STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure Comprehensive Care Plans - The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements for 3 of 16 (Residents #3, #51, #41) residents reviewed for care plans. 1. The facility failed to ensure Resident #3 had a care plan to educate and re-direct the resident from wearing his indwelling urinary catheter collection bag above his bladder. 2. The facility failed to ensure Resident #51's care plan had discharge plans. 3. the facility failed to ensure Resident #41's care plan had discharge plans. This could affect resident and could result in residents not being educated on indwelling catheter positioning and residents not having a discharge plan or goal to set. The Findings: 1. A record review of resident #3's admission record dated 5/20/2026, revealed Resident #3 was admitted on [DATE] with diagnoses which included sepsis due to pseudomonas (Sepsis is a life-threatening medical emergency that happens when your body has an extreme, overactive response to an infection / pseudomonas are bacteria widely distributed across the globe in soil, water, and vegetation) and obstructive and reflux uropathy (bladder disease when the drainage of urine is blocked and begins to flow backwards and cause infections). A record review of Resident #3's admission MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old male admitted for LTC support with his ADLs complicated by his history of pneumonias (infections of the lungs) and Parkinson's disease (a brain disorder that causes problems with movement, balance, and coordination). Resident #3 was assessed with a BIMS score of 13 out of a possible 15 which indicated intact cognition. Resident #3 was assessed with the ability to be understood and could understand others. A record review of Resident #3's physicians orders dated 5/19/2026 with start date of 3/5/2026 revealed the physician prescribed care for Resident #3's indwelling urinary catheter, every shift (name brand) catheter care with soap and water. A record review of Resident #3's care plan dated 5/19/2026 at 1:29 PM revealed Resident #3 had an indwelling urinary catheter without nursing interventions to educate and re-direct Resident #3 with his (continued on next page)

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
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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	habit of wearing his urinary collection bag above his bladder. A record review of Resident #3's nursing medical record reviewed for the period 3/42026 through 5/19/2026 revealed no documentation for educating and directing Resident #3 to wear his urinary catheter collection bag and tubing below his bladder to reduce the potential risk for urinary tract infections. During an observation on 5/19/2026 at 11:05 AM revealed Resident #3 ambulating with his rollator (a mobility aid with three or four wheels that you push while walking) throughout the facility while wearing his indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder. Resident #3 was observed to have walked by CNA K and RN G while wearing his urine collection bag and tubing above his bladder. During an interview on 5/19/2026 at 11:06 AM, CNA K stated she was the CNA caring for Resident #3. CNA K stated Resident #3 had a need for an indwelling urinary catheter. CNA K stated Resident #3 dressed and toileted himself as well as drained his own urine collection bag. CNA K stated she had not dressed him that morning, and she would provide catheter-care for Resident #3 every day by cleaning the catheter with soap and water. CNA K stated Resident #3 had a routine to dress himself and wear his indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder. CNA K stated she had not received training from the nurse to redirect Resident #3 to wear his urinary collection bag below his waist. During an observation on 5/20/2026 at 12:03 PM revealed Resident #3 ambulating with his rollator (a mobility aid with three or four wheels that you push while walking) throughout the facility while wearing his indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder. Resident #3 was observed to have walked by RN G while wearing his urine collection bag and tubing above his bladder. During an interview on 5/20/2026 at 12:16 PM RN G stated she was the charge nurse for Resident #3. RN G stated Resident #3 had a need for an indwelling urinary catheter and was independent with his ADL care, dressed himself and cared for his urinary catheter collection bag. RN G stated Resident #3 had a routine to dress himself and wear his indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder as he was doing today. RN G stated she was concerned Resident #3's habit would put him at risk for an infection. RN G stated, in the past, she had recommended Resident #3 to wear his urinary catheter bag below his waist but could not recall a date and time. RN G stated she could not recall if she had documented her education or re-direction for Resident #3 to wear his urinary collection bag below his bladder. RN G stated she had not redirected Resident #3 to wear his urinary catheter bag below his bladder yesterday nor today. RN G stated she could not refer to Resident #3's care plan and suggested MDS nurse could refer to Resident #3's care plan. During an interview on 5/20/2026 at 12:55 PM, Resident #3 stated he had a history of difficulty emptying his bladder and had a history of recurring urinary infections. Resident #3 stated he had a need or an indwelling urinary catheter and urine collection bag. Resident #3 stated he would take care of his indwelling urinary catheter and urine collection bag himself and would hang the urine collection bag from his belt. Resident #3 stated he had not received any education for keeping his urinary collection bag and tubing below his waist and bladder. Resident #3 stated he would consider any measures to reduce the frequencies of urinary infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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	During an interview on 5/21/2026 at 2:10 PM, the MDS nurse stated her review of Resident #3's care plan had no interventions to address Resident #3's habit of wearing his indwelling urinary catheter collection bag above his waist. MDS Nurse stated she had seen Resident #3 with his urinary collection bag above his bladder and had not assessed Resident #3 with a need to update his care plan to include education and redirection to wear his urine collection bag below his bladder. MDS Nurse stated that the practice of wearing the urine collection bag above the bladder could potentially contribute to an infection of the bladder. MDS Nurse stated that any nurse could have assessed Resident #3 with a need for an update to his care plan. During an Interview on 5/21/2026 at 2:05 PM, Resident #3's Representative stated due to Resident #3's dementia, Resident #3 had a poor recent memory and could not recall recent memories for the past weeks. Resident #3's Representative stated Resident #3 prior to being admitted to the nursing home, lived alone and had a need for an indwelling urinary catheter and had a practice of securing his urine collection bag at his beltline onto his pants and or shorts. Resident #3's Representative stated Resident #3 also had a reoccurring history of UTI's. Resident #3's Representative stated no one had contacted her to provide education that it would be recommended to have Resident #3 wear his urinary collection bag below his waist to reduce the possibility of infections. Resident #3's Representative stated that if she had received the education and report, she would have attempted to re-direct Resident #3 to change his habit and wear his urine collection bag below his bladder. During an interview on 5/22/2026 at 4:00 PM the DON stated Resident #3 had received education and redirection from nursing staff to not wear his urinary collection above his waist and it was Resident #3's choice to wear the bag above his bladder. The DON stated that the documentation was in the updated care plan dated 5/19/2026. A record review of the Facility's Catheter Care, Urinary policy updated July 2024, revealed, The purpose of this procedure is to prevent catheter associated urinary tract infections. general guidelines: . The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . 2. A Record review of Resident #51's admission Record dated 5/21/2026 was documented as she was admitted on [DATE] with diagnoses of Alzheimer's disease, and lack of coordination. A Record review of Resident #51's Quarterly MDS dated [DATE] was documented her BIMs score was 1/15 (severely cognitively impaired), and ADLs were for eating, toileting, upper/lower extremity and putting on footwear required set-up assistance. A Record review of Resident #51's Care Plan dated 2/12/2026 did not have discharge plans. 3. A Record review of Resident #41's admission Record dated 5/22/2026 was documented as she was admitted on [DATE] with diagnosis of low back pain, lack of coordination and cognitive communication deficit. A Record review of Resident #41's Quarterly MDS dated [DATE] was documented that her BIMs score was 15/15 (cognitively intact), she required a wheelchair for mobility and ADLs were for eating, toileting, upper/lower extremity and putting on footwear required set-up assistance. A Record review of Resident #41's Care Plan dated 5/3/2026 did not have discharge plans. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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	During an interview on 5/21/2026 at 4:49 PM, the MDS nurse stated she did not have discharge planning for Resident #51 and #41. The MDS Nurse stated that she had missed it in the coding for discharge planning. The MDS nurse stated she was responsible for care plans. During an interview on 05/22/2026 at 12:09 PM with the ADM stated residents that did not have discharge plans in the care plans would be residents not knowing what the next step would be. Record review of Policy, Care Plan, comprehensive Person-Centered dated March 2022 was documented 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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, interviews, and record reviews the facility failed to ensure Other Environmental Conditions - The facility must ensure that the resident environment is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes: a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 of 2 (100/200 hall and 300/400 hall) main shower rooms in that and 1 of 1 facility common area for accidents and hazards. The facility failed to ensure the 100/200 and the 300/400 shower rooms did not have several razors and 2 chemical sprays used for cleaning in an unlocked area in the shower rooms. This failure could lead to resident accident or injury.The facility failed to ensure on 400 hall in the dining/activity area that 4-5 acrylic paints in various colors were not in a drawer unsecured. This could lead to potential ingestion, skin contact or reactions.The facility failed to ensure that residents could not access and utilize the cookie oven and bread machine in the main dining room area. This failure could lead to injury or burns. These failures could affect all residents that shower in the main shower rooms and could cause water damage or flooding. The Findings:1.Observation on 5/19/2026 at 12:18 PM in the 100/200 hall shower room revealed the door was unlocked. An unlocked cabinet had 4 razors and a disinfecting cleaner bottle stated, caution keep out of reach of children. Observations on 5/19/2026 at 12:19 PM in the 300/400 hall shower room with CNA C revealed the doors were unlocked and had 11 used razors in an open sharp's container. Interview on 5/19/2026 at 12:08 PM in the 100/200 shower rooms, CNA C confirmed it was unlocked. CNA C stated the 100/200 shower rooms and cabinets in the shower rooms should be locked and any harmful chemical sprayer should be locked in cabinets CNA C stated the 4 razors in cabinet should be locked and residents could cut themselves with them and harm themselves with the chemical sprayer. Interview on 5/19/2026 12:27 PM with CNA C in the 300/400 hall shower room confirmed the door was unlocked, and there were 11 used razors in an open sharp's container. CNA C did not respond to additional questions. 23.Observation on 5/19/2026 at 2:52 PM on 400 halls in the dining/activity area, in a drawer there were 4-5 acrylic paints in various colors. Interview on 5/19/2026 at 1:07 PM with CNA L stated she had worked at facility for year. CNA L stated the Residents in the 300/400 halls wander residents in halls, in different rooms, it used to be the memory care unit. CNA L stated there were residents in the 100/200 halls that wander in the facility, and staff re-direct them. CNA L confirmed the acrylic paints in the drawer. Interview on 5/22/2026 at 11:57 AM with ADM stated the showers rooms should be locked, and the razors/disinfect bottle should be locked. The ADM stated residents should be kept away from hazards. The ADM stated the shower leaking water or had puddles of water could affect residents and they could get hurt from a misstep or trip. The ADM stated the acrylic paint; staff want to make sure residents don't have access to any hazards that could cause harm. The ADM stated staff should try to keep residents away from toxins. ADM stated the showers rooms should be locked, and it was important to make sure residents did not go in the shower room, when other residents were in the shower, and residents should be kept away from hazards/harm by staff. The ADM stated the beauticians brought in products and supplies and was responsible for own items. The ADM stated they did not have a policy on acrylic paint. During an observation on 05/19/2026 at 12:03 pm, the surveyor observed a cookie oven and a bread machine in the main dining room on a dresser set under the TV in the room. It was observed that both the cookie oven and the bread machine were plugged in operable. The cookie oven did not have a secured oven door and began heating immediately upon turning on. The bread machine did not have a secure lid and had a mechanism that spun rapidly at the bottom of it that had protruding notches. During an observation on 05/19/2026 at 12:07 pm, the surveyor observed Resident #20 sitting no more than five feet from the dresser with the cookie oven (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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	and bread machine. 4. Record review of Resident #20's Face Sheet, dated 05/21/2026, revealed a [AGE] year-old female that admitted to the facility on [DATE] with diagnoses including Dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities); Cognitive Communication Deficit (condition where a person's ability to communicate effectively is impaired by underlying problems in mental processes, rather than by a language or speech disorder); Insomnia (disorder characterized by difficulty falling asleep, staying awake, or waking up too early and not being able to return to sleep); and Metabolic Disorders (condition disrupting body's normal biochemical processes, affecting how it breaks down, stores, or uses nutrients).Record review of Resident #20's Quarterly MDS, dated [DATE], revealed a BIMS score of 0.0 indicating severe cognitive impairment, suggesting significant difficulties with memory, orientation, and thinking skills. Resident #20's MDS also revealed ambulation with a walker.Record review of Resident #20's Care Plan, revised 05/06/2026, revealed a communication problem, risk for falls, self-care deficit, impaired cognitive function, and impaired thought process.Record review of Resident #20's Order Summary report, dated 05/21/2026, revealed Tylenol for pain, levothyroxine 25mcg, and multi-vitamins.During an interview on 05/19/2026 at 12:37 pm, the AD stated she was unaware that the items were plugged in and that she has only been the AD for about two months. The AD stated that she had been slightly nervous about utilizing the cookie oven herself so she may have only used it once in her time as the AD. The AD stated that she is not sure if the items are normally plugged in. The AD stated that the negative impact could be that a resident gets burned or injured. During an observation on 05/19/2026 at 12:45 pm, the DON and AD observed removing the cookie oven and bread machine from the main dining area. Record review of policy, Hazardous Areas, Devices and Equipment, dated 2001, was documented, all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure residents' safety and mitigate accident hazards to extend possible. Identification of hazards: 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness examples of environment hazards included but not limited to the following; a. equipment and devices that are left unattended or are malfunctioning. C. Sharp objects that are accessible to vulnerable residents d. Open areas or items that should be locked when not in use. e. irregular floor surfaces. g. Access to toxic chemicals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received, and the facility provided, food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 6 residents, and 1 of 1 meal reviewed for palatability, attractiveness, and appetizing foods.The facility failed to provide food that was palatable and at an appetizing temperature for residents. This failure could place residents at risk of a decrease in food intake, hunger, and unwanted weight loss. Findings: Record review of Resident Council Minutes dated 3/23/2026 had concerns with cold food. Record review of Resident Council Minutes dated April 2026 had concerns with cold food. Record review of the Dining Manager, Philly Steak Sandwich, dated 2026 was documented roll, New England Style hot dog/Frank Bun. Record review of Resident #9's Face Sheet, dated 05/20/2026, revealed a [AGE] year-old female that admitted on [DATE] with diagnoses which included Gastro-Esophageal Reflux Disease (chronic condition where stomach acid flows back into the esophagus); Neurogenic Bowel Disorder (condition where nerve damage disrupts normal bowel function, leading to constipation, fecal incontinence, or both); Age-related Physical Debility (progressive decline in strength, endurance, and physiological function that occurs as people age); and Diabetes Mellitus (chronic condition that occurs when the body cannot properly use blood sugar, leading to high blood sugar levels). Record review of Resident #9's Quarterly MDS, dated [DATE], revealed a BIMS score of 14 indicating normal cognitive function with minimal or no memory impairment. Record review of Resident #9's Care Plan, revised 03/09/2026, revealed a risk for falls, self-care deficit, incontinence, and diabetes mellitus. Record review of Resident #9's Order Summary report, dated 05/20/2026, revealed orders for a fortified diet, Humulin 70/30 Pen-Injector inject 11 units in the evening and 13 units in the morning, and Miralax 1 packet mixed into 4-6 ounces of water. Record review of Resident #48's Face Sheet, dated 05/20/206, revealed a [AGE] year-old male that admitted to the facility on [DATE] with diagnoses which included Gastro-Esophageal Reflux Disease (chronic condition where stomach acid flows back into the esophagus); Neurogenic Bowel Disorder (condition where nerve damage disrupts normal bowel function, leading to constipation, fecal incontinence, or both);Adult Failure to Thrive (syndrome of progressive decline in weight, nutrition, physical function, and mental health, often seen in older adults); and Post-Traumatic Stress Disorder (mental health disorder that is caused by an extremely stressful or terrifying event- either being part of it or witnessing it). Record review of Resident #48's Quarterly MDS, dated [DATE]-026, revealed a BIMS score of 14 indicating normal cognitive function with minimal or no memory impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #48's Care Plan, revised 05/11/2026, revealed risk of self-care deficits, falls, hospice services, and nutritional problems related to terminal prognosis. Record review of Resident #48's Order Summary, dated 05/20/2026, revealed orders for a fortified diet, Depakote 250mg twice daily, Baclofen 20mg once daily and every six hours as needed. During an interview on 05/19/2026 at 10:42 am, Resident #9 stated that the food in facility sucks. Resident #9 stated that the food is cold when received and that there were never any fresh vegetables or fruit given. Resident #9 stated they have told the kitchen multiple times but nothing changes. During an interview on 05/19/2026 at 11:25am, Resident #48 stated that the food was horrible, it never tastes good and was always cold. During an observation on 05/19/2025 at 12:11 pm, meal tray cart was observed on the hallway. The cart that the meal trays rested on was observed not enclosed and that the trays had plates covered with lids. During an observation on 05/21/2026 at 10:57 am, during lunch preparation and serving. [NAME] A checked temperatures on serving line and all temperatures were within guidelines at 12:05pm. The surveyor requested a test tray to go out as last tray on the last cart that was sent to hallways. [NAME] A stated that they usually send 200 hall out last at lunch. DA began plating 200 hall cart at 12:37pm. A total of 13 trays were placed on the cart for 200 hall and the test tray was added at 12:44pm. Cart rolled to dining room for nurse to check trays for accuracy at 12:45pm. RN G completed accuracy check and cart was pushed to 200 hall at 12:50pm. Trays were passed residents on 200 hall and the test tray came off of cart at 12:57pm. At 12:58pm the surveyor checked food temperatures for items on tray. Coleslaw temped at 80.4 degrees and was in a bowl set on the warm plate under the food cover, Philly cheesesteak sandwich with a hot dog bum, tempted at 123.6 degrees, potato wedges tempted at 108 degrees, and the cheesecake for dessert temped at 63.3 degrees and was set to the side of the covered warm plate. During an interview on 05/21/2026 at 3:45pm, DM stated that the temperatures for the food items on the tray were not within the guidelines and were in the danger zone for foodborne illnesses. The DM stated that the danger zone was between the 41-degree and 135-degree range. The DM stated that their goal is to get food out at the cooked temperature, as close as possible. DM stated that the coleslaw was too warm and would probably not be appetizing, as well as the cheesecake. The DM stated that she would prefer her sandwich hotter than the temperature the food was when it arrived to the resident. The DM stated she would look into how to get the food to the residents faster. During an interview on 05/22/2026 at 10:10am, [NAME] A stated that the kitchen used to have metal plates that sat in the food warmers that were warmed in their own mechanism, but they broke a while back and everything was removed from the kitchen. Surveyor confirmed that the metal plate sat below the served plates that the food sat on to assist in keeping the heat. During an interview on 5/22/2026 at 12:17 PM with ADM stated the resident food not having the correct temperature and not palatable could cause residents not to eat. During an interview on 05/22/2026 at 2:00 pm, Resident Council was held with 4 residents. Four residents stated that the food at the facility was cold, bland, and did not look good. The 4 residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that the Philly cheesecake sandwich was on a hot dog bun and did not look like a Philly cheesesteak. The food was visually unappealing. Record review of facility grievances, dated 03/13/2026 and 02/15/2026, revealed several complaints of cold food. Record review of facility Food Receiving and Storage Policy, revised November 2022, revealed that the danger zone means temperatures above 41-degrees Fahrenheit and below 135-degrees Fahrenheit allow the rapid growth of pathogenic microorganisms that can cause food borne illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 - Some	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 and to help prevent the development and transmission of communicable disease and infection for 1 of 16 residents (Residents #76) and 1 CNA (CNA E) reviewed for infection prevention and control. The facility failed to ensure the SLP and MA P donned the appropriate PPE when on 5/20/2026 they entered Resident #76's isolation room.The facility failed to ensure while passing out trays on the facility's 300-hall, CNA B sanitized her hands between delivering residents' lunch meal trays. This failure could place residents at risk of cross-contamination and the spread of infection. The findings included: 1. A record review of Resident #76's admission record dated 5/19/2026 revealed an admission date of 5/18/2026, diagnosis included Respiratory Syncytial Virus (RSV, a highly contagious, common respiratory virus that infects the lungs and breathing passages). A record review of Resident #76's admission MDS dated [DATE] revealed Resident #76 was a [AGE] year-old female admitted for LTC ADL supports complicated by her diagnosis of RSV. A record review of Resident #76's care plan dated 5/18/2026 revealed, I have infection related to compromised medical condition: . pneumonia with RSV . strict droplet precautions / isolation . A record review of Resident #76's physicians orders dated 5/18/2026 revealed Resident #76 was to be cared for under isolation with droplet precautions, Strict isolation precautions. Full PPE sic[personal protection equipment] when in room. During an observation and interview on 5/20/2026 at 5:34 PM revealed Resident #76's room had signage on the door which stated stop droplet precautions: everyone must: clean their hands, including before entering and when leaving the room. Make sure their eyes, nose, mouth are fully covered before room entry or remove face protection before room exit. Further observation revealed that SLP prepared to enter Resident #76's room. SLP stated she was entering Resident 76's room to assess her for speech language therapy. SLP was observed to practice hand hygiene, donned (donned; a practice of putting on PPE) a surgical face mask, face shield and gloves without a gown and entered Resident #76's room. During an observation on 5/20/2026 at 5:40 PM, MA P prepared to enter Resident #76's room and practiced hand hygiene, donned gloves, a surgical mask, and goggles and entered Resident #76's room. Observation on 5/20/2026 at 5:44 PM revealed MA P exited Resident #76's room. During an interview on 5/20/2026 at 5:45 PM, MA P stated she entered Resident #76's to administer Resident #76's medications. MA P stated Resident #76 was diagnosed with RSV and was cared for by staff who wore PPE. MA P was asked what PPE she wore and MA P replied, gloves, surgical mask and eye protection. MA P stated she did not wear a gown because she was not trained to do so, and the door poster did not mention the need for a gown. During an interview on 5/20/2026 5:47 PM RN G stated she was the RN for Resident #76 who was diagnosed with RSV and was under droplet precautions isolation. RN G stated her expectation was for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 - Some	staff to wear PPE when entering Resident #76's room which included a gown as well as the gloves, surgical mask, and face shield. RN G stated that when she entered Resident #76's room she would wear a gown with all the other PPE. RN G stated she did not know why the signage did not call for the use of a gown and stated she would refer to the DON for guidance. During an interview on 5/20/2026 6:02 PM the DON and the ADON stated Resident #76 was admitted from the hospital diagnosed with RSV and was cared for under isolation droplet precautions in a private room. The DON and ADON stated they had referred to the CDC online resources and developed and implemented signage for droplet precautions which do not call for the use of gown and stated droplet precautions were for airborne droplets and RSV was not transmitted by contact. A policy to support the DON's statements was requested and as of 5/31/1016 no policy was presented. 2. During an interview on 05/19/2026 at 9:05am, DON stated that facility had two residents on precaution. One resident was on 200 hall and the other resident was on 300 hall. During an observation on 05/19/2026 at 12:15pm, CNA E was observed passing meal trays out on 300 hall. CNA E was not observed sanitizing or washing hands before beginning meal tray pass. CNA E was observed not sanitizing hands before or between passing out meal trays for the first 5 rooms that CNA E passed out trays to on 300 hall. CNA E washed hands and then passed out 3 more trays, sanitizing between each of the 3 trays. During an interview on 05/20/2026 at 10:15am, CNA E stated that staff should sanitize before and after entering a resident room. During an interview on 05/20/2026 at 11:40am, LVN D stated that staff should be sanitizing before and after entering a resident room. During an interview on 05/22/2026 at 2:35pm, DON stated that all staff should be sanitizing or washing their hands per guidelines and when called for, especially between tasks and resident rooms. A record review of the United Stated of America's Centers for Disease Prevention and Control's website titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings Last update: September 2024; accessed 5/21/2026; https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf revealed, Droplet transmission: Droplet transmission is, technically, a form of contact transmission, and some infectious agents transmitted by the droplet route also may be transmitted by the direct and indirect contact routes. The categories of Transmission-Based Precautions are unchanged from those in the 1996 guideline: Contact, Droplet, and Airborne. One important change is the recommendation to don the indicated personal protective equipment (gowns, gloves, mask) upon entry into the patient's room for patients who are on Contact and/or Droplet Precautions since the nature of the interaction with the patient cannot be predicted with certainty and contaminated environmental surfaces are important sources for transmission of pathogens. Modes of transmission: Several classes of pathogens can cause infection, including bacteria, viruses, fungi, parasites, and prions. The modes of transmission vary by type of organism and some infectious agents may be transmitted by more than one route: some are transmitted primarily by direct or indirect contact, (e.g., Herpes simplex virus [HSV], respiratory syncytial virus, Staphylococcus aureus), others by the droplet, (e.g., influenza virus, B. pertussis) or airborne routes (e.g., M. tuberculosis). When applying Standard Precautions, an isolation gown is worn only if contact with blood or body fluid is anticipated. However, when Contact (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 - Some	Precautions are used (i.e., to prevent transmission of an infectious agent that is not interrupted by Standard Precautions alone and that is associated with environmental contamination), donning of both gown and gloves upon room entry is indicated to address unintentional contact with contaminated environmental surfaces. Isolation gowns are always worn in combination with gloves, and with other PPE when indicated. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews the facility failed to ensure Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 1(1 salon) in that: 1. The salon had 2 brushes in a drawer and in the cabinet 4-15 rollers in a tray, with some hair on them. This could affect all residents that use the salon and could cause unsanitary germs to residents. 2. The facility failed to ensure the 300/400 hall shower room did not have bedding sheets on the floor to keep the water from going out in the hall while residents were taking a bath. The findings: 1. Observation on 5/22/2026 at 10:58 AM, with the AD, in the hair salon revealed 2 brushes in a drawer and in the cabinet 4-15 rollers in a tray, with some hair on them.Interview on 5/22/2026 at 10:59 AM with AD confirmed the hair salon 2 brushes in a drawer and 4-15 rollers in a tray, with some hair on them in the cabinet. The AD stated that the Beautician came on Tuesday, 5/19/2026 in the afternoon.Interview on 5/22/2026 at 11:57 AM, the ADM stated that the hair salon room hairbrushes and rollers should be cleaned and disinfected, with daily use. The ADM stated the beautician brought in products and supplies and was responsible for own items. ADM stated no one wanted to have someone else's hair and not be sanitized. ADM stated they did not have a policy on the hair salon. 2. Observation on 5/19/2026 at 12:20 PM in the 300/400 hall shower room had a bed sheet at the entrance that was stained and soaked with water from the shower area. Observations in the 300/400 hall shower rooms revealed 3 shower stalls, these shower stalls were not big enough to fit a shower bed. No other other shower could accommodate the shower beds. Observations of the shower water not going into the shower drain and going towards the hall. There was no metal diversion on the shower floor to divert water from the hall, like the 100/200 hall shower room. Interview on 5/19/2026 at 12:28 PM with CNA C stated she used the bed sheets on the floor to stop the water from going out in the hall, it's been like that for a while (did not recall date). CNA C stated she showered residents on the shower bed, and the water sprayed out onto the floor near the hall. CNA C did not say if she reported this to MD. Interview on 5/19/2026, interview at 3:25 pm, the Maintenance Director and Regional MD, in the 200/400 shower room, stated the floor in the shower room did slope, however the ratio of the slope was not significant enough to drain appropriately. MD stated the water came out of the shower stall when aides use the shower with a resident that required a shower bed. Interview on 5/19/2026 at 3:39 PM, the LSC surveyor stated in the 300/400 hall shower, the floors were not sloped, which allows the water to drain in the drainage. CNA's having to place bed sheets to stop the water from going into the hallway. Interview on 5/21/2026 at 11:10 AM with MD in the 300/400 hall shower room, stated the tile floor was not decreased around the drain, so the water drain does not catch the water from the showers. Record review of policy, Hazardous Areas, Devices and Equipment, dated 2001, was documented, all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure residents' safety and mitigate accident hazards to extend possible. Identification of hazards: 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness examples of environment hazards included but not limited to the following; a. equipment and devices that are left unattended or are malfunctioning. C. Sharp objects that are accessible to vulnerable residents d. Open areas or items that should be locked when not in use. e. irregular floor surfaces. g. Access to toxic chemicals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible, for 1 of 8 residents (Resident #3) reviewed for catheter care.On 5/19/2026 the facility failed to ensure RN G and CNA J educated and redirected Resident #3 when he applied his urinary drainage collection bag above his bladder and secured the urine collection bag to his waist. The failure could place residents at risk for urinary tract infections.The findings included:A record review of resident #3's admission record dated 5/20/2026, revealed Resident #3 was admitted on [DATE] with diagnoses which included sepsis due to pseudomonas (Sepsis is a life-threatening medical emergency that happens when your body has an extreme, overactive response to an infection / pseudomonas are bacteria widely distributed across the globe in soil, water, and vegetation) and obstructive and reflux uropathy (bladder disease when the drainage of urine is blocked and begins to flow backwards and cause infections).A record review of Resident #3's admission MDs assessment dated [DATE] revealed Resident #3 was a [AGE] year-old male admitted for LTC support with his ADLs complicated by his history of pneumonias (infections of the lungs) and Parkinson's disease (a brain disorder that causes problems with movement, balance, and coordination). Resident #3 was assessed with a BIMS score of 13 out of a possible 15 which indicated intact cognition. Resident #3 was assessed with the ability to be understood and could understand others. A record review of Resident #3's physicians orders dated 5/19/2026 revealed on 3/5/2026 the physician prescribed care for Resident #3's indwelling urinary catheter, every shift (name brand) catheter care with soap and water. A record review of Resident #3's care plan dated 5/19/2026 at 1:29 PM revealed Resident #3 had an indwelling urinary catheter with nursing interventions which included, . position catheter bag and tubing below the level of the bladder . A record review of Resident #3's nursing medical record reviewed for the period 3/42026 through 5/19/2026 revealed no documentation for educating and directing Resident #3 to wear his urinary catheter collection bag and tubing below his bladder to reduce the potential risk for urinary tract infections.During an observation on 5/19/2026 at 11:05 AM revealed Resident #3 ambulating with his rollator (a mobility aid with three or four wheels that you push while walking) throughout the facility while wearing his indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder. Resident #3 was observed to have walked by CNA K and RN G while wearing his urine collection bag and tubing above his bladder. During an interview on 5/19/2026 at 11:06 CNA K stated she was the CNA caring for Resident #3. CNA K stated Resident #3 had a need for an indwelling urinary catheter. CNA K stated Resident #3 dressed and toileted himself as well as drained his own urine collection bag. CNA K stated she had not dressed him that morning and she would provide catheter-care for Resident #3 every day by cleaning the catheter with soap and water. CNA K stated Resident #3 had a routine to dress himself and wear his indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder. CNA K stated she had not recommended Resident #3 to wear his urinary collection bag below his waist. During an observation on 5/20/2026 at 12:03 PM revealed Resident #3 ambulating with his rollator (a mobility aid with three or four wheels that you push while walking) throughout the facility while wearing his indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder. Resident #3 was observed to have walked by RN G while wearing his urine collection bag and tubing above his bladder. During an interview on 5/20/2026 at 12:16 PM, RN G stated she was the charge nurse for Resident #3. RN G stated Resident #3 had a need for an indwelling urinary catheter and was independent with his ADL care, dressed himself and cared for his urinary catheter collection bag. RN G stated Resident #3 had a routine to dress himself and wear his (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indwelling urinary catheter collection bag and tubing secured to his short pants belt at his waist above his bladder as he was doing today. RN G stated she was concerned Resident #3's habit would put him at risk for an infection. RN G stated, in the past, she had recommended Resident #3 to wear his urinary catheter bag below his waist but could not recall a date and time. RN G stated she could not recall if she had documented her education or re-direction for Resident #3 to wear his urinary collection bag below his bladder. RN G stated she had not re-directed Resident #3 to wear his urinary catheter bag below his bladder yesterday nor today. During an interview on 5/20/2026 at 12:55 PM, Resident #3 stated he had a history of difficulty emptying his bladder and had a history of recurring urinary infections. Resident #3 stated he had a need or an indwelling urinary catheter and urine collection bag. Resident #3 stated he would take care of his indwelling urinary catheter and urine collection bag himself and would hang the urine collection bag from his belt. Resident #3 stated he had not received any education for keeping his urinary collection bag and tubing below his waist and bladder. Resident #3 stated he would consider any measures to reduce the frequencies of urinary infections. During an Interview on 5/21/2026 at 2:05 PM, Resident #3's Representative stated due to Resident #3's dementia, Resident #3 had a poor recent memory and could not recall recent memories for the past weeks. Resident #3's Representative stated Resident #3 prior to being admitted to the nursing home, lived alone and had a need for an indwelling urinary catheter and had a practice of securing his urine collection bag at his beltline onto his pants and or shorts. Resident #3's Representative stated Resident #3 also had a reoccurring history of UTI's. Resident #3's Representative stated no one had contacted her to provide education that it would be recommended to have Resident #3 wear his urinary collection bag below his waist to reduce the possibility of infections. Resident #3's Representative stated if she had received the education and report she would have attempted to re-direct Resident #3 to change his habit and wear his urine collection bag below his bladder. During an interview on 5/22/2026 at 4:00 PM, the DON stated Resident #3 had received education and redirection from nursing staff to not wear his urinary collection above his waist and it was Resident #3's choice to wear the bag above his bladder. The DON stated the documentation was in the updated care plan dated 5/19/2026. A record review of the Facility's Catheter Care, Urinary policy updated July 2024, revealed, The purpose of this procedure is to prevent catheter associated urinary tract infections. general guidelines: . The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . ER .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchens reviewed for food safety requirements. The facility failed to store food in accordance with professional standards for food service safety. This failure could place residents who eat meals from the kitchen at risk for the spread food borne illness. The findings include: Based on observation on 05/19/2026 at 9:20am, two sandwiches within walk-in cooler that were not dated. Quaker Grits packages were observed in the dry food storage that were not dated. Pureed brownies, cottage cheese and the heresy's chocolate syrup that were in the small refrigerator near the ice machine were observed not to have dates on them. During interview on 05/19/2026 at 9:30am, the DM stated that the foods needed to be labeled and she was not sure why they were not labeled. The DM stated that the brownies were just made, as well as the sandwiches. The DM stated that the negative outcome for residents with undated food items is that there is a potential for the resident to receive bad food. The DM stated that staff had been trained on labeling food items in kitchen. During an interview on 05/19/2026 at 9:40am, [NAME] B stated that all items should have a date on them, this could be the date received, the date opened or the date prepared. [NAME] B did confirm verbally that they had been trained on dating items in the kitchen. Record review of facility Food Receiving and Storage Policy, revised November 2022, revealed that all foods stored and received should be covered, labeled and dated with use by date. Food and Drug Administration food code Section3-501.17 requires date marking on certain items to prevent foodborne illness.