume she completed and sent Resident #1's dietary communication slip to the kitchen because she was his admitting nurse. LVN C stated she would have looked at Resident #1's discharge papers to be able to know what Resident #1's diet was. LVN C stated she could not remember what Resident #1's admitting diet was. LVN C stated there was a risk for (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aspiration for a Resident who was supposed to get a pureed diet but got a regular texture diet.During an interview on 01/28/2026 at 1:18 p.m., the Dietary Manager stated usually when there is a new admission, the dietary department gets the dietary communication slip from the nursing department. The Dietary Manager stated the dietary department does not see clinical for new admissions except the dietary communication slip from the nursing department. The Dietary Manager reviewed her records and stated when Resident #1 was admitted , she first got dietary communication from nurse for regular texture and thin liquids of 12/27/2025. The Dietary Manager stated there was another dietary communication slip completed on 12/31/2025. The Dietary Manager stated Resident #1 received regular texture food from 12/27/2025 to 12/31/2025 because that was the communication she got from the nursing department and then his diet was changed to pureed texture. The Dietary Manager stated that when a resident who was supposed to get pureed texture food gets regular food, they could choke on the regular food. The Dietary Manager stated Therapy sometimes assess the resident and let dietary know of the change of diet.During an interview on 01/28/2026 at 1:32 p.m., the Regional Nurse stated the admitting nurse was responsible for sending the dietary communication slip to the kitchen based on the diet on the resident's clinical from the hospital. The Regional Nurse stated if the recommended diet for Resident #1 while in the hospital was pureed texture, that is what the admitting nurse should have communicated to the dietary department. The Regional Nurse stated if the admitting nurse did not know what the resident's diet was, the nurse should have called the hospital for clarification. The [NAME] Nurse stated the dietary department gets what the nursing department send to them and follows the order. The Regional Nurse stated there was a risk of aspiration and choking, weight loss because the residents cannot eat it. Review of facility's policy titled Therapeutic Diets dated 2021 reflected: Policy Statement--Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.Policy Interpretation and Implementation-- Diet will be determined in accordance with the residents' informed choices, preferences, treatment goalsand wishes. Diagnosis alone will not determine whether the resident is prescribed to a therapeutic diet.2 . A therapeutic diet must be prescribed by the resident's attending physician (or non -physician provider).The attending physician may delegate this task to a registered or licensed dietitian as permitted by statelaw.3. Diet order should match the terminology used by the food and nutrition services department.4. A 'therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part oftreatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the textureof a diet, for example:a. diabetic/calorie controlled diet;b. low sodium diet;c. cardiac diet; andd. altered consistency diet.5. If a mechanically altered diet is ordered, the provider will specify the texture modification.

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide therapy services that evaluate and treat a function that was impaired by illness or injury and increased the resident's functioning for one (Resident #1) of three residents reviewed for Rehab services. The facility's failed to ensure the therapy department evaluated Resident #1 upon admission to the facility per physician order. The facility failed to evaluate and treat Resident #1 after a fall on 01/07/2025 as per care plan intervention. This failure placed residents at risk of not being evaluated in order to get appropriate treatment as needed.Findings included: Review of Resident #1's face sheet printed 01/27/2026 reflected a [AGE] year-old male who was admitted on [DATE] with the following dx. Type 1 Diabetes Mellitus with other diabetic kidney complications (a chronic autoimmune condition where the pancreas produces little to no insulin, causing high blood glucose (sugar) levels.), Sepsis, unspecified organism,(a life-threatening, emergency response to infection where the immune system damages the body's own tissues and organs) nontraumatic subarachnoid hemorrhage (is a life-threatening, often fatal emergency involving bleeding between the brain and surrounding membranes, typically caused by a ruptured intracranial aneurysm), hemiplegia (paralysis affecting one side of the body, resulting from brain or spinal cord damage, often from stroke, traumatic injury, or cerebral palsy, causing weakness, stiffness (spasticity), and impaired movement in the face, arm, and leg on that side) and hemiparesis(a neurological condition causing weakness or partial paralysis on one side of the body) following cerebral infarction (a critical medical condition where restricted blood flow causes tissue death (necrosis) in the brain.), Acute Bronchiolitis(a common, self-limiting lower respiratory tract viral infection) due to respiratory syncytial virus, Orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down.). Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of 09, indicated moderate cognitive impairment. Section GG Functional Abilities reflected Resident #1 was 06. Independent - Resident completes the activity by themself with no assistance from a helper 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity with transfers and toileting. Section J-Falls 0. Review of Resident #1's physician order dated 12/31/2025 reflected: PT, OT, ST to eval and treat as indicated active 12/31/2025. Review of Resident #1's care plan initiated 12/31/2025 reflected Resident #1 had an ADL selfcare performance deficit related to confusion, moderate risk for falls related to confusion. Fall on 01/07/26 with intervention for fall, PT to evaluate and treat PRN. Review of Resident #1's incident report dated 01/07/2025 at 07:50 p.m. reflected, Resident #1 had a fall next to the kitchen door. Review of Resident #1's Nursing to Therapy Screen Request in PCC dated 01/07/2026 and was locked on 1/28/2026 reflected:Reason-Post FallDiscipline requested to screen-PTPhysical function-recent fall. During an interview on 01/27/2026 at 12:38 p.m., the DOR stated usually all residents are screened/evaluated upon admission. The DOR stated after evaluation or screening, if treatment was needed, the therapy department verify with the BOM if the resident's insurance authorized therapy services. The DOR stated she did not screen or evaluate Resident #1 upon admission because she asked the BOM and was told Resident #1 did not come from the hospital with authorization from the hospital, so she did not bother to screen/evaluate Resident #1. The DOR stated she had to have a form of funding, usually the therapy department does not treat a resident without funding. The DOR stated that sometimes the Administrator would give a direct order to treat residents without funding based on the screening result.During an interview on 01/27/2026 at 12:54 pm the BOM stated all new admissions were screened/evaluated by the therapy department unless they were only (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676035	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kingsland	3727 W Ranch Rd 1431 Kingsland, TX 78639

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 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted for nursing services. The BOM stated treatment was based on the payer source. The BOM stated the therapy department would send the verification of benefit to the BOM after screening/evaluation and she would send it back with payer source. The BOM stated, if the resident did not have a payer source, based on the screening report, an Admin Auth (administrative authorization) form is sent to the Administrator, and the resident would get some therapy visits/treatments. The BOM stated she told the DOR that Resident #1's was Admin Auth and the DOR was supposed to fill out the form and give it to the administrator. The BOM stated treatment would have been based on the evaluation/screening. During an interview on 01/27/2026 at 2:20 p.m., the Administrator stated all new admission was supposed to be screened by the therapy department regardless of payment source. The Administrator stated Resident #1 was assessed by nursing staff upon admissions. During an interview on 1/28/2026 at 1:32 p.m., the Regional Nurse stated PT should evaluate with every fall, that was the facility's standard, but she was not sure of what their fall policy indicated. The Regional Nurse stated that usually the IDT team discuss falls in their morning meetings. The Regional Nurse stated that once there is a fall, it triggers a form to be sent to the therapy department in electronic record System to evaluate the Resident. The Regional Nurse stated payer source did not stop therapy from evaluating a Resident upon admission or after a fall. The Regional Nurse stated therapy should screen every resident; there is no cause for the evaluation, further treatment was what mattered. The Regional Nurse stated if the initial intervention for Resident #1's fall on 01/07/2026 was not addressed, there was a risk for further falls. The Regional Nurse stated the interventions was to minimize the injury that could occur from a fall because some falls could not be prevented. During another interview with the DOR on 1/28/2026 at 2:55 p.m., she stated there was a communication from nursing in the electronic medical record regarding Resident #1 dated 1/7/2026. The DOR stated she had just seen the communication on 01/27/2026 after the State Surveyor began asking questions. The DOR stated that she did not see the communication, she was supposed to check the dashboard in PCC daily. The DOR stated she was new to the position and was still learning the process. It was brought to my attention yesterday. The DOR stated her regional boss was sending over an in-service for her to review. The DOR stated she did not believe screening Resident #1 would have prevented him from falling. The DOR stated she was not notified of Resident #1's falls on 01/07/26 and 1/10/2026 and it was not discussed in the morning meeting. During another interview with the Administrator on 1/28/2026 at 3:30 p.m., the Administrator stated Resident #1 should have been screened by therapy if there was a request in PCC to minimize the resident from falling. The Administrator stated the therapy department should have assessed Resident #1, assessment was assessment, and the payer source was not the factor for the need to conduct the assessment. Review of facility's policy titled Fall Risk assessment dated [DATE] reflected: Policy StatementThe nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information.Policy Interpretation and ImplementationAssessment data shall be used to identify underlying medical conditions that may increase the risk of injury from fallsThe staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition. Review of facility's policy titled Falls - Clinical Protocol revised September 2012 reflected: Assessment and Recognition- 1. As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling.Staff will ask the resident and the caregiver or family about a history of (continued on next page)

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