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	11/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 12 (Residents #1, #2, and #3) residents reviewed for comprehensive care plans.The facility failed to have a care plan for Resident #1's dialysis, diabetic care, glaucoma, seizures, mental health needs, wound care, blood pressure monitoring, ADL assistance, and vaccine status. The facility failed to have a care plan for Resident #2's mental health and behavioral issues, pain, high blood pressure, hospice services, ADL needs, communication, cognitive status, nutritional status, risk to skin impairment, incontinence, or vaccination status. The facility failed to have a care plan for Resident #3's code status, mental and behavioral needs, kidney disease, pain, dietary or fluid restrictions, low thyroid, hypertension, diabetic care, respiratory needs, ADL needs, risk of falls, range of motion impairment, vision needs, or vaccination status. These failures could place residents at risk for not receiving appropriate care and supervision.Findings included: Resident #1Review of Resident #1's admission Record, dated 11/17/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dialysis, epilepsy, pain, diabetes, history of foot ulcers, depression, glaucoma, and heart failure.Review of Resident #1's Quarterly MDS assessment dated [DATE] revealed:She had impaired vision.She had a BIMS Score of 15 of 15 (indicating she was cognitively intact).She scored a 1 of 27 on her depression screening (is a scale that used to measure the severity of the depression.She used a wheelchair for mobility.She had a therapeutic diet.She was at risk for developing skin sores.She had diabetic foot sores.She received insulin injections 7 of 7 days. She was on an anti-anxiety medication, an antidepressant medication, an anticoagulant, needed hypoglycemic agents, and was on an anticonvulsant.She received at least 2 days of therapy.Review of Resident #1's Order Summary Report, dated 11/17/25 revealed orders:Receive Dialysis services Tuesday - Thursday - Saturday dated 7/15/25Was on a fluid restriction dated 7/15/25Preventative care to left foot dated 11/8/25Blood pressure medications Amlodipine, Clonidine, Lostartan Potassium, and Metoprolol with hold parameters. Start date 7/16/25. Antianxiety medication Buspar start date 7/15/25Blood thinner Apixaban start date 7/13/25The neuropathy medication Gabapentin, start date 7/15/25Glucagon shot as needed for low blood sugar dated 7/15/25Short acting Insulin sliding scale (amount varies depending on blood sugar) dated 9/7/25.Long-acting Insulin dated 7/23/25Antiseizure medication LevetiracetamAnti-depressant medication Mirtazapine, Trazadone, and Sertraline dated 7/15/25Glaucoma eye drops dated 7/13/25Migraine medication Rimegepant Sulfate dated 7/15/25Kidney medication Sevelamer Carbonate dated 7/13/25. Review of Resident #1's care plan initiated 7/20/25 revealed care plans for Resident #1's code status, allergy to latex, and personal care/activity preferences. There was no care plan for dialysis including shunt monitoring and care or fluid restriction; diabetic care including blood sugar checks, dietary restrictions or insulin needs; glaucoma including adaptations for vision; seizures including medications, monitoring labs, or safety precautions; depression and anxiety including medications, side effects and behavior monitoring/ follow up; diabetic foot ulcers including enhanced barrier precautions, wound care, barriers to wound healing; blood pressure monitoring including frequency; ADL assistance needs; risk of complications, and vaccine status. Resident #2Review of Resident #2's admission Record, dated 11/14/25, revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including stroke, pain, dementia with behaviors, hypothyroidism (when your thyroid gland doesn't make and release enough hormone into your bloodstream), malnutrition, anxiety, heart problems, arthritis, gout (excessive build-up of uric acid in a joint, frequently the foot, causing pain), closed fracture of the neck bones, and hospice care. Review of Resident #2's admission MDS dated [DATE] showed the following Care Area Assessments: Cognitive Loss/Dementia, Communication, Urinary Continence, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcers, and Psychotropic Drug Use. All areas had a care planning decision dated 7/28/25. Review of Resident #2's Quarterly MDS Assessment, dated 8/8/25 revealed:He had a BIMS score of 1 of 15 (indicating severe cognitive impairments).He wandered 1 to 3 days of 7 in the previous 7 days.He used a wheelchair for mobility.He needed substantial or maximum assistance for toileting.He needed partial to moderate assistance for hygiene, bathing, and dressing.He had a catheter and was always incontinent of bowel. He had a prognosis of less than 6 months to live.He had 1 fall with minor injury since the previous assessment.He was on a mechanically altered diet