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	10/31/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 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 interviews and record reviews the facility failed to ensure the residents had the right to voice grievances to the facility without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which had been furnished as well as those which were not furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay, for 1 of 4 residents reviewed (Resident #3) for making grievances. On the morning of 8/14/2025 LVN A failed to generate a grievance report on behalf of Resident #3's complaint Resident #4 had harassed him for his personal property and both Residents had engaged in a verbal shouting match with an exchange of cursing insults between Resident #3 and Resident #4. This failure could place residents at risk for harm by not having their grievances heard and resolved. The findings included: A record review of Resident #3's admission record dated 10/28/2025 revealed an admission date of 9/1/2024 with diagnoses which included mood disorder and schizoaffective disorder bipolar type (a chronic mental health condition that combines symptoms of both schizophrenia and bipolar disorder. Individuals with this type of schizophrenia experience psychotic symptoms like hallucinations and delusions, along with manic [highs] and depressive [lows] episodes that characterize bipolar disorder.) A record review of Resident #3's quarterly MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old male admitted for long term care related to his needs for ADL supports with myasthenia (a chronic autoimmune disorder that causes progressive muscle weakness that worsens with activity and improves with rest) and safety supports with his schizoaffective disorder. Further review revealed Resident #3 was assessed with adequate hearing, adequate speech pattern, could make himself understood, could understand others, and used eyeglasses. Resident #3 was assessed with a BIMS score of 9 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #3's care plan dated 10/28/2025 revealed, I have the potential to be verbally aggressive related to ineffective coping skills, poor impulse control . anticipate and remove triggers that cause me to show signs of agitation, anger or aggression. A record review of Resident #4's admission record dated 10/28/2025 revealed an admission date of 8/22/2022 with diagnoses which included dementia (a general term for a loss of mental abilities, like memory and thinking skills, that is severe enough to interfere with daily life), anxiety, major depressive disorder, and impulse disorders (a group of psychiatric conditions characterized by the inability to resist an urge or impulse to perform an act that is harmful to oneself or others). A record review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident #4 was a [AGE] year-old female admitted for long term care with supports for her needs related to Parkinson's disease (a progressive neurological disorder that affects movement, caused by the death of brain cells that produce dopamine, a chemical messenger) and dementia. Resident #4 was assessed with moderate difficulty hearing, did not use hearing aids, had clear speech, could usually make herself understood and could usually understand others. Resident #4 was assessed with impaired vision without eyeglasses. Resident #4 was assessed with a BIMS score of 13 out of a possible 15 which indicated she was cognitively intact. A record review of Resident #4's care plan dated 10/28/2025 revealed, I have the potential to be verbally aggressive related to dementia . Anticipate my needs; food, thirst, toileting needs, comfort level, body positioning, pain, . If behavior is a threat to myself or others, immediately call for assistance. observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and or others . A record review of the facility's grievance log dated August 2025 revealed the log was blank revealing no grievances were documented for the month. A record review of Resident #3's nursing progress notes revealed LVN A documented a note on 8/14/2025 at 7:57 AM, Note Text: Alerted by staff that Resident [#3] was in dining room yelling, screaming, and shouting at other Resident [#4] this morning. Resident was becoming increasingly aggressive and verbally aggressive towards other Resident[s] and staff. Resident [#3] redirected by this nurse and other staff members. During an interview on 10/28/2025 at 11:00 AM Resident #3 stated on 8/14/2025 prior to the breakfast meal he and peer residents assembled in the dining room to await the breakfast meal the staff were preparing. Resident #3 stated the dietary staff and CNAs served coffee prior to the meal. Resident #3 stated he had purchased and kept his own powdered flavored creamer and had a routine where he would pour some creamer into a cup and take it to the dining room. Once there he would add the creamer to his coffee and would enjoy his flavored coffee. Resident #3 stated during this time Resident #4 had approached him to demand he give her his creamer to which he denied her request

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 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 interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In response to allegations of abuse, neglect, exploitation, or mistreatment for 2 of 4 residents (Residents #3 and #4) reviewed for reporting allegations of ANE.On the morning of 8/14/2025 LVN A failed to report an allegation of verbal abuse and exploitation to the Administrator when Resident #4 harassed Resident #3 for his personal property, coffee creamer, and both Residents engaged in a verbal shouting match with an exchange of cursing insults between Resident #3 and Resident #4. This failure could place residents at risk for harm by verbal abuse and exploitation of personal property. The findings included: A record review of Resident #3's admission record dated 10/28/2025 revealed an admission date of 9/1/2024 with diagnoses which included mood disorder and schizoaffective disorder bipolar type (a chronic mental health condition that combines symptoms of both schizophrenia and bipolar disorder. Individuals with this type of schizophrenia experience psychotic symptoms like hallucinations and delusions, along with manic [highs] and depressive [lows] episodes that characterize bipolar disorder.) A record review of Resident #3's quarterly MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old male admitted for long term care related to his needs for ADL supports with myasthenia (a chronic autoimmune disorder that causes progressive muscle weakness that worsens with activity and improves with rest) and safety supports with his schizoaffective disorder. Further review revealed Resident #3 was assessed with adequate hearing, adequate speech pattern, could make himself understood, could understand others, and used eyeglasses. Resident #3 was assessed with a BIMS score of 9 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #3's care plan dated 10/28/2025 revealed, I have the potential to be verbally aggressive related to ineffective coping skills, poor impulse control . anticipate and remove triggers that cause me to show signs of agitation, anger or aggression. A record review of Resident #4's admission record dated 10/28/2025 revealed an admission date of 8/22/2022 with diagnoses which included dementia (a general term for a loss of mental abilities, like memory and thinking skills, that is severe enough to interfere with daily life), anxiety, major depressive disorder, and impulse disorders (a group of psychiatric conditions characterized by the inability to resist an urge or impulse to perform an act that is harmful to oneself or others). A record review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident #4 was a [AGE] year-old female admitted for long term care with supports for her needs related to Parkinson's disease (a progressive neurological disorder that affects movement, caused by the death of brain cells that produce dopamine, a chemical messenger) and dementia. Resident #4 was assessed with moderate difficulty hearing, did not use hearing aids, had clear speech, could usually make herself understood and could usually understand others. Resident #4 was assessed with impaired vision without eyeglasses. Resident #4 was assessed with a BIMS score of 13 out of a possible 15 which indicated she was cognitively intact. A record review of Resident #4's care plan dated 10/28/2025 revealed, I have the potential to be verbally aggressive related to dementia . Anticipate my needs; food, thirst, toileting needs, comfort level, body positioning, pain, . If behavior is a threat to myself or others, immediately call for assistance. observe for and immediately report to the nurse and coordinator any signs or symptoms posing a danger to myself and or others . A record review of the Texas Unified Licensure Information Portal websitehttps://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252Faccessed 10/28/2025, revealed no information / report for the incident between Resident #3 and Resident #4 on 8/14/2025. A record review of Resident #3's nursing progress notes revealed LVN A documented a note on 8/14/2025 at 7:57 AM, Note Text: Alerted by staff that Resident [#3] was in dining room yelling, screaming, and shouting at other Resident [#4] this morning. Resident was becoming increasingly aggressive and verbally aggressive towards other Resident[s] and staff. Resident [#3]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 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 observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights for 1 of 4 residents (Resident #1) reviewed for care plans. On 8/21/2025 Resident #1 returned to the facility after hospitalization for a left arm fracture. Resident #1 was prescribed to wear a stabilization arm sling. The sling was not added to the care plan. This failure could place residents at risk for not having a care plan for care needed. The findings included: A record review of Resident #1's admission record dated 10/28/2025 revealed an admission date of 7/9/2024 with diagnoses which included hemiplegia (a medical condition characterized by paralysis or severe weakness on one side of the body). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old male admitted for LTC with supports for ADLs and his needs for care with semi-paralysis. Resident #1 was assessed with a BIMS score of 13 which indicated intact cognition. Resident #1 was assessed with adequate eyesight without glasses, adequate hearing without hearing aids, and had the ability to understand others and could make himself understood. A record review of Resident #1's physicians orders dated 8/22/2025 revealed the physician ordered for Resident #1 to wear an arm sling, Ensure sling to left arm is in place - may remove for showers and skin assessments - non weight bearing to left arm - every shift - related to fracture of upper end of left humerus (the long bone in the upper arm, extending from the shoulder joint to the elbow joint). A record review of Resident #1's care plan dated 10/30/2025 revealed, I had an actual fall 8/21/2025 r/t self-transferring to toilet from W/C without assist, Injury noted, Date Initiated: 04/21/2025, Revision on: 10/29/2025. Further review revealed no focus, goal, nor interventions to support Resident #1 with his need for a stabilizing arm sling for his fractured left arm. During an observation and interview on 10/30/2025 at 4:10 PM revealed Resident #1 self-ambulating in the facility in his wheelchair. Resident #1 presented with a left arm soft cast / brace and a sling. Resident #1 stated he was prescribed the sling to stabilize his broken left arm until the doctor decided how to fix his arm. Resident #1 stated the nurses and CNAs helped him with his sling and were very good to him. During an interview on 10/28/2025 at 4:00 PM LVN A stated she was a nurse who cared for Resident #1. LVN A stated she Resident #1 had a fall where he fractured his left arm and now was prescribed to use a sling and soft cast to his left arm. LVN A stated she reviewed the care plan, and no focus, goals, and interventions were documented for the soft cast brace / sling. LVN A stated although there were no care plan interventions for Resident #1; she ensured Resident #1 wore his sling and delegated to her CNAs to ensure Resident #1 wore his sling. During an interview on 10/30/2025 at 12:00 PM the DON stated Resident #1 had a fall from his toilet, fractured his left arm, was hospitalized , and returned from the hospital with a prescribed sling for his left arm. The DON stated she was responsible for reviewing all post hospitalization admissions. The DON stated Resident #1 had returned from the hospital after being diagnosed with his left arm broken and was prescribed to wear a sling. The DON stated she failed to ensure the care for the sling was care-planned. The DON stated the potential negative outcome for residents not having their orders care-planned could be no support for their needed care. A record review of the facility's Care Plans, Comprehensive Person-Centered policy dated March 2022, revealed, Policy Statement:A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation: .2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan:a. includes measurable objectives and time frames;b. describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, .