

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Avir at Luling		STREET ADDRESS, CITY, STATE, ZIP CODE 501 W Austin St Luling, TX 78648	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain all mechanical, electrical, in safe operating condition for 1 of 1 kitchen reviewed for safe operating condition. 1. The facility failed to ensure refrigerator #2 maintained a safe storage temperature and not allow food items to be improperly stored.2. The facility failed to ensure the inside kitchen freezer maintained a safe storage temperature and did not allow food items to thaw. These failures pose a risk to all residents of the facility who eat food from the kitchen as they are at risk for food borne illnesses. Findings included: Observation on 9/23/2025 at 7:20 AM, Refrigerator #2 silver in color, temperature revealed to be at 52 degrees. Observation on 9/24/2025 at 12:45 PM, refrigerator #2 silver in color, temperature revealed to be at 58 degrees and second freezer in dry pantry room reflected 30 degrees. Interview conducted with DM at 1:17pm, surveyor advised DM the temperature on the freezer in the dry storage area was out of compliance that food was thawing. DM stated the electric breaker box must have triggered off causing the freezer temperature to be out of compliance for a little while, DM stated maintenance has been made aware of the issue. The surveyor advised DM the silver refrigerator was out of compliance, DM stated she think the thermometer inside is not working, she placed another thermometer, and the temperature was still out of compliance at 58 degrees. Interview conducted with ADM at 1:20 PM, he was notified of the concerning refrigerator temperatures. ADM stated he was contacting a company to come out to check the refrigerator this day. Observation and interview on 9/25/2025 at 8:25 AM, Refrigerator #2 silver in color, temperature revealed to be at 60 degrees on outside thermometer and 58 degrees on inside thermometer. DM stated at 5:30 AM, the temperature reads at 39 degrees. DM stated maintenance came by and adjusted the seal. DM stated the repair company did not come out yesterday. DM stated she will remove the items out of the refrigerator until it was repaired. DM stated the refrigerator should be at 41 degrees and below. DM stated the potential harm of not having appropriate temperature could lead to food spoiling. She said if the food spoils if could make the residents sick. An interview was conducted with ADM on 9/25/2025 at 3:18 PM, ADM stated the maintenance director cleaned the silver refrigerator coils, and it was working in the morning as reported by the DM. ADM was advised the refrigerator temperature was out of compliance again. ADM stated the service man was not able to come on yesterday but was scheduled to come later in the afternoon. ADM stated the potential harm from food being stored at inappropriate temperatures can cause residents to become ill. Record review of facility policy on 9/25/2025 named Food Receiving, and Storage indicated: 1.Danger Zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness.2. PHF/TCS foods are stored at or below 41 F, unless otherwise specified by law.Record review of facility policy on 9/25/2025 named Refrigerators and Freezers indicated:This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines.1. Refrigerators and/or freezers are maintained in good working condition. Refrigerators keep foods at or below 41 F and freezers keep frozen foods frozen solid.2. Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures.3. Monthly tracking sheets include time, refrigerator temperature, temperature of PHF/TCS food, initials, and action taken. The last column will be completed only if (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperatures are not acceptable.4. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.5. The supervisor takes immediate action if temperatures are out of range. Actions necessary to correct the temperatures are recorded on the tracking sheet, including the repair personnel and/or department contacted.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe, clean, comfortable, and homelike environment for four (Resident #6, Resident #14, Resident #31, and Resident #42) of eight residents reviewed for safe operating patient care equipment and for 1 of 1 kitchen reviewed for safe operating condition. A) The facility failed to ensure Resident #6, Resident #14, Resident #31, and Resident #42 had a functioning toilet in their rooms. This failure could place residents at risk of unsanitary conditions, and these failures pose a risk to all residents of the facility who eat food from the kitchen as they are at risk for food borne illnesses. Findings included: A) Record review of Resident #6's Face sheet printed on 09/25/2025 revealed a [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Cerebral Infarction (temporary lack of blood flow to the brain), Type 2 Diabetes (disorder related to abnormal blood sugar levels), and bipolar disorder (mental illness that causes extreme mood changes). Record review of Resident #6's Other Payment Assessment MDS dated [DATE] reflected a BIMS score of 13 (no to minimal cognitive decline). Record Review of Resident #6's Care Plan printed on 09/25/2025 reflected a Focus area of Self-Care Deficit: Bathing, Dressing, Feeding Date Initiated: 07/24/2025. Related interventions reflected, Provide assistance with ADLs/IADLs (activities of daily living/ instrumental activities of daily living) as needed Date Initiated 07/24/2025. Record review of Resident #14's Face sheet printed on 09/25/2025 reflected a [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Alzheimer's Disease (dementia that damages the brain), Type 2 Diabetes (disorder related to abnormal blood sugar levels), and bipolar disorder (mental illness that causes extreme mood changes). Record review of Resident 14's Other Payment Assessment MDS dated [DATE] reflected a BIMS score of 7 (severe cognitive decline). Record Review of Resident 14's Care Plan printed on 09/25/2025 reflected a Focus area of Self-Care Deficit: Bathing, Dressing, Feeding Date Initiated: 06/27/2025. Related interventions reflected, Maintain consistent schedule with daily routine Date Initiated 07/28/2025. Record review of Resident #31's Face sheet printed on 09/23/2025 reflected a [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Type 2 Diabetes (disorder related to abnormal blood sugar levels), Need for Assistance with Personal Care, and Difficulty in Walking. Record review of Resident #31's Other Payment Assessment MDS dated [DATE] reflected a BIMS score of 10 (moderate cognitive decline). Record Review of Resident #31's Care Plan printed on 09/25/2025 reflected a Focus area of Self-Care Deficit: Bathing, Dressing, Feeding Date Initiated: 06/25/2025. Related interventions reflected, Provide assistance with ADLs/IADLs (activities of daily living/ instrumental activities of daily living) as needed Date Initiated 06/25/2025. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #42's Face sheet printed on 09/25/2025 reflected a [AGE] year-old male, admitted on [DATE]. Diagnoses included Type 2 Diabetes (disorder related to abnormal blood sugar levels), Dementia, and Constipation. Record review of Resident #42's Other Payment Assessment MDS dated [DATE] reflected a BIMS score of 10 (moderate cognitive decline). Record Review of Resident #42's Care Plan printed on 09/25/2025 reflected a Focus area of Self-Care Deficit: Bathing, Dressing, Feeding Date Initiated: 07/09/2025. Related interventions reflected, Provide assistance with ADLs/IADLs (activities of daily living/ instrumental activities of daily living) as needed Date Initiated 07/29/2025. Record review of Grievances for the last six months reflected no Maintenance related grievances related to the bathrooms/toilets. In an observation and interview with Resident #14 on 9/23/2025 at 12:18PM, revealed that the toilet for Resident #14 did not flush. There was urine visible in the toilet bowl. Odor of urine is present in the bathroom. Resident #14 stated that the toilet in his room had been broken since 09/18/2025. He stated that he had told someone but was not sure who it was. He stated he was using the public restroom in the hallway. Observation on 09/24/2025 at 8:50 AM revealed that Resident #14's toilet did not flush. There is urine visible in the toilet bowl. Odor of urine is present in the bathroom. Resident #14 was not in the room at that time. In an interview with MD on 09/24/2025 at 09:00AM, he stated the facility called a service out to review the water pressure and toilet issue on 09/23/2025. He stated that the town had known water pressure issues. He stated that after their review, it was communicated to him that due to the water pressure and variations in the level of sediment buildup from hard water and years of use, some of the toilets on the right side of the 100 hall were having trouble flushing. He stated that the facility was waiting for the invoice from the company to start the work of replacing the pipes for the facility. He stated that he changed the float valve and ruled out other causes for the toilets that would cause the toilets not to flush. He stated that the sink in the bathroom for Resident #14 gets water, but not the toilet. He stated that it was common for the toilet to go first when there are plumbing issues related to pressure and corrosion. He stated that the toilet for Resident #14 was the only toilet not working at that time. He stated that he was working on a plan to have bottled water available for staff to use to refill the toilet tank to allow the toilets to flush. He stated that the facility would do this for residents until the toilets were able to be fixed. He stated that he did not want to leave the water out for safety reasons, where residents could access it directly. He stated that he was informed by Resident #14 the day prior that the toilet was no longer able to flush. During an interview with Resident #14 on 09/24/2025 at 9:10 AM, he stated that having the staff refill the toilet tank after use to flush the toilets was an okay solution. He stated he does not mind using the shower room restroom down the hall, but he stated that he does not like the smell of the stagnant urine in the toilet in his room. Observation on 09/25/2025 at 08:38AM for the toilet shared by Resident's #6, Resident #31, and Resident #42 revealed that the toilet would not flush. The toilet was clean with no odors in the bathroom. There is no water in the tank of the toilet. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA C on 09/25/2025 at 08:41AM, she stated that she was not aware the toilet for the restroom shared by Resident's #6, Resident #31, and Resident #42 was not working. She stated that she knew there were water pressure issues with the toilet in the past, but she did not know that it was not functioning. She stated that Resident's #6, Resident #31, and Resident #42 were the only residents who used that bathroom. She stated that Resident #14 was the only resident who toileted himself in the bathroom for his room. Observation and interview with the MD on 09/25/2025 at 08:46PM revealed that there was a gallon jug of water under the counter for the sink in the resident bathroom for Resident's #6, Resident #31, and Resident #42. He used the water to fill the back tank of the toilet and then flush the toilet. He stated that he was working on a schedule for staff to refill the toilets temporarily. He stated that he told the residents to let the nurses know when they use the restroom so that staff could refill and flush the toilets. In an interview with Resident #6 on 09/25/25 at 08:49AM, he stated that having the staff fill the toilet tank from water jugs was a fine solution. He stated that he usually uses the shower room restroom in the hallway. In an interview with Resident #31 on 09/25/2025 at 08:58AM, with interpreter services from HHSC Spanish language interpreter #47477, he stated that the toilet works sometimes and then breaks down again. He stated that it was hard for him to put the water in the toilet tank on his own. He stated that he was not sure if it bothered him enough to want another room. He stated that he would like to speak to the woman that runs the place to discuss the issue further. In an interview with Resident #42 on 09/25/2025 at 09:01AM, he stated that he was using the shower room restroom in the hallway. He stated that he was fine with that solution at that time. In an interview with Resident #14 on 09/25/2025 at 09:09AM, he stated that he was using the hallway bathroom. He stated that the staff had not emptied the toilet and there was a bad smell in there again. In an interview with the DON on 09/25/2025 at 09:25AM, she stated that she spoke to the resident in Spanish and she informed him that he can tell staff when he uses the restroom so that they can fill the toilet to flush it if he needs help. She stated that they were waiting for the invoice from the plumbing company that was there on 09/23/2025 so that they can start repairs. Observation of the shower room restroom on the 100 hall on 09/25/2025 at 01:50PM revealed that the toilet seat for the toilet was not attached on one side. In an interview with the ADON on 09/25/2025 at 03:37PM, she stated that the toilet seat in the shower room for 100 Hall had been repaired by MD. She stated that there is no privacy available for the shower room bathroom. She stated the door does not lock. She stated that residents have the right to a private working toilet. She stated it was not sanitary to have nonfunctioning toilets for residents. In an interview with the DON on 09/25/2025 at 03:56PM, she stated that residents have the right to a private working toilet. She stated that residents can use their restroom and have staff add the water to the tank to flush the toilet. She stated that she had in serviced the CNAs to monitor the rooms for Resident#14, Resident's #6, Resident #31, and Resident #42. She stated that the CNAs would check the bathroom every two hours with resident rounds. She stated that they are working on the bathroom (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	situation. She stated that residents are able to use the shower room restroom if they choose. She stated that she knew that the bathrooms could not lock for privacy due to safety concerns. She stated that residents could walk in on each other while using the restroom in that bathroom. She stated that there are other working restrooms in the facility that residents can use if they ask the staff. She stated that the potential impact to residents of not having a private working toilet would be that they might hold their urine or become frustrated with the situation. In a follow up interview with MD on 09/25/2025 at 03:58PM, he stated that he was informed earlier that day that the toilet seat was broken. He stated that it was fixed at that time. He stated that the door does not lock from the inside for safety reasons. He stated that the restroom is more public that the restrooms in the resident rooms. In an interview with the ADM on 09/25/2025 at 04:01PM, he stated that residents have the right to a private working bathroom. He stated that the facility was working to correct the plumbing problems with the restrooms on the 100 hall. He stated that using the shower restroom in the 100 hallway was an acceptable solution temporarily. He stated that it was an all-male facility, so it was fine that the door did not lock. He stated that if there were women in the facility it would not be acceptable. He stated that privacy could be provided with a closed door or closed curtain. Record review of facility policy for Quality Control, Environmental Services dated 12/2009 does not address environmental concerns not related to housekeeping and laundry services. Record review of facility policy for Resident Rights dated 02/2021does not address resident rights related to environmental conditions.		

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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 reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 3 (Residents #51, Resident #38, and Resident #26) of 8 residents reviewed for care plans. 1.The facility failed to ensure that Resident #51's central venous catheter (a temporary access placed into a large vein in the neck or chest) for dialysis care was addressed in the comprehensive care plan. 2. The facility did not ensure Resident #38 had a care plan that identified possible triggers when Resident #38 had a history of trauma. 3. The facility failed to ensure that Resident #26's parole-issued ankle monitor was addressed in the comprehensive care plan. This failure could place residents at risk of not receiving necessary care or receiving incorrect care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing. The findings included: 1. Record review of Resident #51's Face sheet printed on 09/24/2025 reflected a [AGE] year-old male, admitted on [DATE]. Diagnoses included: pneumonia (lung infection), end stage renal disease (late-stage kidney failure), and cognitive communication deficit (problem with communication caused by cognition rather than a language or speech deficit). Record review of Resident #51's quarterly MDS dated [DATE] reflected a BIMS score of 12 (moderate cognitive impairment). Section O indicated the resident required hemodialysis (a medical procedure that cleans the blood and removes extra fluid when the kidneys have failed). Record review of Resident #51's Physician Orders printed on 09/24/2025, reflected an order dated 09/24/2025, which stated, wipe insertion site with alcohol, cover with 2x2, tape on three sides. Side not taped is the lumen side for care related to the central venous catheter for dialysis access. An order dated 08/06/2025, stated, Dialysis provided by [designated dialysis center]. Dialysis days are Monday, Wednesday, Friday with a chair time of 10am. Days may vary based on holidays and dialysis center schedule. Record Review of Resident #51's care plan printed on 09/24/2025 reflected no Focus areas, Goals, or Interventions/Tasks related to the central venous catheter (a flexible tube inserted into a large vein, usually in the neck, chest, or groin, that ends in a large vein near the heart) for dialysis access. Record Review of Resident #51's Progress Notes reflected a note on 09/17/2025 at 09:54PM indicating Resident #51 was being readmitted from the hospital and reflected, [Resident #51] has a perma catheter (CVC for dialysis use) to left side chest wall, dressing intact. In an observation and interview with Resident #51 on 09/23/2025 at 08:22AM, he stated that he receives dialysis three times a week. He stated that he was happy with the care from the facility. In an observation of Resident #51's CVC for dialysis use on 9/23/2025 at 01:00PM revealed a gauze dressing with paper tape on three sides, as described in the physician orders. Dressing was clean, dry, and intact. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with TN on 09/25/2025 at 09:12AM, she stated that she was not sure who updates the care plans. She stated that her responsibility was to update wound care recommendation orders from the contracted wound care nurse practitioner who visits the facility. She stated that she does not initiate or resolve wounds in the care plans. She stated that she communicates updates with wound care orders to the DON. She stated that medical devices should be a part of the care plan for a resident. 2. Record review of Resident #38's Face sheet printed on 09/24/2025 reflected a [AGE] year-old male, originally admitted on [DATE]. Initial admission date is listed as 04/10/2025. The most recent admission date is listed as 09/17/2025. Diagnoses included atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery), auditory hallucinations, major depressive disorder (persistent low mood or lack of interest in activities, significantly affecting a person's ability to function in daily life), anxiety disorder (a mental health condition where feelings of intense fear and worry are constant, overwhelming, and interfere with daily life), unspecified mood disorder (a mental health condition where feelings of intense fear and worry are constant, overwhelming, and interfere with daily life), and post-traumatic stress disorder (PTSD). The diagnosis for PTSD has an onset date of 06/02/2022 and is categorized as During Stay. Record review of Resident #38's Discharge (return anticipated) MDS dated [DATE] and signed by ADON, reflected an active diagnosis of anxiety disorder and Post Traumatic Stress Disorder under Section I in the Psychiatric/Mood Disorder category. Record review of Resident #38's Care Plan printed on 09/24/2025 reflected there was no focus area in the care plan for PTSD with related person-centered goals and interventions or possible triggers for the PTSD. In an interview with Resident #38 on 09/23/2025 at 9:36AM, he stated that he had no concerns for nursing care in the facility. He stated that the staff treated him well. In an interview with DON on 09/25/2025 at 03:17PM, she stated that the ADON was responsible for everything related to care plans. She stated that she bears some responsibility for care plans but has not been trained on how to use the care plan system yet. She stated that new wounds, new dialysis access, and anything new related to care should be part of the resident's care plan with individualized goals and interventions. She stated that if care plans are not updated with new diagnoses or resident needs that residents may receive incorrect care. In an interview with ADON on 09/25/2025 at 03:37PM, she stated that care plans should be updated with any new medical devices, wounds, new diagnoses, PASARR results, refusals, behaviors, hallucinations and/or delusions. She stated that Resident #51 should have care plan areas and interventions related to the wound to his left arm and his new dialysis access device. She stated that she was not in the building when Resident #51 returned from the hospital. She stated she was only in the facility one day between her return from her time off to the start of the survey. She stated that the impact to the residents of not updating care plans accordingly then resident care could be missed or overlooked. In an interview with ADM on 09/25/2025 at 04:01PM, he stated that he believed the ADON updated and monitored care plans. He stated he was not sure how new areas were started for resident care plans. He stated that the care plans should be updated with new medical devices, new diagnoses of PTSD, and for new treatments. He stated that if care plans are not updated with current care needs (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for a resident, then it could result in potential harm to the resident. Record review of the facility policy for Trauma Informed Care and Culturally Competent Care dated 2001, reflected, Resident Care Planning 1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident. 3. Recognize the relationship between past trauma and current health concerns (e.g. substance abuse, eating disorders, anxiety and depression). 4. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values. For example: a. food preparation and choices; b. clothing preferences such as covering hair or exposed skin; c. physical contact or provision of care by a person of the opposite sex; or d. cultural etiquette, such as avoiding eye contact or not raising the voice. 3. Record Review of Resident 26's Face sheet dated 09/24/2025 revealed and admission date of 05/13/2025 with diagnoses of Cirrhosis of Liver (late stage of liver disease with severe scarring), Gastro-Esophageal Reflux Disease (acid reflux), and Schizoaffective Disorder, Bipolar Type (hallucinations and delusions). Record Review of Resident #26's MDS assessment, dated 08/12/2025, reflected Resident #26 had a BIMS score of 4 out of 15, indicating severe cognitive impairment. Record Review of Resident #26's comprehensive care plan on 09/24/2025, lacked documentation of the presence of the paroled issued monitor, the potential impact on skin integrity, safety, and daily care, or any staff interventions to monitor and report concerns. Record Review of Resident #26's progress notes on 09/24/2025, reflected on 5/17/2025, Parole could not get a signal, it was discovered that resident removed his ankle monitor stating it had hurt his leg. Observation conducted on 9/23/2025 at 9:27 AM, Resident #26 was observed wearing an ankle monitor. Interview conducted on 09/25/2025 at 10:40 AM, CNA C stated that Resident #26 was admitted from prison with a parole-issued ankle monitor. The CNA stated staff were not provided with information about the reason for the monitor, only that the parole department calls the facility and asked the staff to take the resident outside when the device needs to be reset. The CNA further reported that the facility instructed staff to ensure the monitor remains charged. She stated that she personally checks the resident's skin under the monitor because it is a foreign object on the resident's body; however, she had not been given written instructions or guidance in the care plan regarding this intervention. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CNA stated that in her opinion, the ankle monitor should be included in Resident #26's care plan, as it is part of the resident's daily care and could affect the resident's well-being if not monitored for tightness, irritation, or skin breakdown. Interview conducted on 09/25/2025 at 2:31 PM, the ADON stated she has not been trained completely on completing care plans as she has been working in two different positions. She confirmed Resident #26 was admitted from prison with the ankle monitor and stated parole comes to the facility to check placement. She reported the parole monitoring system calls the facility when the monitor does not register and instructs staff to move the resident to another location to reset the device. She stated the resident is required to wear the battery for only one hour per day. The ADON acknowledged that the ankle monitor should have been included in the care plan and reported she contacted corporate earlier the same day to ask about this issue. She was told that ankle monitors had not been included in care plans previously but confirmed that the device was added to Resident #26's care plan today, along with another resident's monitor. The ADON stated potential harm from not including the monitor in the care plan could result in skin breakdown or pressure injuries. Interview conducted on 09/25/2025 at 3:06 PM, the ADM stated the facility did not have a policy in place for residents with parole-issued ankle monitors. He stated Resident #26 was admitted with the monitor from prison. ADM stated when they receive residents from prisons, they are sent clinical records, and they are screened for medical necessity. ADM further stated in all the years he has worked in the nursing facility; the ankle monitor has never been included in a comprehensive care plan. The Administrator explained that if redness occurred, a CNA would notify the charge nurse, who would then contact parole, and parole has previously advised the facility to cut off a monitor if it caused problems. He further stated the battery charging of the monitor was the resident's responsibility, not the facilities, but parole may call at any hour, including 3 AM, to request staff assist in resetting the resident's monitor if it's does not pick up signal. When asked about agency nursing being unfamiliar with the device, the Administrator stated, If everyone in nursing were doing their jobs, there may not be a need for the monitor to be care planned. He stated weekly skin assessments are conducted, and since the facility does not supply the monitor, he did not believe there was potential harm in not including it in the comprehensive care plan, as long as staff checked skin as expected. Record review of the facility policy on Care Plans, Comprehensive Person-Centered dated 2001, reflected: 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 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. Review of the facility's policy Care Plans, Comprehensive Person-Centered dated 03/2022 reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan . includes measurable objectives and timeframes. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including; services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The interdisciplinary team reviews and updates the care plan. when the desired outcome is not met.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 36 of 90 days (third quarter 2025) reviewed in that: The facility failed to ensure they had a RN on duty daily for 36 days of the 90 days in the third quarter from 04/2025 through 06/2025. This deficient practice placed residents at risk of missing nursing assessments, resident supervision and skilled nursing treatment. Findings included: Review of the facility's RN staffing hours for the third quarter of 2025 reflected no RN hours for the following days: 04/06 (SU); 04/12 (SA); 04/13 (SU); 04/19 (SA); 04/20 (SU); 04/24 (TH); 04/25 (FR); 04/26 (SA); 04/27 (SU); 04/28 (MO); 04/29 (TU); 04/30 (WE); 05/03 (SA); 05/04 (SU); 05/07 (WE); 05/09 (FR); 05/10 (SA); 05/11 (SU); 05/13 (TU); 05/14 (WE); 05/17 (SA); 05/18 (SU); 05/21 (WE); 05/24 (SA); 05/25 (SU); 05/26 (MO); 05/27 (TU); 05/31 (SA); 06/01 (SU); 06/07 (SA); 06/08 (SU); 06/14 (SA); 06/15 (SU); 06/21 (SA); 06/22 (SU); 06/28 (SA); 06/29 (SU). In an interview on 09/24/2025 at 11:24 AM the Administrator stated the RN days listed on the PBJ staffing did not have RN coverage. He stated he was unable to get an RN for those days and has tried to recruit one with aids. The Administrator stated he was not using agency for this and was working on getting a waiver. He stated the facility did not have a policy for RN coverage that the facility used the TAC. The Administrator stated the facility should have an RN on duty 8 hours a day 7 days a week. Review of the TAC Title 26 S554.901 of this chapter (relating to Quality of Care) reflected . (2) Registered nurse. (A) The facility must use the services of a registered nurse for at least eight consecutive hours a day, seven days a week, except when waived under paragraph (5) or (6) of this subsection.		

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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. Based on observations, record review and interviews, the facility failed to prepare food by methods that conserve nutritive value and flavor for 5 pureed diets of 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to ensure [NAME] A and DM refrained from adding an unmeasured amount of liquid to spaghetti and meatballs, and green bean pureed meals during lunch service on 9/23/2025. This failure could place residents who received a pureed diet at risk for diminished or altered nutritional status and potential weight loss Findings included: In an observation and interview conducted with Resident #3 on 9/23/2025, at 8:42 AM revealed Resident #3 was observed in his room drinking his coffee after completing his breakfast. Resident stated the food was pitiful. Observation on 9/23/2025, at 10:35 AM, revealed [NAME] A poured an unmeasured amount of milk into the spaghetti noodles without measuring. After mixing, the spaghetti was noted to be loose; [NAME] A then tore slices of bread and pureed them into the mixture. The DM walked over and subsequently added additional milk, also without measuring. For the green beans, [NAME] A added slices of bread to thicken the mixture; when it became too thick, she added another unmeasured amount of milk. [NAME] A was then observed preparing meatballs, adding an unmeasured amount of milk twice, followed by pieces of a hamburger bun to the pureed mix. Interview was conducted with [NAME] A on 9/23/2025, at 1:18 PM, stated she had been employed at the facility since November 2024 and that this was her last day (today). She stated feeling she had no support in the dietary department. When asked about her training on the puree process, [NAME] A stated she was shown the procedure by a temporary dietary manager who was not certified. Cook A stated that during the lunch service on 09/23/2025 during meal preparation, she estimated she prepared enough for five puree diet residents but did not consult the recipe. When asked about adding bread to multiple items, she stated she was instructed to use bread and was aware it was not according to the recipe but was told to follow the process she had been shown. She stated that prior to about a month ago, she had not pureed food with bread and that the facility always used milk in the puree process because broth was never available. She stated she was told residents Need bread anyway, so it doesn't hurt to mix it in. When asked about potential effects of not following the recipe, [NAME] A stated it could change the flavor of the food and potentially create chewing issues, choking hazards, or risk of aspiration for residents. A Test tray was requested and received on 9/24/2025 at 11:30 AM. The meal served was homemade tamale pie. Test trays were received for both a regular texture diet and a pureed diet. The regular diet plate was flavorful and tasted as expected. The pureed diet plate had a sticky texture and had a bland taste; it did not replicate the regular diet taste. Interview conducted with DON on 9/25/2025, at 2:56 PM, who stated they had been with the facility since May 2025. DON was asked if she could explain the facility puree process for the residents ordered pureed diets. The DON stated she knows there was a pureed policy, but she was not able to say what it included verbatim. She explained they have a dietician that comes once a week to work with the cooks. DON also stated the tray ticket and food are checked by the nurse before being given to the residents. When asked if she knew what should be used to puree food, she stated she was unsure. DON stated she expects the dietary department to follow the recipes. When asked what could happen if the puree diet recipe was not followed, she stated that residents could potentially lose calories if too much liquid was used. DON also added that the taste and nutritional value of the food may be affected. Interview conducted with ADM on 9/25/2025, at 3:18 PM, ADM stated the pureed diet should be of a pudding, mashed potato consistency. ADM stated his expectation was for dietary staff to follow the recipes as written. He explained that if the pureed diet was not prepared according to the recipe, the potential harm to residents was that they may not receive the correct caloric intake or adequate nutritional value. Interview conducted with DM on 9/25/2025, at 3:46PM. DM stated her first day back at the facility was on Tuesday, when survey started. DM stated she worked at the facility previously. DM stated she does not know if the cooks were trained properly on preparing diet textures. DM stated the (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dietary manager was responsible for training all dietary staff. DM stated moving forward it will be her providing the training and in-services. DM stated her expectations was for all dietary staff to follow the recipes. DM stated she will also retrain herself from policies. DM manager stated they will be incorporating broth and gravy into puree recipes to enhance the flavors. DM stated the potential risk of harm from not following the recipe could lead to nutrition being affected and possible choking. Record Review of facility diet order conducted on 09/23/2025, revealed there were 5 residents on pureed diets. Review of facility's diet and nutrition care manual reflected:1. Pureed foods are generally cohesive, moist mashed potato or pudding-like consistency for people who cannot tolerate regular or mechanical soft foods. Food is pureed in a food processor to achieve a consistent smooth and easy-to-swallow product. Fluid may be added, or commercial thickening agents can be used to assure the proper consistency is achieved.2. Pureed food should appear and taste like real food (as close to the regular diet as possible), while easing the chewing and swallowing process. Formed pureed foods can be purchased or prepared in? house. Standardized pureed recipes are the first step to assure a product that is consistent in taste, appearance, consistency and nutrient content.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to label and date all food items located in refrigerators, freezers and in the dry food pantry area on 9/23/2025, 9/24/2025, and 9/25/2025. 2. The facility failed to discard expired food items located in the refrigerator and in the dry food pantry area. 3. The facility failed to ensure the trash containers were covered with lids on 9/23/2025, 9/24/2025, and 9/25/2025. 4. The facility failed to clean and sanitize its food storage areas, to include the freezers in the outside storage room on 9/23/2025, 9/24/2025, and 9/25/2025. These failures could place residents who received meals from the kitchen at risk of foodborne illnesses. The findings included: Observation during the initial tour of the kitchen on 9/23/2025 beginning at 7:20 AM, revealed the following was observed: 2 trash containers with trash inside, no lids. Refrigerator #1 white in color noted to have 12 unlabeled bowls that looked like pudding and applesauce. Refrigerator #2 silver in color, temperature was noted to be at 52 degrees, above required temp, this refrigerator reflected: 1 container of tuna dated 9/17/2025, with shelf life of 3 days, 6 days past the discard date 1 container of ham salad 9/17/2025, with shelf life of 3 days, 6 days past the discard date 1 gallon container of salad dressing, 1/4 left, not labeled, not dated. 2 sour creams, not labeled, not dated. 1 ham sandwich, dated 9/17/25, shelf life 3 days, 6 days past discard date 1-gallon plastic ice cream container, labeled chicken alfredo with a 9/17 label, no discard date 4 frozen bags of unknown yellow/orange substance, bottom of refrigerator, not labeled on package, metal container holding items stated eggs 8/28, no discard date DM led the surveyor to the outside freezer storage room: Freezer 1, -no thermometer, dirty residue inside of refrigerator, 3 bags of peas not labeled, not dated. Freezer 2- large plastic bag of fish, not labeled, not dated. Freezer 3 - very dirty inside doors with dark brown residue with dead bugs Freezer 4 - 7 unboxed waffles no label, not labeled, not dated, large bag of meatballs with stamp date 4/28/2025, no label or date to clarify if the stamped date is a produced date or expiration date. 5 bags of white cake mix with a written date of 8/30/2024, not clear if its received or discard date. During a follow-up tour of kitchen on 9/24/2025 beginning at 10:50AM, the following was observed: A second freezer in the kitchen dry pantry area was observed: 1 large freezer bag with open spam meat, labeled 4 bags of spam, 9/10, no discard date 1 opened bag of meat strips, labeled chicken 9/15/25, no discard date 1 pack of [NAME] labeled 9/15/25, no discard date 1 opened box of hamburger patties labeled, open 1/2 gone, no dates 1 large bag resembling zucchini, labeled shelf life 9/15/25 During an additional tour of the kitchen on 9/24/2025 beginning at 12:45 PM, observation/interview occurred: Refrigerator #2 silver in color, temperature was noted to be at 58 degrees on outside thermometer and 52 degrees noted on inside thermometer, above required temp, this refrigerator reflected: 1 container of cooked meatballs from the previous day lunch, no discard date 1 energy drink (belonged to staff) 2 20 oz soft drinks (appeared to belong to staff) 1 can of soft drink (appeared to belong to staff) 1 large bowl of opened fruit cocktail dated 9/23/25, no discard date 2 bowls of uncovered pureed fruit, not labeled or dated. 1 large bag of breakfast sausage patties, not labeled or dated 2 remaining bags of unknown yellow/orange substance, bottom of refrigerator, not labeled on package, metal container holding items stated eggs 8/28, no discard date Second freezer in kitchen dry pantry area was observed: Temperature was at 30 degrees, out of compliance. 6 bags of waffles appeared to be thawing, not labeled or dated 2 bags of pancakes appeared to be thawing, not labeled or dated 1 package of [NAME] starting to thaw Dry Pantry area: 9 loaves of bread, with received date only, no discard date 2 packages of hamburger buns, with best buy date of 9/22/2025. Outside freezers: Freezer 1, thermometer added, dirty residue inside of refrigerator, 3 bags of peas not labeled, not dated. Freezer 2- large plastic bag of fish, not labeled, not dated. Freezer 3 - very dirty inside doors with dark brown residue with dead bugs Interview (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with DM at 1:17pm, surveyor advised DM the temperature on the freezer in the dry storage area was out of compliance that food was thawing. DM stated the electric breaker box must have triggered off causing the freezer temperature to be out of compliance for a little while, DM stated maintenance has been made aware of the issue. Surveyor advised DM the silver refrigerator was out of compliance, DM stated she think the thermometer inside was not working, she placed another thermometer, and the temperature was still out of compliance at 58 degrees. Interview conducted with ADM at 1:20 PM, he was notified of the concerning refrigerator temperatures. ADM stated he was contacting a company to check out the refrigerator. ADM was advised that the temperature of the food will need to be checked immediately. Observation/Interview with DM at 1:25 PM, revealed DM checked the temp of the dairy products in the refrigerator: Milk was at 57 degrees Lactose milk at 55 degrees Sausage at 60 degrees DM stated she will discard the food if needed. An interview was conducted with DA on 9/25/2025, at 12:13PM DA stated they have worked at the facility for 16 years. DA stated they all are responsible for labeling and dating food products in the kitchen. She explained that all food items are to be labeled with the date received. Once opened, the item should be labeled with the open date and discarded within three days. She reported that expired food was discarded as required. The DA further stated that staff food was not permitted to be stored in the kitchen refrigerators. The DA stated that staff are expected to clean daily inside the kitchen; however, there was no specific written cleaning schedule. She reported that cooks are responsible for cleaning the outside freezers, while she was assigned her own refrigerator inside to maintain. She stated that expired food was discarded when found. When asked about the potential harm of serving expired food, she responded that she has never given anyone expired food but acknowledged it could make a resident very sick. The DA stated she was aware of the required refrigerator and freezer temperatures and provided the correct ranges. She also stated that trash cans are required to have lids. She stated that the trash can located by the dishwasher on her side did not come with a lid; she stated covers it with a trash bag instead. The DA stated that she has informed the administrator several times after previous State visits that she needs a trash can with a lid but has not yet received one. She identified the potential harm of not having a lid on the trash can as odor and germ issues, which could negatively affect residents. An interview was conducted with DON on 9/25/2025 at 2:56 PM when the DON was asked if she was familiar with the labeling, dating, and discarding of food policy in the kitchen. She stated that she has not reviewed the policy. DON was asked her expectation of the dietary staff when labeling, dating, and discarding of expired. She stated, I would hope they will follow whatever the policy says. DON was asked the potential risk to residents if the labeling, dating, and discarding of the expired food products are not followed the DON stated residents can have gastric and bowel issues, she also stated bad dairy products could open the door to so many variables. Interview conducted with ADM on 9/25/2025, at 3:18 PM when the ADM stated he was familiar with the labeling and dating policies for the kitchen. He explained that food items should be labeled and dated with the open date, use-by and discard date. He further stated expired items should be thrown away by dietary staff. ADM stated his expectation is for dietary staff to keep the kitchen areas clean, and he expects the Dietary Manager to create and maintain a cleaning schedule. The ADM stated trash cans in the kitchen are supposed to have lids. When asked about potential resident harm, the Administrator stated that serving expired or contaminated food could result in residents becoming ill. Interview conducted with DM on 9/25/2025, at 3:46PM. DM stated her first day back at the facility was on Tuesday, when survey started. DM stated she worked at the facility previously. DM stated she was not familiar with this facility's labeling, dating, and storage policy. She explained that in her previous facilities, items were labeled with the date received, the open date, and the discard date. DM stated trash cans in the kitchen are required to have tight-fitting lids. She stated the kitchen staff is to be trained by the dietary manager. DM stated she will be responsible for conducting all future training. She added that she will need to retrain staff and explain her expectations moving forward. DM stated her goal for the week was to complete a deep cleaning of the kitchen. She (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified the potential harm of serving outdated food as food poisoning and illness for residents. She further noted that not having a trash can with a lid could cause cross-contamination. DM stated all refrigerators and freezers should have temperature logs, with temperatures monitored daily in the mornings and afternoons. She stated the potential harm of improper temperatures was that food can spoil[BH11] , and residents could become sick with foodborne illnesses, such as salmonella. Interview conducted with [NAME] B on 9/25/2025, at 4:36 PM, [NAME] B stated she has been employed at the facility since January 2025. [NAME] B reported that she was trained by a dietary aide who was no longer employed at the facility. [NAME] B stated she was trained to label and date items with the open date, and that items are discarded after the third day. [NAME] B stated she does label receive dates as she was not at work when food was delivered. She identified the potential harm of serving residents outdated food as residents becoming sick. This interview with [NAME] B ended; as she was not cooperative. Record review of facility policy on 9/25/2025 named Sanitation revealed:Policy StatementThe food service area is maintained in a clean and sanitary manner.Policy Interpretation and Implementation1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. Record review of facility policy on 9/25/2025 named Food Receiving, and Storage revealed: Policy StatementFoods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation1. Critical Control Point means a specific point, procedure, or step in food preparation and serving process at which control can be exercised to reduce, eliminate, or prevent the possibility of a food safety hazard. Some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating of foods, and employee hygienic practices. 2.Danger Zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. 3. Food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times.Dry Food4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in - first out system.Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).2. PHF/TCS foods are stored at or below 41 F, unless otherwise specified by law.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews, and record review, the facility failed to ensure resident rights to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 of 8 residents (Resident #25) reviewed for resident rights. The facility failed to ensure Resident #25's door was closed when provided personal care to provide respect and dignity. This failure could place residents at risk of feeling uncomfortable, embarrassed and decreased privacy. Findings included: Review of Resident 25's Face sheet dated 09/24/2025 reflected an admission date of 05/12/2025 with diagnoses of type II diabetes mellitus with diabetic chronic kidney disease, Alzheimer's disease with early onset (brain disease that affects memory, thinking), and unspecified dementia (cognitive decline). Review of Resident 25's MDS assessment, dated 08/18/2025, reflected Resident #25 had a BIMS score of 2 out of 15, indicating severe cognitive impairment. Review of Resident 25's comprehensive care plan on 09/24/2025, reflected resident's ADL care will be met by staff. Observation on 9/23/2025 at 9:21 AM, revealed CNA C provided personal care to Resident #25 with his door open. Interview conducted on 09/25/2025 at 10:31 AM, CNA C revealed that she had been trained on resident rights. CNA C stated that when providing personal care, staff should knock on the door before entering, inform the resident of the care to be provided, and close the door to ensure privacy. When surveyor advised her of the observation of her providing personal care to Resident #25 on 9/23/2025 with the door open, the CNA stated she did not recall the specific incident. She reported she had assisted the resident with applying pressure booties at the request of the wound nurse. Surveyor described the steps to CNA C that were completed with Resident #25, which included opening the resident's brief on both sides and adjusting it, rolling resident over with brief exposed all while putting a pad under him while the door remained open. The CNA acknowledged that not closing the door could affect the resident's dignity, stating it could be embarrassing for the resident and would affect his sense of respect, noting that all residents would want privacy just like we do. Interview conducted on 09/25/2025 at 2:50 PM, the DON stated her expectation of nursing staff is to always knock on residents' doors and close the doors when providing care. She said staff are expected to show respect, be kind, and treat residents as if they were their own family members. The DON acknowledged that failure to close a resident's door during care could constitute a dignity infraction and lead to psychosocial issues for the resident. She stated the facility usually does a good job with maintaining dignity. Review of facility's dignity policy reflected 1. Residents are treated with dignity and respect at all times. 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the PASRR program for 1 of 5 residents (Resident #38) reviewed for PASRR assessments. The facility did not refer Resident #38 to the appropriate state-designated mental health authority for review when he received a new diagnosis of post-traumatic stress disorder (condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations) or during readmission to the facility on [DATE]. This failure could place residents at risk of not being evaluated and receive needed PASRR services. Findings included: Record review of Resident #38's Face sheet printed on 09/24/2025 reflected a [AGE] year-old male, originally admitted on [DATE]. Initial admission date is listed as 04/10/2025. The most recent admission date is listed as 09/17/2025. Diagnoses included atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery), auditory hallucinations, major depressive disorder (persistent low mood or lack of interest in activities, significantly affecting a person's ability to function in daily life), anxiety disorder (a mental health condition where feelings of intense fear and worry are constant, overwhelming, and interfere with daily life), unspecified mood disorder (a mental health condition where feelings of intense fear and worry are constant, overwhelming, and interfere with daily life), and post-traumatic stress disorder (PTSD). The diagnosis for PTSD has an onset date of 06/02/2022 and is categorized as During Stay. Record review of Resident #38's Discharge (return anticipated) MDS dated [DATE] and signed by ADON, reflected an active diagnosis of anxiety disorder and Post Traumatic Stress Disorder under Section I in the Psychiatric/Mood Disorder category. Record review of Resident #38's Care Plan printed on 09/24/2025 reflected no focus area for PTSD with related person-centered goals and interventions. Record review of Resident #38's only PASRR Level I, dated 11/08/2018, reflected he did not have any mental illness. In an interview with Resident #38 on 09/23/2025 at 09:36AM, he stated that he had no concerns for the nursing care in the facility. He stated that staff treated him well. In an interview with ADON on 09/24/2025 at 03:35PM, she stated that Resident #38 did not have PTSD when he was admitted in 2018. She stated that she just started working at the facility in January 2025. She stated that she was responsible for PASRR related duties at the facility. She stated that she recently completed a self-study to train for PASRR and was still learning. She stated that she thought Resident #38 should have been positive for mental illness in 2018 due to the admitting diagnoses of major depressive disorder and anxiety. She stated that she was not sure if he should have had been evaluated for PASRR with readmissions to the facility. She stated that she was not aware that he had not had an evaluation since 2018 before she was asked by the survey team. In an interview with DON on 09/25/2025 at 03:17PM, she stated that a PASRR evaluation should be completed with a new diagnosis of PTSD. She stated that the impact to the resident is that he may not receive the services he needs, because those special services were not identified with the PASRR evaluation. In a follow-up interview with ADON on 09/25/2025 at 03:37PM she stated that Resident #38 should have been screened for PASRR with a new mental health diagnosis, especially PTSD. She stated that not providing PASRR screening with a new mental health diagnosis could lead to the resident not being screened for or provided services related to the resident's mental health diagnosis. In an interview with ADM on 09/25/2025 at 04:01PM, he stated that a PASRR evaluation should be done for a new diagnosis of PTSD for a resident. He stated that the potential impact of not receiving an evaluation with a new mental health diagnosis of PTSD is that they may not receive services that could affect their quality of life. Record review of the facility policy for PASRR dated 07/29/2025 reflected: Purpose The PASRR program aims to ensure that individuals with mental illness or intellectual disabilities receive appropriate care and services. It assesses whether the (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing home is the most suitable setting for the individual's needs. Procedure1. admission Process:a). Exempted hospital discharge happens when a physician at an acute care hospital (a medical acute care hospital, not a psychiatric hospital) has determined the person might need a nursing facility stay of 30 days or less for rehabilitation purposes. b). Expedited admission is for those discharged from a medical acute care hospital or a nursing facility transfer. There are seven expedited admission categories: convalescent care, terminal illness, severe physical illness, delirium, emergency protective services, respite and coma. c). Preadmission happens when a person is coming from the community (psychiatric hospital, home, group home, jail, assisted living, etc.). This includes anywhere other than a medical acute care hospital or another nursing facility. The person, coming from the community with a PASRR Level 1 that indicates suspicion of IDD, and/or mental illness must also have a completed PASRR Evaluation submitted before they can be admitted to a nursing facility. This process must be followed to ensure people coming from a community setting can receive education about other placement alternatives before nursing facility admission. d). Negative indicates the person has a negative PL 1 screening, and is not suspected of having an intellectual disability, developmental disability and/or mental illness. 2. Screening Process: a). Level I Screening: This initial screening determines if the individual may have a mental illness or intellectual disability. It is generally completed by the nursing facility before admission. b). Level II Evaluation: If the Level I screening indicates potential mental illness or intellectual disability, a Level II evaluation is conducted. This comprehensive assessment is performed by a qualified mental health professional and evaluates the individual's needs and whether nursing home placement is appropriate. 3. Documentation: Facilities must maintain thorough documentation of the PASRR assessments, including the Level I and Level II evaluations, as well as the recommendations made. 4. Care planning: Based on the findings of the Level II evaluation, a care plan is developed that may include specialized services or living arrangements tailored to the individual's needs. Collaboration with mental health professionals and Local Authority to ensure continuity of care. 5. Ongoing Review: Residents who are admitted under PASRR guidelines may undergo periodic reviews to ensure that their needs are met and that they continue to require nursing home care. 6: Compliance: Nursing homes must comply with all federal and state regulations regarding PASRR. Failure to do so can result in penalties or loss of funding. The facility follows HHS PASRR For Nursing Facility guidelines. Record review of the facility policy for Trauma Informed Care and Culturally Competent Care dated 2001, reflected, Resident Care Planning 1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident. 3. Recognize the relationship between past trauma and current health concerns (e.g. substance abuse, eating disorders, anxiety and depression). 4. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values. For example: a. food preparation and choices; b. clothing preferences such as covering hair or exposed skin; c. physical contact or provision of care by a person of the opposite sex; or d. cultural etiquette, such as avoiding eye contact or not raising the voice.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to review and revise the person-centered, comprehensive care plan for 1 (Resident #43) of 6 residents reviewed for comprehensive care plan revisions. The facility failed to update Resident #43's care plan to reflect his current need for assistance with his indwelling catheter bag placement after self-transfers. This failure could put residents at risk of not receiving the appropriate care, services, or treatments they need. Findings included: Review of Resident #43's Face Sheet reflected he was admitted on [DATE] and readmitted on [DATE] with the following diagnoses cerebral infarction (the pathological process that results in an area of necrotic tissue in the brain) encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion.) and retention of urine (inability to urinate). Review of Resident #43's Quarterly MDS dated [DATE] reflected Resident #43 was assessed to have a BIMS score of 12 indicating moderate cognitive impairment. Resident #43 was assessed to require partial to moderate assistance with transfers. Resident #43 was assessed to have an indwelling urinary catheter. Review of Resident #43's Comprehensive Care Plan dated 07/09/2025 reflected a focus area Bladder Incontinence- with the presence of catheter: [x] indwelling, has one of the following DX: Obstructive Uropathy, retention. Interventions reflected Change catheter/ drainage bag/ tubing per MD orders. Encourage adequate hydration. Ensure staff are aware of correct placement of catheter gravity drainage bag and tubing. Keep tubing/ bag below the bladder, do not kink tubing. Monitor urine for odor, color, sediments, amount of urine, etc. and report any abnormalities to MD. Review of Resident #43's Consolidated Physician orders reflected an order dated 09/24/2025 FOLEY: change catheter 16fr 10ml bulb and drainage bag based on clinical indications such as infection, obstruction, or when the closed system is compromised. one time a day every 3 month(s) starting on the 24th for 84 day(s) for retention change every 3 months on the 24th. Observation on 09/23/2025 at 10:30 AM revealed Resident #43 in bed asleep. Resident #43's indwelling catheter bag was lying on the floor next to his bed. Observation and interview on 09/24/2025 at 9:25 AM revealed Resident #43 in his room in bed. Resident #43's indwelling catheter bag was lying on the floor next to his bed. Resident #43 stated he put himself in bed. When asked about the catheter bag on the floor he stated he did not know what to do with it. Observation on 09/24/2025 at 2:55 PM revealed Resident #43 in bed. Resident #43's indwelling catheter bag was lying on the floor next to his bed. In an interview on 09/24/2025 at 3:00 PM CNA C stated she worked with Resident #43. She stated that his catheter bag should not be on the floor. She stated Resident #43 only gets out of bed for smoke breaks then goes right back to bed and transfers himself most of the time. CNA C stated she should go check on Resident #43 after smoke breaks to make sure his catheter bag is positioned properly by hanging from the bed. She stated she did not think about it to be honest. CNA C stated with Resident #43's catheter bag being on the floor it could cause infections, and it could cause him to fall and trip on it or cause him trauma. In an interview on 09/25/2025 at 9:40 AM the DON stated Resident #43's catheter bag should not be on the floor, and it was her expectation that the staff check on him frequently to ensure the bag is not on the floor. She stated the care plan should reflect his need for staff to check his catheter bag placement after self-transfers. She stated failure to ensure the catheter bag is stored properly could lead to infections, and trauma. In an interview on 09/25/2025 at 9:47 AM the ADON stated she oversaw the updating of care plans. She stated Resident #43 does put himself to bed after smoke breaks and staff should go check on him to ensure his catheter bag is not on the floor. She stated his need for staff to assist with his catheter bag placement should be on the care plan to ensure staff know to go check on him and position his catheter bag correctly. She stated she did not know why the care plan was not updated but she would update the care plan. Review of the facility's policy Care Plans, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Person-Centered dated 03/2022 reflected 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. The comprehensive, person-centered care plan . includes measurable objectives and timeframes. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including; services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The interdisciplinary team reviews and updates the care plan. when the desired outcome is not met.		

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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 observation, interview and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of two residents reviewed for catheters (Resident #43). The facility failed to ensure Resident #43's received care to prevent Urinary Tract Infections when they stored his catheter bag on the floor. These failures could place residents with foley catheters at risk for urinary tract infections and change of condition. Findings Included: Review of Resident #43's Face Sheet reflected he was admitted on [DATE] and readmitted on [DATE] with the following diagnoses cerebral infarction (the pathological process that results in an area of necrotic tissue in the brain.) encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion.) and retention of urine (inability to urinate). Review of Resident #43's Quarterly MDS dated [DATE] reflected Resident #43 was assessed to have a BIMS score of one 12 indicating moderate cognitive impairment. Resident #43 was assessed to require partial to moderate assistance with transfers. Resident #43 was assessed to have an indwelling urinary catheter. Review of Resident #43's Comprehensive Care Plan dated 07/09/2025 reflected a focus area Bladder Incontinence- with the presence of catheter: [x] indwelling, has one of the following DX: Obstructive Uropathy, retention. Interventions reflected Change catheter/ drainage bag/ tubing per MD orders. Encourage adequate hydration. Ensure staff are aware of correct placement of catheter gravity drainage bag and tubing. Keep tubing/ bag below the bladder, do not kink tubing. Monitor urine for odor, color, sediments, amount of urine, etc. and report any abnormalities to MD. Review of Resident #43's Consolidated Physician orders reflected an order dated 09/24/2025 FOLEY: change catheter 16fr 10ml bulb and drainage bag based on clinical indications such as infection, obstruction, or when the closed system is compromised. one time a day every 3 month(s) starting on the 24th for 84 day(s) for retention change every 3 months on the 24th. Observation on 09/23/2025 at 10:30 AM revealed Resident #43 in bed asleep. Resident #43's indwelling catheter bag was lying on the floor next to his bed. Observation and interview on 09/24/2025 at 9:25 AM revealed Resident #43 in his room in bed. Resident #43's indwelling catheter bag was lying on the floor next to his bed. Resident #43 stated he put himself in bed. When asked about the catheter bag on the floor he stated he did not know what to do with it. Observation on 09/24/2025 at 2:55 PM revealed Resident #43 in bed. Resident #43's indwelling catheter bag was lying on the floor next to his bed. In an interview on 09/24/2025at 3:00 PM CNA C stated she worked with Resident #43. She stated that his catheter bag should not be on the floor. She stated Resident #43 only gets out of bed for smoke breaks then goes right back to bed. CNA C stated she should go check on Resident #43 after smoke breaks to make sure his catheter bag is positioned properly by hanging from the bed. She stated she did not think about it to be honest. CNA C stated with Resident #43's catheter bag being on the floor it could cause infections, and it could cause him to fall and trip on it or cause him trauma. In an interview on 09/25/2025 at 9:40 AM the DON stated Resident #43's catheter bag should not be on the floor, and it was her expectation that the staff check on him frequently to ensure the bag is not on the floor. She stated failure to ensure the catheter bag is stored properly could lead to infections, and trauma. Review of the facility's policy Catheter Care, Urinary dated 07/2024 The purpose of this procedure is to prevent catheter-associated urinary tract infections. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Be sure the catheter tubing and drainage bag are kept off the floor.		

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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, interviews, and record review, the facility failed to ensure residents who were 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 4 residents (Resident # 38) reviewed for trauma-informed care. The facility did not ensure Resident #38 had a trauma screening that identified possible triggers when Resident #38 had a history of trauma. This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. The findings included: Record review of Resident #38's Face sheet printed on 09/24/2025 reflected a [AGE] year-old male, originally admitted on [DATE]. Initial admission date is listed as 04/10/2025. The most recent admission date is listed as 09/17/2025. Diagnoses included atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery), auditory hallucinations, major depressive disorder (persistent low mood or lack of interest in activities, significantly affecting a person's ability to function in daily life), anxiety disorder (a mental health condition where feelings of intense fear and worry are constant, overwhelming, and interfere with daily life), unspecified mood disorder (a mental health condition where feelings of intense fear and worry are constant, overwhelming, and interfere with daily life), and post-traumatic stress disorder (PTSD). The diagnosis for PTSD has an onset date of 06/02/2022 and is categorized as During Stay. Record review of Resident #38's Discharge (return anticipated) MDS dated [DATE] and signed by ADON, reflected an active diagnosis of anxiety disorder and Post Traumatic Stress Disorder under Section I in the Psychiatric/Mood Disorder category. Record review of Resident #38's Care Plan printed on 09/24/2025 reflected there was no focus area in the care plan for PTSD with related person-centered goals and interventions or possible triggers for the PTSD. In an interview with Resident #38 on 09/23/2025 at 9:36AM, he stated that he had no concerns for nursing care in the facility. He stated that the staff treated him well. In an interview with ADON on 09/24/2025 at 3:35PM, she stated that Resident #38 should have PTSD as part of his care plan. She stated that she started working at the facility in January 2025. She stated she was responsible for all aspects of resident care plans. She stated that the DON and the nurses do not update the care plans at this time. She stated that without updating the care plan with new resident needs or diagnoses, their care can be missed or overlooked. In an interview with DON on 09/25/2025 at 3:17PM, she stated that the ADON was responsible for everything related to care plans. She stated that she bears some responsibility for care plans but has not been trained on how to use the care plan system yet. She stated that PTSD should be part of the resident's care plan with individualized goals and interventions. She stated that if care plans are not updated with new diagnoses or resident needs, that residents may receive incorrect care. In an interview with ADMIN on 09/25/2025 at 4:01PM, he stated that care plans should be updated with a diagnosis of PTSD. He stated that not having the appropriate care plan updates and interventions could result in potential harm to the residents. Record review of the facility policy for Trauma Informed Care and Culturally Competent Care dated 2001, reflected, Resident Care Planning1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident. 3. Recognize the relationship between past trauma and current health concerns (e.g. substance abuse, eating disorders, anxiety and depression).4. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values. For example: a. food preparation and choices; b. clothing preferences such as covering hair or exposed skin; c. physical contact or provision of care by a person of the opposite sex; or d. cultural etiquette, such as avoiding eye contact or not raising the voice.		

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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 observations, interviews, and record reviews, the facility failed to establish and 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 diseases and infections for 2 of 4 residents (Residents #13 and Resident #25) reviewed for infection control. The facility failed to ensure: 1. TN used clean, sanitized scissors during wound care for Resident #25 on 09/24/2025. 2. LVN D performed hand hygiene prior to preparing an injection for Resident #13 on 09/24/2025. 3. LVN D wore proper gloves (PPE) while administering an injection for Resident #13 on 09/24/2025. This failure could place residents at risk of exposure and/or possible transmission of communicable diseases and infections. Findings included: Record review of Resident #25's Face sheet printed on 09/24/2025 reflected a [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Type 2 Diabetes (disorder related to abnormal blood sugar levels), Severe Dementia, and Pressure Ulcer of Left Heel. Record review of Resident #25's Significant Change MDS dated [DATE] reflected a BIMS score of 2 (severe cognitive decline). Section I for Active Diagnoses included a pressure ulcer of left heel. Record review of Resident #25's Care Plan reflected a Focus area stating, I am at risk for frequent infections, pressure/venous/stasis ulcers, vision impairment, hyper/hypoglycemia, renal failure, cognitive/ physical impairment/ skin desensitized to pain or pressure, slow healing process R/T (related to) DX (diagnosis) of Diabetes Mellitus. Date Initiated: 05/26/2025 There was an additional Focus area for Wound management - Unstageable to right heel Date Initiated 05/24/2025. Related interventions reflected, Monitor ulcer for signs of infection Date Initiated 05/24/2025. Record review of Resident #25's Physician Orders printed on 09/24/2025 reflected and order for WOUND CARE: Cleanse L) (left) heel with wound cleanser, pat dry. Apply Medi honey medical grade honey fiber to wound bed, secure with kerlix and tape, this to be done 3Xweek (three times a week), and PRN (as needed) with a date of 09/19/2025. Additional order with a start date of 09/17/2025 reflected the resident be admitted to hospice services related to Alzheimer's (dementia that damages the brain) diagnosis. Record review of Resident #13's Face sheet printed on 09/25/2025 reflected a [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Type 2 Diabetes (disorder related to abnormal blood sugar levels), Dementia, and Hypertension (high blood pressure). Record review of Resident #13's Quarterly MDS dated [DATE] reflected a BIMS score of 14 (no cognitive decline). Record review of Resident #13's Care Plan printed on 09/25/2025 reflected a Focus area for Impaired Physical Mobility dated 04/23/2025, with related goal stating, Resident's Skin Will Remain Intact Date Initiated: 04/17/2025 Target Date: 11/09/2025. Record review of Resident #13's Physician Orders printed on 09/25/2025, reflected an order for NovoLIN R Injection Solution (Insulin Regular (Human)) Inject as per sliding scale : if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; 451 - 500 = 14 units; 501+ IF BLOODSUGAR IS GREATER THAN 501, CALL MD, subcutaneously (into the fatty layer under the skin) three times a day related to TYPE 2 DIABETES MELLITUS. During an observation of wound care for Resident #25 on 09/24/2025 at 9:20AM revealed TN used a clean pair of scissors to cut the gauze dressing off of Resident #25's left foot. She then used the soiled scissors to cut the Manuka honey impregnated dressing that was applied directly to the exposed wound bed on Resident #25's left heel. During an observation of medication administration for Resident #13 on 09/24/2025 at 10:57AM revealed that LVN D returned to the medication cart after checking Resident #13's blood sugar. When exiting the room, she removed the gloves that she was wearing for the blood sugar check and a sanitary wipe at that time to clean the glucose monitor. Then, she used a sterilely packaged insulin syringe and reusable, multidose vial of Novolin R insulin to draw up the prescribed amount of medication for Resident #13. In an interview with LVN E on 09/25/2025 at 9:27AM, who stated that she was a travel nurse. She stated that she had been coming to the facility periodically since June (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Avir at Luling		STREET ADDRESS, CITY, STATE, ZIP CODE 501 W Austin St Luling, TX 78648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2025. She stated she was trained in wound care and able to perform wound care for residents, if needed. She stated that hand hygiene should be performed before and after care and before and after removing gloves. She stated that it was a standard of care to wear gloves during blood sugar checks and while giving medication injections to a resident. She stated that if scissors are used during a dressing change or other procedure, she would clean the scissors after using them for a dirty portion of the procedure. She stated that the potential risk to residents of not performing hand hygiene appropriately, not wearing appropriate PPE during medication injections, and using soiled supplies for a dressing change could all potentially result in an infection for the residents. In an interview with TN on 09/24/2025 at 9:37AM who stated that she did not clean her scissors during Resident #25's wound care. She stated that she cleaned the scissors prior to the wound care and after the wound care was completed. She stated that she should have cleaned the scissors after she used them to cut off the soiled dressing and prior to using the scissors to cut the clean dressing that was applied directly to the wound. She stated the impact to the residents could be possible cross contamination. In an interview with the DON on 09/25/2025 at 03:17PM, who stated that all supplies for dressing changes should be cleaned before and after use. She stated that scissors that are used during a dressing change should be cleaned between using them with dirty dressings and clean dressing supplies. She stated that the potential risk to residents of not using clean supplies during a dressing change could be possible infection. She stated that nurses should perform hand hygiene before preparing anything for a resident, including injectable medications. She stated it is best practice to wear gloves while administering an injection. She stated that the risk to residents of not using proper hand hygiene and PPE during injections was the potential for infection and cross contamination. In an interview with ADMIN on 09/25/2025, he stated that hand hygiene should be performed before and after injections and after cleaning the glucose monitors. He stated that he would have to defer to his clinical team regarding the use of gloves for injections. He stated that the risk to the residents of not performing hand hygiene and wearing appropriate PPE for injections could potentially cause an adverse effect for the residents. Record review of facility policy for Infection Control dated 4/2013 reflected: General Guidelines1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes.3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:a. Before and after direct contact with residents;b. When hands are visibly dirty or soiled with blood or other body fluids;c. After contact with blood, body fluids, secretions, mucous membranes, or non?intact skin;d. After removing gloves;e. After handling items potentially contaminated with blood, body fluids, or secretions; Record review of the facility policy dated 2001 reflected: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation Administrative Practices to Promote Hand Hygiene.2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Indications for Hand Hygiene1. Hand hygiene is indicated:a. immediately before touching a resident;b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device);c. after contact with blood, body fluids, or contaminated surfaces;d. after touching a resident;e. after touching the resident's environment;f. before moving from work on a soiled body site to a clean body site on the same resident; andg. immediately after glove removal.4. Single-use disposable gloves should be used:a. before aseptic procedures;b. when anticipating contact with blood or body fluids; andc. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. Record review of facility policy for Wound Care dated 10/2010, reflected: Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. 1. Dressing material, as indicated (i.e., gauze, tape, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Avir at Luling		STREET ADDRESS, CITY, STATE, ZIP CODE 501 W Austin St Luling, TX 78648	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scissors, etc.); It does not address the cleaning of scissors and when to do so in the policy. Record review of facility policy for Insulin Administration, dated 09/2014, did not address the PPE required for subcutaneous (the fatty layer just under the skin) injections. The policy stated hand washing should be performed prior to blood glucose check and after the disposing of the needle post injection.		