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	02/04/2026

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to assess residents for risk of entrapment from bed rails prior to installation, failed to review the risks and benefits of bed rails, and failed to check bed rails regularly to make sure they are still installed correctly with 1 (Resident #1) of 4 residents reviewed for the use of bed rails. Resident #1 used one-quarter bed rails bilaterally for increasing bed mobility. However, the facility did not conduct safety assessments for bed rails quarterly per the facility care plan, and the bed rails were installed incorrectly as evidence by not lowering the bed rails because the bed rails were jammed. This failure could place residents at risk of injury, hinder residents from getting out of bed, and/or cause a decline in resident's ability to engage in activities of daily living.Findings included: Record review of Resident #1's face sheet, dated 02/03/2026, revealed she was an [AGE] year-old female, originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses of hypertensive heart disease (condition with damage to the heart because of high blood pressure), obesity (complex disease involving having too much body fat), and muscle wasting and atrophy (breakdown of muscles). Further record review of the resident's face sheet revealed the resident was discharged to an acute hospital on [DATE]. Record review of Resident #1's Quarterly MDS assessment, dated 01/15/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognition was intact. The resident had no impairment to upper and lower extremities regarding functional limitation in range of motion, and the resident was dependent (helper does all of the effort) for chair to bed and toilet transfers. Record review of Resident #1's comprehensive care plan, dated 05/05/2025, revealed the resident needed to have mechanical transfers with two persons , and using bilateral 1/4 rails for increased independence with bed mobility. For the intervention, Staff should ensure side rails are securely fastened to bed frame and do not swivel/slide. If rails have a gap greater than 2 1/3rd inches between rail and mattress, place pillows in gap to minimize risks. Nurses will review quarterly to minimize risks and ensure device is least restrictive. Record review of Resident #1's physician order, dated 10/20/2025, revealed the resident had the order of May use 1/4 rails to bed bilaterally for bed mobility and positioning. Record review of Resident #1's Bed Rail Assessment, dated 05/05/2025, revealed that the resident could use her bed rails safely as evidence by Side Rails/Assist Bar are indicated and serve as an enabler to promote independence. Further record review of the resident's bed rail assessments revealed there were no more bed rail assessments to September (2nd quarter) and December (3rd quarter), 2025. Observation on 02/03/2026 at 2:30 p.m. revealed Resident #1's bed had one-quarter bed rails bilaterally, and the bed rails were up. CNA-A tried to lower the bed rails but could not because the both bed rails were jammed. During an interview on 02/03/2026 at 2:30 p.m., CNA-A stated Resident #1 was in an acute hospital (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since 01/30/2026, and the resident used the bed rails for increasing bed mobility, instead of transferring, because the resident could not transfer from the bed to the wheelchair by herself, and required mechanical transfer with two persons. The resident used the bed rails when she changed her positions on the bed by herself; such as turning to right or left. CNA-A said she could not lower Resident #1's bed rails because the bed rails were jammed. CNA-A said she did not know when the bed rails were not working correctly, because the resident never complained about her bed rails. During an interview on 02/03/2026 at 2:33 p.m., LVN-B stated she did not know when Resident #1's bed rails could not be lowered because they were jammed, and Resident #1 never reported her bed rails were not working correctly. LVN-B said Resident #1 used her bed rails for increasing bed mobility, and the resident did not have any injury because of bed rails. LVN-B said she did not know what reasons the facility nurses did not conduct bed rail assessments for safety regarding Resident #1's bed rails quarterly. During an interview on 02/03/2026 at 2:50 p.m., the DON stated Resident #1 used her bed rails for only increasing bed mobility because the resident required mechanical transfers with two persons. So the resident's bed rails not working correctly did not affect the resident's transfer, but the bed rails should have been lowered without any problem for safety. During an follow up interview on 02/04/2026 at 2:55 p.m., the DON said the facility nurses should have completed Resident #1's bed rails assessments quarterly because the resident's care plan indicated nurses should review the assessment quarterly, but there were no bed rail assessments done September (2nd quarter) and December (3rd quarter), 2025, and because the facility nurses did not conduct the assessments, the facility did not know Resident #1's bed rails were not working correctly. The DON said it was her responsibility to make sure the facility nurses conducted the assessment quarterly, but she reviewed and updated only the care plans, instead of the resident's bed rail assessments. The DON said bed rails were not working correctly, and not conducting bed rail assessments quarterly might affect Resident #1's safety by not checking the functions of bed rails. Record review of the facility's policy, titled Bed Safety and Bed Rails, dated August 2022, revealed . 9. Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit. For Use of Bed Rails. 5. If attempted alternative did not adequately meet the resident's needs the resident may be evaluated for the use of bed rails.