STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676100	A. Building B. Wing	06/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at San Angelo	5455 Knickerbocker Rd 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 0689 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review the facility failed to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 5 residents (Resident #2 and Resident # 3) reviewed for accident and hazards: The facility failed to implement care planned anti-slip strips on the floor in front of Resident # 2's recliner. The facility failed to implement care planned [NAME] sheet (anti-slip device) in Resident #3's wheelchair. This failure could place residents at risk of a diminished quality of life leading to a variety of emotional and physical problems/issues because of accident hazards. Findings included: Review of Resident #2's admission Record, dated 2/3/25, revealed she was an [AGE] year-old female admitted to the facility with diagnoses including dementia, diabetes (a disorder where the body does not use blood sugar properly), and history of falls. Review of Resident #2's Quarterly MDS, dated [DATE], revealed: She had a mental status score of 14 of 15 (indicating she was cognitively intact) She used a wheelchair. She needed supervision or steadying assistance with transfers. She had two or more falls since the previous assessment with no injury. Review of Resident #2's Care Plan, revised on 3/22/23 revealed she had falls related to poor balance and poor communication/comprehension, impaired mobility, depression, anxiety, weakness, and incontinence. The identified goal was she would resume her usual activities without further incident through the review date. Identified interventions included anti-skid strips to floor in front of recliner initiated 7/14/23 and place anti-skid strips in front of dresser/shelfing revised on 4/11/25. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Fall Risk Evaluation, dated 6/9/25, revealed she was at risk for falls. Observation and interview on 6/14/25 at 1:21 p.m. of Resident #2's room revealed no anti-skid strips in the room. Resident #2 had a large gash across half of her forehead with stitches. Resident #2 stated the fall happened because she was going through her papers at night and got upset and fell out of her wheelchair. Resident #2 stated she worked herself up. Interview on 6/14/25 at 3:57 p.m. Resident #2's physician stated he did not think the facility could have prevented Resident #2's fall because she was too independent physically and did not like to ask for help. The physician stated he was notified of her 6/9/25 fall. Interview and observation on 6/14/25 at 5:50 p.m. the DON stated Resident #2 should have anti-slip strips. The DON went to Resident #2's room and said she did not have strips in front of her recliner, and she would tell Maintainence to get it done. The DON said the facility was not following their care plan for Resident #2. Interview on 6/14/25 at 6:11 p.m. the DON stated a lot of Resident #2's falls were from her wheelchair. The DON said Resident #2 needed stand-by assistance with transfers and needed help putting her blankets on her when she was in her recliner to go to bed. The DON stated to protect Resident #2 from injury they determined to put in the anti-slip strips, which should have been in place, they had the doctor review her medications and monitored Resident #2's blood pressure closely. The DON stated she had previously in-serviced staff about checking on Resident #2 frequently and making sure her call light was in place. The DON said the nurses were supposed to lay eyes on all high-risk residents. Review of Resident #3's admission Record, dated 6/14/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia, history of falls, and unspecified convulsions. Review of Resident #3's Quarterly MDS, dated [DATE], revealed: He had a mental status score of 0 of 15 (indicating he was severely cognitively impaired). He had physical behaviors directed towards others (hitting, kicking, grabbing) four to six times a week. He used a wheelchair. He was dependent on staff for transfers. He had one fall with no injury since the previous assessment. Review of Resident #3's Care Plan, revised 4/11/25, revealed Resident had an actual fall, poor balance, unsteady gait, change in environment. The goal was the resident would resume activities without further incident through the review date. Identified interventions included [NAME] sheet in wheelchair to help aid in positioning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Fall Risk assessment dated [DATE] revealed he scored a 13 and was at risk for falls. Interview and observation on 6/14/25 at 8:03 p.m. the DON checked Resident #3's wheelchair for a [NAME] sheet and stated there was not one on his wheelchair. The DON stated if it was on the care plan it should be on the wheelchair. Interview on 6/14/25 at 6:11 p.m. the DON stated ultimately, she was responsible for making sure all the interventions were in place and for monitoring it was done. The DON said once there was a fall the whole team talked about the fall in the morning meeting and devised a plan and updated the care plan. Review of the facility's policy on Falls - Clinical Protocol, revised 4/2025, revealed: Treatment/Management Based on the preceding assessment, the staff and physician/physician extender will identify pertinent interventions to try to prevent falls and to address the risks of clinically significant consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). Monitoring/Follow-Up The staff and physician/physician extender will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed. If the individual continues to fall, the staff and physician/physician extender will reevaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. As needed, and after an appropriately thorough review, the physician/ physician extender will document any uncorrectable risk factors and underlying causes.