

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Avir at Sherman		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Sara Swammy Dr Sherman, TX 75090	
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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure completion of a discharge summary including a recapitulation of the resident's stay, and final status at discharge for one of three residents (Resident #1) reviewed for discharge summary. The facility failed to complete a discharge summary for Resident #1. This failure could place residents at risk of not having complete records after permanent discharge from the facility and disruption in the continuity of care. Findings included: Record review of Resident #1's face sheet dated 02/03/26, indicated a [AGE] year-old female who admitted to the facility on [DATE] and discharged from the facility on 01/02/26 with diagnoses which included dementia (memory loss), metabolic encephalopathy (disease affecting the brain leading to impaired brain function), unspecified protein calorie malnutrition (inadequate intake or absorption of protein and energy). Record review of Resident #1's discharge MDS assessment dated [DATE], indicated discharge assessment-return not anticipated. Resident #1 was discharged to another Nursing home-Long-term care facility. Record review of Resident #1's Nurse progress note dated 01/02/26 at 4:30 p.m. by LVN A reflected, Resident transferred out of facility to new facility in [Name of Town]. Personal belongings and meds sent with resident. Record review of Resident #1's Electronic Medical Record on 02/03/26 revealed Resident #1 did not have a discharge summary. In an interview on 02/03/26 at 1:00 p.m. with Regional Nurse Consultant, she stated a discharge summary with a recapitulation of the resident's stay was expected to be completed within 72 hours of a resident's discharge. She stated it was a part of the overall discharge process which was begun on every resident at the time of their admission. In an interview with the Social Worker on 02/03/26 at 1:45 p.m. she stated she was told by the Administrator and DON to find placement for Resident #1 in a facility with a secured unit due to her exit-seeking attempts. She stated she had spoken with the Responsible Pary for Resident #1 who agreed with the discharge. She stated she located a sister facility who was able to admit the resident and provided the resident's information to the receiving facility. She stated she was not sure who was responsible for the discharge summary in the resident's record. She stated she had not received any instruction on who was responsible for the completion of the discharge summary. In an interview on 02/03/26 at 2:20 p.m., the DON she said they had recently changed electronic record systems in January 2026 and she and the staff were still learning the process. She stated nursing was responsible for initiating the discharge summary in the electronic record, documenting what medications were sent with the resident, summary of the care they had received while in the facility, and medical history. She stated she was informed today (02/03/26) she was responsible for reviewing all discharge summaries. She stated they would all be receiving training on the new process immediately. In an interview with the Administrator on 02/03/26 at 2:40 p.m. he said the discharge summary should be completed the day the resident was discharged or the day after and should be a part of residents' electronic health record. The Administrator said failure to complete a discharge summary placed the</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676120
		If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Avir at Sherman		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Sara Swammy Dr Sherman, TX 75090	
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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident at risk for not knowing the final disposition of the resident upon their discharge from the facility and a summary of what care was provided to them during their stay at the facility. He stated the facility was accountable to provide a discharge summary for continuity of care. Record review of facility policy titled, Discharge Summary and Plan, dated October 2022, reflected, When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. The discharge summary includes a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge shall include a description of the resident's: Current diagnosis; medical history; course of illness; current laboratory, radiology, consultation, and diagnostic test results; physical and mental functional status; Ability to perform activities of daily living.nutritional status.medication therapy.A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records.The discharge summary</p>		