STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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 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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section, for two of eight residents (Residents #3, #8), in the facility reviewed for residents' rights, in that:1. CNA B did not knock nor announce themselves before entering Resident #3's room.2. CNA C did not knock nor announce themselves before entering Resident #8's room. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth.The findings included:Record review of Resident #3's admission Record, dated 09/15/2025, revealed the resident being a [AGE] year-old female, originally admitted to the facility on [DATE], with a current admission date of 8/31/2024. Record review of Resident #3's admission Record, dated 09/15/2025, reflected an admission diagnosis of other idiopathic peripheral autonomic neuropathy (damage to multiple peripheral nerves, leading to symptoms such as weakness, numbness, and pain) and other diagnoses. Record review of Resident #3's MDS, dated [DATE], revealed the resident's BIMS score a 14 out of 15 which suggested the resident's cognition was intact. Record review of Resident #8's admission Record, dated 09/15/2025, revealed the resident being a [AGE] year-old female, originally admitted to the facility on [DATE], with a current admission date of 07/12/2025. Record review of Resident #8's admission Record, dated 09/15/2025, reflected an admission diagnosis of chronic systolic (congestive) heart failure (impairment in the heart's ability to fill with and pump blood) and other diagnoses.Record review of Resident #8's MDS, dated [DATE], revealed the resident's BIMS score a 15 out of 15 which suggested the resident's cognition was intact. During an observation and interview on 09/10/25 at 4:13 p.m., revealed Resident #3, while being interviewed by the State Surveyor, was interrupted by CNA B. CNA B was observed opening Resident #3's room door without knocking or announcing themselves. CNA B proceeded to place and set up Resident #3's meal tray on the bedside table and then exited the bedroom and closed the door. During an interview on 9/10/2025 at 4:14pm p.m., Resident #3 stated they did not hear CNA B knock or announce themselves. During an observation on 9/10/2025 at 4:15pm, revealed CNA C entered Resident #8's room while at the same time stating, knock knock . During an interview on 9/10/2025 at 4:20 p.m., CNA B stated she knocked and didn't know if they knocked too soft on Resident #3's but it was needed for privacy for the residents. CNA B stated they did not hear anyone say come in and entered the room. CNA B stated residents did not usually say come in.During an interview on 9/10/2025 at 4:30 p.m., CNA C stated they knocked as they walked into Resident #8's room, so they don't startle anyone. CNA C stated anytime anyone enters a room they should knock before so the residents know they are coming and for privacy.During an interview on 09/16/2025 at 4:42 p.m., with the LVN, when asked what is the resident privacy policy and how is it implemented, the LVN stated staff knock before entering and close the curtains. LVN stated they wouldn't want to be exposed .During an interview on 09/17/2025 at 11:36 a.m., with the ADON, when asked what is the resident privacy policy and how is it implemented, the ADON stated the right to their privacy, curtains for care, knock on the door and close their door.During an interview on 09/17/2025 at 12:10 p.m., with the DON, when asked what is the resident privacy policy and how is it implemented, the DON stated the right to privacy, so staff knock on their (residents) door, pull the curtain if they are going to work with them, make sure their rights aren't violated. During an interview on 09/17/2025 at 12:35 p.m., with the ADM, when asked what is the resident privacy policy and how is it implemented, the ADMIN stated all resident personal info is kept private, residents are covered, curtains were closed, knock on the door and announce themselves Record review of the facility's policy titled Residents Rights, revealed the following:1.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: a. a dignified existence b. be treated with respect, kindness, and dignity; . t. privacy and confidentiality.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, for one of one resident (Resident #6), in the facility reviewed for respiratory care, in that: The facility failed to ensure Resident #6's oxygen tubing was connected to the oxygen machine (on and running). This failure placed residents at risks of decreased oxygen levels, respiratory distress, falls, a decrease in the ability to perform daily tasks, and hospitalization. The findings included: Record review of Resident #6's admission Record dated 09/15/2025 reflected a [AGE] year-old male originally admitted to the facility on [DATE] with a current admission date of 04/21/2025. Record review of Resident #6's admission Record dated 09/15/5025 under the Diagnosis Information section revealed an admission diagnosis of chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing damage to the airways and air sacs in the lungs, making it difficult to breathe), and other diagnoses including coronary artery disease. Record review of Resident #6's MDS dated [DATE] reflected a BIMS score of 12 out of 15, which suggested a moderate cognitive impairment (some difficulty making decisions about care and things that affected daily life). Further review reflected Resident #6 required oxygen therapy while in the facility and had chronic obstructive pulmonary disease. Record review of Resident #6's Comprehensive Care Plan provided on 09/15/2025 revealed no documented focus area for chronic obstructive pulmonary disease. Further review reflected a focus area for the following: The resident has coronary artery disease (CAD), initiated on 09/11/2025, with interventions including OXYGEN SETTINGS: O2 via (nasal prongs) @ 2-4L (every shift). During an observation in Resident #6's room on 09/10/2025 at 4:00 p.m., revealed Resident #6 wore an oxygen nasal cannula (2-pronged device to deliver oxygen directly into the nose) in his nose. The connection point (opposite from nasal prongs) of the oxygen cannula tubing was not connected to the oxygen machine/humidifier. The oxygen machine was on, running, and set to deliver two liters per minute of oxygen through tubing. During an interview on 09/10/2025 at 4:02 p.m. Resident #6 stated he wore oxygen with the nasal cannula all the time because if he did not, he could get short of breath. When asked if his oxygen was on and running, Resident #6 stated yes, the oxygen was running through the tubing/prongs in his nose, but he did not feel short of breath at that time. During an interview on 09/10/2025 at 4:10 p.m., with RN A, Resident #6's charge nurse at that time, when asked what she saw when she looked at Resident #6's portable O2 tank's tubing, RN A stated that the resident's O2 tubing was in his nose but not connected to the oxygen machine. When asked the risks of a resident not being properly connected to an oxygen machine were RN A said, . could cause shortness of breath . woozy, dizzy. doesn't get enough air to the brain, he can get weird. When asked who was responsible for making sure oxygen tubing was set-up properly and the tubing was connected to the machine, RN A stated, the charge nurse on duty. Requested the facility's/a facility respiratory care policy from the Administrator on 09/10/2025 at 4:12 p.m., the policy was not provided before the survey exit on 09/17/2025.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to 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 three of eight residents (Residents #3, #6, #8), in the facility reviewed for infection control, in that: 1.Resident #6's oxygen tubing (oxygen machine side) was observed uncovered and on the floor. Resident #6's portable oxygen tubing was stored uncovered. 2. CNA B did not sanitize their hands between providing Resident #3 with a meal tray and then proceeding to pick up the next meal tray. 3. CNA C did not sanitize their hands between providing Resident #8 with a meal tray and then proceeding to pick up the next meal tray. These failures placed residents at risks of tubing contamination with/ transmission of infectious diseases, damaged tubing, respiratory infections, and risks of bacterial infections/diseases. Record review of Resident #8's admission Record, dated 09/15/2025, revealed the resident being a [AGE] year-old female, originally admitted to the facility on [DATE], with a current admission date of 07/12/2025. Record review of Resident #8's admission Record, dated 09/15/2025, reflected an admission diagnosis of chronic systolic (congestive) heart failure (impairment in the heart's ability to fill with and pump blood) and other diagnoses. Record review of Resident #8's MDS, dated [DATE], revealed the resident's BIMS score a 15 out of 15 which suggested the resident's cognition was intact and requiring substantial/maximal assistance, or partial/moderate assistance, or supervision or touching assistance or setup or clean-up assistance and dependent assistance with eating, hygiene, bathing, and dressing. During an observation on 09/10/2025 at 4:13 p.m., revealed CNA B providing Resident #3 with a meal tray, moving the side table closer to the resident, setting up the meal tray for the resident, then exiting the resident's room and picking up the next meal tray without sanitizing their hands and entering the next resident's room. During an observation on 09/10/2025 at 4:15 p.m., revealed CNA C providing Resident #8 with a meal tray, setting up the meal tray for the resident, then exiting the resident's room and picking up the next meal tray without sanitizing their hands and entering another resident's room During an interview with CNA B on 09/10/2025 at 4:20 p.m., when asked what the process was when passing out meal trays CNA B stated they took the tray, knocked on the resident's room door, and sat the patient up right so they could eat. The aide said they set up the tray for the patient. When moving on, next the aide would do the same thing. CNA B stated they did sanitize their hands before bringing in Resident #3's tray and she knew she did not sanitize between the next tray, which was needed to prevent infections. During an interview with CNA C on 9/10/2025 at 4:30 p.m., when asked what the process for handing out meal trays CNA C stated a nurse looked over the trays to make sure they are correct then trays are passed out one by one, in order. CNA C stated they make sure the ticket is correct, and if the resident needs set up the aide will set up and will sanitize their hands right away, especially if they (the aide) are touching anything, to make sure their hands are clean and prevent infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled “Standard Precautions,” revised in September 2022 revealed the following: 1.Hand Hygiene a. Hand hygiene refers to handwashing with soap (anti-microbial or non-antimicrobial) or the use of alcohol-based hand rub (ABHR), which does not require access to water. b. Hand hygiene is performed with ABHR or soap and water. (1) before and after contact with resident; (2) before preforming an aseptic task; (3) before moving from work on a soiled body site on the same resident; (4) after contact with items in a resident's room; and (5) after removing gloves. The findings included: 1. (Resident #6) Record review of Resident #6's admission Record dated 09/15/2025 reflected a [AGE] year-old male originally admitted to the facility on [DATE] with a current admission date of 04/21/2025. Record review of Resident #6's admission Record dated 09/15/5025 under the Diagnosis Information section revealed an admission diagnosis of chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing damage to the airways and air sacs in the lungs, making it difficult to breathe), and other diagnoses including coronary artery disease (a condition where the arteries that supply blood to the heart become narrowed or blocked). Record review of Resident #6's MDS dated [DATE] reflected a BIMS score of 12 out of 15, which suggested a moderate cognitive impairment (some difficulty making decisions about care and things that affected daily life). Further review reflected Resident #6 required oxygen therapy while in the facility and had chronic obstructive pulmonary disease. Record review of Resident #6's Comprehensive Care Plan provided on 09/15/2025 reflected a focus area for the following: “The resident has coronary artery disease (CAD),” initiated on 09/11/2025, with interventions including “OXYGEN SETTINGS: O2 via (nasal prongs) @ 2-4L (every shift).”. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in Resident #6's room on 09/10/2025 at 4:00 p.m., revealed Resident #6 wore an oxygen nasal cannula (2-pronged device to deliver oxygen directly into the nose) in his nose. The [machine] connection end of the oxygen cannula tubing was not connected to the running oxygen machine. Further observation revealed the oxygen connector tubing was uncovered on the floor over a house slipper next to Resident #6's bed. A portable oxygen tank near Resident #6's bed with a connected nasal cannula oxygen tubing partially on the floor, hanging over the portable oxygen tank holder stand and behind the oxygen tank. The tubing/ nasal cannula was not in a bag or other covering and was open to air. During an interview on 09/10/2025 at 4:02 p.m. Resident #6 stated he wore oxygen with the nasal cannula all the time because if he did not, he could get short of breath. When asked if his oxygen on and running, Resident #6 believed the oxygen tubing was connected to the machine. He stated he used the portable oxygen daily when he left his room. During an interview with RN A on 09/10/2025 at 4:10 p.m., when asked what she saw when she looked at Resident #6's portable O2 tank's tubing, RN A stated the O2 tank had tubing that was on the floor, and the tubing should have been in a bag for infection control reasons. RN A stated the O2 tubing Resident #6 had in his nose was not connected to the oxygen machine and was on the floor. When asked why the portable O2 tank tubing should have been in a bag, RN A stated to prevent bacteria from getting into line. During an observation and interview on 09/10/2025 at 4:10 p.m., RN A took and replaced Resident #6's oxygen machine and portable oxygen tank tubing. When asked why, RN A said, “Because they were contaminated and, on the floor, and anything that touched the floor needs to be replaced.”. During an interview on 09/17/2025 at 12:10 p.m. with the DON, when asked how oxygen tubing should be stored, the DON stated “Special bags for it, with a string hang over the concentrator [oxygen machine] above the floor, on the bed. Always in a bag when not in use.” When asked, what were the concerns with oxygen tubing being on the floor or other soiled surfaces, the DON stated, “Throw it away and replace, concern would be that it be on the floor again, solution so it doesn't go to the floor again.”. Record review of the facility's policy titled “Standard Precautions,” revised in September 2022 the following: “5. Resident-Care Equipment a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure. contamination of clothing, and transfer of microorganisms to other residents and environments. b. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. c. Single use items are properly discarded.”. 2 & 3. (Residents #3 and #8)