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	05/07/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for one (Resident #21) of three residents reviewed for PASRR Level 1 screenings. The facility failed to refer Resident #21 to the State-designated authority for a PASRR Level II review when she was admitted with a diagnosis of schizophrenia and a PASRR Level 1 positive for mental illness. This failure could place residents with mental illness at risk of not receiving a PASRR Evaluation, individualized care, or special services to meet their needsFindings include: A record review of Resident #21's face sheet, dated 5/7/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included depression (mental health condition that causes a persistent low mood and loss of interest in activities), anxiety (cognitive decline caused by vessel damage that features panic like episodes), schizophrenia (a serious mental health condition that affects how people think, feel and behave) unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A record review of Resident #21's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 which indicated moderate cognitive impairment. Resident #21's active diagnoses included non-Alzheimer's dementia (cognitive decline caused by brain diseases other than Alzheimer's), depression and schizophrenia. A record review of Resident #21's PASRR Level 1 Screening completed on 7/26/2023 by the referring hospital revealed Resident #21 had an indicator of mental illness. During an interview on 5/7/2026 at 12:15PM with Resident #21 she stated she has been at the facility for a while but was not sure exactly how long. Resident #21 stated she had not received services through PASRR before. During an interview on 5/7/2026 at 2:40 PM, the MDS Coordinator stated Resident #21 had a mental illness diagnosis, thus the PASRR screening was positive. She stated a corrected screening should have been completed and sent to the local authority for evaluation. The MDS Coordinator stated Resident #21 was admitted with the schizophrenia diagnosis. The MDS Coordinator stated she needed to fill out a form to notify the Local Authority of the diagnosis. The MDS Coordinator stated PASRR was her responsibility and she would correct the issue. She stated the risk of PASRR not being accurate could be lack of services for the resident. During an interview on 5/7/26 at 4:49PM, the DON stated she expected the PASRRs to be accurate and timely. She stated if an error on a PASRR was later found, a corrected form was sent. The DON stated the MDS Coordinator was responsible for the accuracy of PASRR documents. She stated residents may not have received the benefits or treatments they needed or were entitled to if the PASRR screening was inaccurate. During an interview on 5/7/2026 at 5:00PM with the Administrator, he stated it was the MDS Coordinator's responsibility to update and follow through with PASRR. He stated the risk of not doing so could lead to a decrease in quality of life and not receiving services that could be beneficial to the residents. During a record review of facility's policy dated 11/2023 titled PASRR revealed:In the event of a positive PL1 that indicates the individual may have ID/DD or MI the MDS Coordinator will notify the LIDDA within 2 calendar days of admission and initiate the PASRR evaluation process.

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
	676100	A. Building B. Wing	05/07/2026

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 - Some	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 observations, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one of three residents (Resident #11) and 9 of 47 sharps containers reviewed for accidents and hazards. The facility failed to ensure bed alarm was plugged in while Resident #11 was in bed as indicated on his current comprehensive care plan and current physician's orders. The facility failed to ensure sharps containers were replaced when full in 9 rooms (Rooms: 105, 106, 108, 109, 111, 113, 207, 210, and 401). The failures could place residents at risk for injury.The findings include: 1. Resident #11 A record review of Resident #11's face sheet, dated 05/7/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #11 had diagnoses which included unspecified dementia (A group of thinking and social symptoms which interferes with daily functioning), senile degeneration of the brain (a decline in an individual's memory, behavior, and cognitive abilities), anxiety disorder (excessive, persistent, and uncontrollable fear or worry that disrupts daily life). A record review of Resident #11's quarterly MDS dated [DATE] indicated he had a BIMS score of 4 which indicated severe cognitive impairment. The MDS also indicated she was dependent on staff for transfers and changing positions from sitting to standing. A record review of Resident #2's care plan initiated on 1/12/2026 revealed: 01/12/26 fall-hospice to provide low bed and scoop mattress-family has insisted he have bed/chair alarms, 1/21/2026 fall-pharmacy consult to evaluate medications, 3/17/26 Fall-assess Foley to ensure draining, 04/9/26 Fall-med review, 04/26/26 Fall-do not take resident to the dining room until closer to mealtime, 05/2/2026 Fall-assist to bed shortly after dinner is ended. The care plan initiated on 4/20/2026 revealed: Problem-Resident uses bed and chair alarms related to confusion secondary to demand from family and hospice. Goal- The resident will remain free of complications related to restraint use through the next review date. A record review of Resident #11's May 2026 physician's orders revealed an order with start date of 4/20/2026 resident may have bed and chair alarm to mitigate fall risk per family and hospice demand. Check for placement and functionality of bed and chair alarm two times a day. An observation on 05/7/26 at 1:22pm, revealed Resident #11 was lying in bed with his eyes closed. Resident #11's bed alarm was not plugged into the box that would sound. An observation on 5/7/26 at 2:19pm, revealed Resident #11 was lying in bed with his eyes closed. Resident #11's bed alarm was not plugged into the box that would sound. An observation on 5/7/26 at 3:29pm revealed Resident #11 was lying in bed with his eyes closed. Resident #11's bed alarm was not plugged into the box that would sound. During an interview on 05/7/26 at 4:03 PM, the DON stated the staff unplugged the bed alarm to keep it from sounding when they were getting him up and forgot to plug it back in. The DON stated it was the nurses and CNAs responsibility for ensuring the functionality of alarms. The DON stated the risk related to alarms being unplugged could be staff not aware that the resident was attempting to get out of bed. During an interview on 05/7/2026 at 4:36pm with the Administrator, the Administrator stated the resident was to have a bed alarm as indicated in his care plan and physician's orders. The Administrator stated not having the bed alarms could result in a fall and staff not knowing the resident was not in bed. The Administrator stated it was all staff's responsibility to ensure the alarms are plugged in for the safety of the resident, but the main responsibility fell on the nurse caring for the resident at the time. The Administrator stated they do not have a policy for bed alarms as he does not agree with having them in the facility. A Record review of the facility's Fall Prevention Program Policy revised 8/15/22 reflected Each resident will be assessed for fall risk and will receive care and services in accordance with their Individualized level of risk to minimize the likelihood of falls. When a resident who does not have a history of falling experiences a fall, the facility will update the care plan and interventions. 2. Sharps (continued on next page)

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	05/07/2026

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 - Some	ContainersObservation on 05/05/2026 at 11:12 AM, revealed the sharps container in room [ROOM NUMBER] was filled up over the full line. Observation on 05/05/2026 at 11:22 AM, revealed the sharps container in room [ROOM NUMBER] AM was filled up over the full line and had needles and gloves sticking out of the top. Observation on 05/05/2026 at 11:30 AM, revealed the sharps container in room [ROOM NUMBER] was filled to the full line. Observation on 05/05/2026 at 11:32 AM, revealed the sharps container in room [ROOM NUMBER] was filled up over the full line. Observation on 05/05/2026 at 11:34 AM, revealed the sharps container in room [ROOM NUMBER] was filled to the full line. Observation on 05/05/2026 at 11:36 AM, revealed the sharps container in room [ROOM NUMBER] was filled up over the full line. Observation on 05/07/2026 at 11:07 AM, revealed the sharps container in room [ROOM NUMBER] was filled to the full line. Observation on 05/07/2026 at 11:10 AM, revealed the sharps container in room [ROOM NUMBER] was filled up over the full line. Observation on 05/07/2026 at 11:12 AM, revealed the sharps container in room [ROOM NUMBER] was filled up over the full line. During an interview on 05/07/2026 at 3:55 PM with the DON, she said all nurses were responsible for changing full sharps containers. The DON said they really needed to remove all sharps containers from the rooms because they were also on the med carts. During an interview on 05/07/2026 at 4:01 PM with LVN E, she said if she noticed a full sharps container she would change it if she had the key. She said she did not have one for the sharps containers in resident rooms. She said she has had for the medication cart. During an interview on 05/07/2026 at 4:20 PM with the Administrator, he said changing out full sharps containers was a nurse function. He said the deficiency could cause preventable injuries to staff, residents, and visitors. Record review of the facility's Sharps Disposal Policy, dated 2001, revealed in part. Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container.

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	05/07/2026

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 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 observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure stored foods were properly stored, labeled, and dated.2. The facility failed to ensure prepared food was discarded after 72 hours (3 days) per facility policy. 3. The facility failed to prevent cross-contamination of food items when pureeing food.4. The facility failed to ensure personal food items were not stored in 1 of 2 of the kitchen refrigerators. 5. The facility failed to ensure the dietary staff wore beard covers while in the kitchen.These failures could place residents who received prepared meals from the kitchen at risk of food borne illness and cross-contamination. The findings included:During the initial tour of the kitchen on 05/05/2026 at 9:00 AM, the following was observed: The DM did not have a beard cover over his beard.Milk Refrigerator:A glass bottle of tea was opened.A container labeled ketchup had a prep date of 12/1 and use by date (UBD) of 12/25.A pitcher labeled lemonade had one date, 5/1.Clean Dish Area:Small plates, small bowls, and salad bowls were faced up and not covered.Muffin pans and baking sheets were faced up and not covered.Dry storage:Paper napkins and plastic spoons were open, not sealed, and not covered.Salad bowls were faced up and not covered.A plastic bag containing 2 different pastas was not labeled and had one date, 4/4/26.A plastic bag labeled fettuccini had one date, 1/10.A plastic bag labeled spiral pasta was not sealed and had one date, 4/8/26. A plastic bin labeled dry milk had one date, prep date 1/15/25.An open bag of powdered sugar was inside another plastic bag. The original bag had UBD 7/19/24. The outside bag had one date, 5/3/26.A bag of powdered sugar had UBD 8/27/24.A bag of powdered sugar had UBD 4/29/25.A plastic bin labeled corn meal had one date, 3/30/26.A plastic bin labeled sugar had one date, 3/30.A plastic bin labeled flour had one date, 4/10/26.A bag of frosted flakes was not sealed.A plastic bin labeled cheerios had one date, 5/3.A plastic bin labeled rice krispies had one date, 4/16.A plastic bin of flakes did not have a label or any dates.Refrigerator #1:A metal storage container labeled tot casserole had one date, 4/2.Dessert bowls labeled fruit cup had one date, 4/30. A bag labeled salisbury steak had one date, 4/12.A bag labeled salad was brown and had one date, opened 5/1.A bag labeled pork had one date, 5/5.A bag labeled cubed ham had one date, 5/4/26. Freezer:A bag labeled beef patties was not sealed.A bag labeled tater tots was not sealed. Cooking/serving utensils, pans, and strainers hung on a hanging rack, above the steam table, and was not covered. During the follow-up visit to the kitchen on 05/06/2026 at 4:10 PM, the DM did not wash the blender after pureeing carrots. He rinsed it with water before pureeing the chicken and broccoli rice casserole.During an interview with the DM on 05/05/2026 at 9:05 AM, he said the tea in the glass bottle in the milk refrigerator belonged to a staff member. He said the staff was aware they are not allowed to store personal items in the milk refrigerator.During an interview with the Administrator on 05/07/2026 at 4:28 PM, he said the DM was responsible for all things pertaining to the kitchen and that it had improved in the last 6 months. During an interview with the DM on 05/07/2026 at 5:00 PM, he said his expectations for labeling all items is: the received date, the open date, and the UBD. He said his staff had been trained in labeling, personal food items, and storage of food items. He said he is aware he should always wear a beard cover in the kitchen. The DM said these deficiencies could cause out-of-date food to be served to residents, cross-contamination, residents to become ill, and a pest problem in the kitchen.Review of the facility policy Employee Hygiene for Food Safety, dated 2023, revealed in part . All employees will: Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.Review of the facility policy Food Receiving and Storage, revised November 2022, revealed in part. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen, or (continued on next page)

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	05/07/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discarded.Review of the facility policy Food Safety and Sanitation, dated 2023, revealed in part. Leftovers are used within 72 hours (or discarded). When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed 06/19/2025 revealed: 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers .(B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement .Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.

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	05/07/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations, interviews and record review the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpsters reviewed for environment. The facility failed to ensure garbage was placed in a covered dumpster.These failure could affect residents by placing them at risk of illnesses, or be provided an unsafe, unsanitary, and uncomfortable environment.Findings include:Observation on 05/05/2026 at 10:15 AM of garbage area outside, revealed a large rectangle roll off dumpster that did not have a lid and the bags of trash were piled higher than the rim.During an interview on 05/07/2026 at 4:12 PM with the Administrator, he said they do not have a garbage disposal policy. He said he was aware of the roll off dumpster and he had instructed staff not to use it. He said he emailed city offices to get it hauled off. The administrator said that using it for regular daily trash could cause pests and trash could be scattered by the wind and/or pests.

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	05/07/2026

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 - 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 reviews, the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and time frames to meet a resident's medical and nursing needs and describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #23, and Resident #42) of 12 residents reviewed for care plans. The facility failed to develop a comprehensive person-centered care plan for Resident #23 for ADL dependence and means to address psychosocial needsThe facility failed to develop a comprehensive person-centered care plan regarding hospice services for Resident #42.This deficient practice could place residents in the facility at risk of not receiving the necessary care or services. Findings include:Findings: Resident #23Record review of Resident #23's face sheet, dated 05/06/2026, had revealed admission to the facility on 2/17/2026. Resident #23 was a [AGE] year-old female with diagnoses of Multiple Myeloma (a type of blood cancer), depression, Parkinsonism (an umbrella term that refers to a group of conditions characterized by similar movement-related symptoms, including slowed movements, stiffness, tremor, and balance issues), and collapsed vertebra. Record review of Resident #23's Comprehensive MDS, dated [DATE] revealed Resident #23 had a BIMS score of 8 which indicated moderate cognitive impairment. Section GG-Functional Abilities, dated 02/24/2026, revealed that Resident #23 was coded as 01, fully dependent, on staff for sections GG0130, which included tasks such as showering/bathing self, toileting hygiene, eating, and personal hygiene. It also reflected that the resident used a manual wheelchair. For sections GG0170 sections G-I, M, and P, the sections were coded as 88, indicating that these tasks would have not been attempted due to a medical condition or safety concern. Section H-Bowel and Bladder under section H0300-Urinary Continence, revealed Resident #23 had been coded as a 3, which indicated that the resident was always incontinent of bladder. Section H0400-Bowel Continence had been coded as a 1, which indicated that the resident had been occasionally incontinent of bowels. Section I-Active Diagnoses in the Last 7 Days Prior to Assessment, section I0020, which was to indicate the primary medical condition of the resident, had been coded as a 13 which was for medically complex conditions. There had also been indicators reflecting that she had an active diagnosis at the time of this MDS assessment of cancer (I0100), Gastroesophageal Reflux Disease (GERD) or ulcer (I1200), Depression (I5800), and Cataracts, Glaucoma, or Macular Degeneration (I6500). Additional active diagnosis included Multiple Myeloma having not achieved remission, Parkinsonism, Constipation, Collapsed Vertebrae, Muscle weakness, acute cough, and abnormal weight loss. Section K-Swallowing/Nutritional Status section K0520-Nutritional Approaches had revealed that while she was a resident at the facility, she would have received a Mechanically Altered died (pureed food, thickened liquids).Record review of Resident #23's most up to date comprehensive care plan, last updated on 5/6/2026, consisted of two focus sections. The first section had not specified whether Resident #23 had been independent from staff assistance or fully dependent on staff for assistance on ADLs. In two columns, there had been two columns, column A labeled Care Area Triggered and column B labeled Care Planning Decision. Review of the care plan showed that the only Care Planning Decision marked that had been listed as a focus area on the Care Plan Report had been interventions/tasks listed for ADLs During an interview with Resident #23 on 5/5/2026 at 3:23pm while she had been in her room, she said that she had been at the facility for about two or three weeks at the time of the interview and had resided at this facility in the past. During an interview with the MDS Coordinator on 5/7/2026 at 5:12pm, she said that she had been the MDS nurse at the facility starting at the end of November 2025. She stated when she had first started at the facility, the care plans were a mess. She stated she had managed the care plan scheduling at times during which the facility had not had a Social Services Director. She stated the (continued on next page)

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	05/07/2026

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 - Few	issue with the care plans had been identified in Quality Assurance and Performance Improvement and the facility had been trying to get this addressed. The MDS Coordinator said that a care plan should have included just about everything. She said that it was important to look at Section B when creating a care plan so that it could have addressed any visual or hearing limitations of the resident, as well as any other relevant concerns that regarded the resident such as effective and safe behavioral interventions. The MDS Coordinator said other things that should have been included were code status, going over higher-risk medications, and making sure the care plans were individualized in a way which made the resident identifiable without knowing whose care plan it was. The MDS Coordinator said it was important for members of the interdisciplinary team to be present for the care plan meetings, such as the MDS nurse, a nurse who directly cared for the patient, rehab/therapy director, and the social worker. She stated the risk of not having a care plan could lead to decline in quality of care due to staff not knowing residents preferences or care requirements.During an interview with the DON on 5/7/2026 at 4:50pm she had said that her involvement with care plans was that she would attend the meetings to explain medications, health conditions, and discuss care. The DON said the meetings had typically been scheduled once per week. The DON stated that a care plan should include as much as possible with input from the facility's IDT (Interdisiplinary Team). The DON said if a care plan was missing information regarding care and needs of the resident, the resident could have possibly missed out on services that they could have benefited from. During an interview on 5/7/2026 at 5:03pm with the Administrator, he said that he had been involved in care plans as needed. The Administrator said that a care plan would need to focus on the needs of the resident and would have to be individualized as every resident was a unique individual. When asked what could happen if a care plan had been inadequate, he stated That is an open-ended question that I cannot answer.Resident #42Record review of Resident #42's face sheet, dated 05/07/2026, had revealed an admission to the facility on [DATE] and re-admission on [DATE]. Resident #42 was an [AGE] year-old male with diagnoses of Parkinson's Disease (a progressive neurological disorder) and chronic kidney disease (a progressive disease of the kidneys).Record Review of Resident #42's Order Summary, dated 05/07/2026, had revealed an order, dated 03/26/2026, to admit to hospice services: Dx: Parkinson's disease with dyskinesia (G20.B2) Record review of Resident #42's Comprehensive MDS, dated [DATE], revealed the resident received hospice care while a resident in Section O - Special Treatments, Procedures, and Programs, option K1 - Hospice Care was selected. Record review of Resident #42's Comprehensive Care Plan, dated 04/15/2026, revealed hospice care was not included in the care plan. During an interview on 05/07/2026, at 3:55 PM with the DON, she said Resident #42 was on hospice and the MDS Coordinator was responsible for including hospice in the care plan. The DON said the deficiency could prevent Resident #42 from receiving applicable care, mentally and physically. During an interview on 05/07/2026, at 4:05 PM with the MDS Coordinator, she said she was not aware Resident #42 was receiving hospice care. She said she was responsible for verifying the accuracy of care plan and hospice care should have been included in Resident #42's Care Plan. The MDS Coordinator said she did not have an excuse for it not being included. She said she had multiple trainings on accurate care plans over the years she has worked in nursing facilities. During an interview on 05/07/2026, at 4:20 PM with the Administrator, he said hospice care should have been care planned and care plans were part of nursing services, and the DON was responsible. He said the deficiency could result in the resident not receiving the care he needs. Record review of the facility's Care Plans, Comprehensive Person-Centered Policy, dated March 2022, had revealed: 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 - The comprehensive, person-centered care plan: .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being,

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	05/07/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 2 residents (Resident #8) reviewed for trauma-informed care. The facility failed to ensure Resident #8 had a trauma screening completed upon admission to the facility that identified possible triggers when Resident #8 had a history of trauma. This failure could place residents at an increased risk for psychological distress due to re-traumatization.The findings included: A record review of the face sheet, dated 05/07/26, reflected Resident #8 was a [AGE] year-old female who initially admitted to the facility on [DATE] with a diagnosis of PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). A record review of the quarterly MDS assessment, dated 04/14/26, revealed Resident #8 had clear speech and was understood by others. The MDS revealed Resident #8 was able to understand others. The MDS reflected Resident #8 had a BIMS score of 14, which indicated intact cognition. The MDS reflected Resident #8 had no behaviors or refusal of care. The MDS revealed Resident #8 had an active diagnosis of PTSD. A record review of the comprehensive care plan, revised 10/9/2025, revealed Resident #8 had a history of hallucinating and delusions related to PTSD. The goal was to not experience distress because of these. No triggers or history were noted in the care plan. A record review of Resident #8's, assessments reviewed on 5/7/2026, revealed no assessment to identify Resident #8's trauma or triggers that could cause re-traumatization. During an interview on 05/07/26 beginning at 3:49 PM, the Social Services Director stated she was responsible for completing the initial trauma informed assessments on admission. The Social Services Director stated she was aware the Trauma Informed Assessment was not completed for Resident #8 and she was going to start working on it, but she just started working at the facility last week. The Social Services Director stated there was no trauma screening completed on admission that she was aware of. The Social Services Director stated it was important to ensure residents were screened for a history of trauma, and potential triggers were identified to maintain the correct environment to prevent triggers that could have caused re-traumatization. The Social Services Director stated it would have been important to know the potential triggers to prevent aggravation, frustration, or other behaviors. During an observation and interview on 05/07/26 beginning at 4:02 PM, revealed Resident #8 was sitting up in the dining room eating a snack. Resident #8 did not want to leave the dining room, unable to complete the interview regarding her PTSD diagnosis. During an interview on 05/07/26 beginning at 1:12 PM, the DON stated the Social Worker was responsible for trauma informed care if the resident had a PTSD diagnosis. The DON stated she reviewed the clinical record for psychotropic medication and behaviors. The DON stated she reviewed the diagnosis to ensure the referral was appropriate for admission to the facility. The DON stated she was responsible for monitoring assessments and making sure they were completed. During an interview on 05/07/26 beginning at 4:41 PM, the Administrator stated his expectation was for the Social Worker to complete the required assessments based on the resident's diagnosis. The Administrator stated the Social Services Director was responsible for completing the initial social history assessment, which included trauma screening questions. The Administrator stated he was unaware that this had not been completed. The Administrator stated that this Social Worker had only been at the facility for about 2 weeks. The Administrator stated it was important to ensure residents were assessed for a history of trauma, and potential triggers were identified to prevent re-traumatizing and maintaining the safety of the residents and staff. Record review of the Trauma Informed Care and Culturally Competent Care policy, revised August 2022, revealed .To address the needs of trauma survivors by minimizing triggers and/or re-traumatization .

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	05/07/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure a medication error rate of less than 5%, and the medication error rate was 7.14% with 2 errors in 28 opportunities involving 1 staff (LVN D) and 1 resident (Resident #3) reviewed for medication pass. LVN D did not fully administer the crushed medications to Resident #3 via PEG tube. (Percutaneous Endoscopic Gastrostomy, a medical procedure used to insert a feeding tube directly into the stomach through the abdominal wall.) This failure could place residents at risk of not receiving their medications as prescribed according to physician's orders and facility policy and procedures. Findings include: Record review of Resident #3's admission record dated 05/07/2026 indicated she was admitted to the facility on [DATE] with diagnoses of stroke and essential hypertension (high blood pressure). She was [AGE] years of age. Record review of Resident 3's physician's orders dated 05/07/2026 indicated in part: Lisinopril Oral Tablet 40 MG Give 40 mg via PEG-Tube one time a day related to essential hypertension (high blood pressure). Start date 04/18/2026. Carvedilol Oral Tablet 25 MG Give 1 tablet via PEG-Tube two times a day related to essential hypertension. Start date 04/17/2026. Observation and interview on 05/07/2026 at 8:36 AM revealed LVN D administered Resident #3 her medications via PEG tube. The LVN prepared the medications on the medication cart before bringing them into the resident's room. LVN D poured the following medications into a medicine cup and then crushed them one at a time as she poured each medication in an individual cup. The nurse poured one 25mg pill of Carvedilol and one 40mg pill of Lisinopril. The LVN then entered the resident's room and put on some PPE and proceeded to administer the medications. LVN D poured some water into Resident #3's PEG tube with the use of a syringe and then poured the medications one at a time. The LVN was finished, and the cups were observed to have some of the medication residual at the bottom of the cup. LVN D was asked regarding the medication residual left in the cups. The LVN said that she had not poured more water into each cup to try and get the residual because she had done that in the past when she had been observed by a sState surveyor, and the facility had gotten cited for her giving too much water to the resident. LVN D said she agreed that it was more important for the resident to get her full dose of medication but since the facility she had worked at before had gotten a citation for too much water administered she decided not to use more water to get the residual medication that was left in the cup. Interview on 05/07/2026 at 8:54 AM the DON was shown the 30 ml medicine cups that contained the medication residual left over from the Carvedilol and Lisinopril medications. The DON said she believed that the nurse should have attempted to get more of the medication from the cups. The DON said that if the resident did not receive their full dose of the medication, it could lead to the medication not having the effect it was intended to do. The DON said that the resident could possibly have an adverse effect due to them not getting the entire medication as ordered. Interview on 05/07/2026 at 05:55 PM the Administrator was made aware of the medication error rate being 7.14% due to LVN D not fully administering the crushed medications. The Administrator said it was expected for the nurse to administer as much of the medication as possible because if not, that could lead to the resident not receiving the desired outcome. Record review of the facility's policy titled administering medications dated April 2019 indicated in part: Medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders, including any required timeframe.

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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 store all drugs and biologicals in locked compartments for 1 of 4 (hall 2 cart) observed for medication storage and security. MA C failed to ensure her medication cart was secured when it was left unattended on 05/05/2026. These failures could place clients at risk for drug diversion or accidental ingestion. Findings included: Observation and interview on 05/05/2026 at 9:14 AM the hall 2 medication cart was seen unlocked and unsupervised. The DON was made aware of the cart unlocked. The cart was inspected with the DON present. On the top drawer were several over the counter medication bottles. Inside the other drawers were some blister packs that contained several prescribed medications. The DON said that it was expected for the staff to lock the medication carts whenever they left the carts unattended. Interview on 05/05/2026 at 9:22 AM MA C said the hall 2 medication cart was the cart she had used today 05/05/2026. The MA said she was sure she had locked the cart when she had stepped away. MA C said she was the only one that had keys for that cart, so it must have been her that left it unlocked. The MA said that if the medication cart was left unlocked and unattended there was a possibility of medications being robbed and residents could have access to the medications as well. Interview on 05/07/2026 at 5:46 PM the DON said it was expected for the medication carts to be locked when left unattended. The DON said that if the cart was left unlocked then there was a possibility of residents getting into the medications in the cart and possibly taking them. Interview on 05/07/2026 at 5:52 PM the Administrator said it was expected for the medication carts to be locked when left unattended. The Administrator said that if the cart was left unlocked, it could lead to medications being stolen or going missing. Review of the facility's policy titled Medication labeling and storage dated 02/2023 indicated in part: The facility stores all medications and biologicals in locked compartment under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Compartments (including, but not limited to, drawers, cabinets, rooms, carts, and boxes) containing medications and biologicals are locked when not in use and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.

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	05/07/2026

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 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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #37) of 3 residents reviewed for infection control. CNA A failed to change her gloves after they became contaminated while assisting Resident #37 with incontinent care. This failure could place residents' risk for cross contamination and the spread of infection. Finding include: Record review of Resident #37's admission record dated 05/05/2026 indicated he was admitted to the facility on [DATE] with diagnoses of dementia and unsteadiness on feet. He was [AGE] years of age. Record review of Resident #37's MDS dated [DATE] indicated in part: Urinary continence = Always incontinent. Bowel continence = Always incontinent. Record review of Resident #37's care plan revised on 05/07/2026 indicated in part: The resident has bowelIncontinence. The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Clean peri-area with each incontinence episode. Observation on 05/05/2026 at 3:02 PM CNA B and CNA A performed incontinent care for Resident #37. Both CNAs washed their hands then put on a pair of new gloves. CNA A undid the resident's brief and took some wipes and wiped the resident's penis and scrotum area. CNA B then assisted with turning Resident #37 on his side, and CNA A then wiped the resident's rectal area. The resident had a bowel movement, CNA A wiped several times until the resident was clean. While still wearing the same gloves, CNA A took a clean brief and fastened it to Resident #37 and then afterwards removed her gloves. Interview on 05/05/2026 at 3:24 PM CNA A said that she should have changed her gloves after they became contaminated when she wiped Resident #37's private areas. The CNA said that she realized that she should have changed gloves before getting the clean items but got nervous and forgot. CNA A said not changing her gloves could have led to the spread if infections. Interview on 05/07/2026 at 5:48 PM the DON said it was expected for the staff to change their gloves and sanitize their hands when going from dirty to clean. The DON said staff not changing their gloves could possibly lead to the spread of infections. Interview on 05/07/2026 at 5:50 PM the Administrator stated and that there was a possible outcome of cross contamination. Record review of the facility document titled Perineal Care dated 2001 indicated in part: The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation and to observe the resident's skin condition. Beginning steps. Wash hands, wear gloves and follow standard precautions if contact with blood or body fluids if likely. If resident is heavily soiled with feces, turn resident on side and clean away feces with tissue, wipes or incontinent brief. Discard soiled gloves along with the soiled brief and/or wipes in trash bag. Cover the resident, provide safety measures and wash hands with soap and water. Discard soiled gloves, sanitize hands. Re-glove prior to touching clean linens/adult brief.