STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Killeen	5000 Thayer Dr Killeen, TX 76549

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents are given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs) for 2 of 5 residents (Resident #1 and Resident #2) reviewed for hygiene. The facility failed to ensure Residents #1 and Resident #2 were provided with care and services for hygiene. This failure could place residents at risk for poor self-esteem, infections, socialization, ADL decline and diminished quality of life.Findings included: Record review of Resident #1's face sheet dated 3/31/26 revealed a [AGE] year-old female who was admitted into the facility on 2/1/2026 with an initial admission date of 2/22/2023. Resident #1 was diagnosed with type 2 diabetes mellitus with circulatory complications (various cardiovascular issues that can arise due to poorly managed diabetes, significantly increasing the risk of serious health problems), acute combined systolic (congestive) and diastolic (congestive) heart failure (a serious condition where the heart cannot pump enough blood, requiring immediate medical attention), nondisplaced trimalleolar fracture of unspecified lower leg, sequela (a fracture involving the three malleoli of the ankle: the medial malleolus (fibula), lateral malleolus (fibula), and posterior malleolus (tibia), chronic kidney disease, stage 3B (a moderate to severe loss of kidney function, with an estimated glomerular filtration rate (eGFR), edema, unspecified (swelling caused by fluid accumulation in body tissues without a clearly identified underlying cause). Record review of Resident #1's quarterly MDS, dated [DATE] revealed; Resident #1 had a BIMS score of 15, which indicated cognitively intact. Record review of Resident #1's care plan last updated 2/26/26 revealed no focus or intervention addressing Resident #1 history of refusing showers. Resident#1 reflected Focus: ADL self-care performance deficit r/t limited mobility. Goal: Resident #1 will maintain current level of function. Interventions: Bathing/Showering Resident # will be provided sponge bath when a full bath or shower cannot be tolerated. The resident is totally dependent X1 staff to provide bath/shower. Record review of Resident #1's shower sheet dated 3/3/2026 to 3/31/2026 reflected:03/03/2026 @ 12:59 PM Yes03/05/2026 @ 17:59 PM Yes03/07/2026 @ 1:25 PM and 23:30 PM Not Applicable03/09/2026 @ 00:30 AM Yes03/10/2026 @ 00:02 AM Yes03/11/2026 @ 01:50 PM and 22:43 Not applicable03/12/2026 @ 14:37 PM and 22:31 PM Yes03/13/2026 @ 20:28 PM Not Applicable03/14/2026 @ 23:36 PM Not Applicable03/15/2026 @ 17:59 PM Resident Refused and 22:04 Not Applicable 03/16/2026 @ 12:59 PM Yes03/17/2026 @ 22:02 PM Yes03/18/2026 @ 23:55 PM Yes03/19/2026 @ 23:27 PM Yes03/20/2026 @ 15:05 PM Yes03/21/2026 @ 22:13 PM Yes03/22/2026 @ 20:14 PM Not Applicable03/23/2026 @ 17:59 PM No03/24/2026 @ 17:59 PM Resident Refused03/26/2026 @ 17:59 Yes03/28/2026 @ 17:59 PM Resident Refused03/31/2026 @ 16:04 PM Not Applicable During an interview with Resident #1 on 3/31/2026 at 4:10 pm, she stated she has not had a shower since last Tuesday 3/24/2026. She stated she did not refuse showers. She stated they tell her sometimes they were short and they cannot give her a shower. She stated sometimes she has denied taking a shower if she was in too much pain or had a doctor's appointment. The resident stated her shower days were Tuesdays, Wednesdays, and Saturdays. Resident was observed without an odor as she stated she gets a bed bath in between showers. She was dressed in (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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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a dress that appeared to be clean. Record review of Resident #2's face sheet dated 03/31/2026, revealed Resident #2 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #2 was diagnosed with acute systolic (congestive) heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), type 2 diabetes mellitus with other diabetic kidney complication (the condition where prolonged high blood sugar levels lead to kidney damage, commonly known as diabetic nephropathy), legal blindness, as defined in USA (having a best-corrected visual acuity of 20/200 or worse in the better-seeing eye, or a visual field of 20 degrees or less.), epilepsy, unspecified, not intractable, without status epilepticus (characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain). Record review of Resident #2's quarterly MDS, dated [DATE] revealed; Resident #2 had a BIMS score of 15, which indicated cognitively intact. Resident #2 has the ability to bathe self. Including washing, rinsing, and drying self (excluded washing of back and hair). Does not include transferring in/out of tub/shower. Record review of Resident #2's care plan dated 03/09/26, revealed Resident #2 had an ADL self-care performance deficit r/t Limited ROM, Resident #2 is non-compliant with showers at times. Interventions: Resident can bathe herself. Record review of Resident#2's shower sheet dated 3/3/2026 to 3/21/2026 reflected:03/03/2026 @ 17:59 PM Yes03/04/2026 @ 21:00 PM Yes03/05/2026 @ 17:59 PM Yes03/07/2026 @ 1:56 PM and 23:33 PM Not Applicable03/09/2026 @ 00:37 AM Yes03/10/2026 @ 00:06 AM and 00:07 AM Yes03/11/2026 @ 00:06 AM Yes and 17:59 Yes03/12/2026 @ 15:00 PM Yes, 15:01 PM Yes, 22:49 PM Yes, 22:50 PM Yes03/13/2026 @ 20:44 PM and 20:45 PM Not Applicable03/14/2026 @ 23:36 PM and 23:37 PM Not Applicable03/15/2026 @ 22:06 PM Not Applicable 03/16/2026 @ 17:59 PM Yes03/17/2026 @ 17:59 PM Yes and 22:55 PM Resident Refused03/18/2026 @ 21:53 PM Yes03/19/2026 @ 23:32 PM and 23:34 PM Yes03/20/2026 @ 21:14 PM and 21:15 PM Not Applicable03/21/2026 @ 21:46 PM Not Applicable During an interview with Resident #2 on 04/01/2026 at 11:20 am, she stated she was not getting showers like she was supposed to. She stated there was one lady that works at night that makes sure she received her showers and her hair was washed. She stated she will wash herself in the sink in the bathroom. She stated she refused a shower once because she had an appointment, but she stated once she returned, she would take her shower, but no one ever said anything once she returned. She stated she was supposed to get a shower today 3/31/2026. Resident # 2 did not have any foul odor. She was dressed appropriate for the weather. Her shower days were Tuesdays. Thursdays, and Saturdays. During an interview with Med Aide A, on 3/31/2026 at 5:17 PM she stated they make rounds every 2 hours, but they answer the call lights. She stated when she was working, she sees the aide's giving showers to the residents, but sometimes the residents refused. She stated the nurses were supposed to be charting. The aides were supposed to let the nurses know so the nurses can make sure the refusals were charted. She stated she wasn't really on the floor to give showers. She stated she will work on the med cart before going on the floor. She stated she has brought people in to just focus on showers. She had one resident whose family member wanted to know when they give showers, and she stated she told the ADON. She stated the staff marks shower sheets when they give out showers, or they just write resident refused. She stated staff just have not been checking the resident refused in the electronic health records. During an interview on 4/1/2026 at 1:53 PM with the ADM, she stated they cannot force the residents to take a shower because it was their right. She stated it was care planned that the resident refused showers. She stated the goal was to give them a shower once a week. The ADM stated the scheduled staff will attempt to give the resident a shower, and if they cannot, they will try with a particular person they like to give it to them. If that does not work, they will have family get involved. During an interview on 4/1/2026 at 2:25 PM with the DON, she stated her expectations of her nurse aides was to provide showers and ADL care to the residents and also chart. She stated a lot of the residents refused showers. The DON stated she was asking the residents to agree to take a shower at least once a week. She stated it will be care planned and let the family know. The DON stated the resident will receive bed baths or a wash up. She stated they cannot go past a week (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without a shower because it could cause skin breakdown, they will start to smell, and they can get an infection. She did not know why the staff was charting refusals in the electronic health system, but they did have shower sheets. Record review of the Activities of Daily Living policy dated February 2025 revealed Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary tomaintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care).

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for 1 of 2 residents (Resident #1) reviewed for pressure injuries. The facility nurse did not provide wound care to Resident #1 on 03/28/2026 as ordered. This failure could place residents at risk of improper wound management, deterioration in existing pressure injuries, infection, and pain.Findings included: Record review of Resident #1's face sheet dated 3/31/26 revealed a [AGE] year-old female who was admitted into the facility on 2/1/2026 with an initial admission date of 2/22/2023. Resident #1 was diagnosed with type 2 diabetes mellitus with circulatory complications (various cardiovascular issues that can arise due to poorly managed diabetes, significantly increasing the risk of serious health problems), acute combined systolic (congestive) and diastolic (congestive) heart failure (a serious condition where the heart cannot pump enough blood, requiring immediate medical attention), nondisplaced trimalleolar fracture of unspecified lower leg, sequela (a fracture involving the three malleoli of the ankle: the medial malleolus (fibula), lateral malleolus (fibula), and posterior malleolus (tibia), chronic kidney disease, stage 3B (a moderate to severe loss of kidney function, with an estimated glomerular filtration rate (eGFR), edema, unspecified (swelling caused by fluid accumulation in body tissues without a clearly identified underlying cause). Record review of Resident #1's quarterly MDS, dated [DATE] revealed; Resident #1 had a BIMS score of 15, which indicated cognitively intact. M0150. Risk of Pressure Ulcers/Injuries: Is the resident at risk of developing pressure ulcers/injuries - Yes. Record review of Resident #1's Comprehensive Care Plan initiated 02/26/2026, revealed focus impairment to skin integrity of the right anterior leg, right medial leg left second toe; with interventions which include observation of the skin, keep skin clean and dry, hydrate the skin with lotion as needed, and report any skin alterations to the nurse. Record review of Resident #1's Physician Order Summary dated 4/1/2026 revealed an order wound #5 left medial leg venous ulcer to cleanse with wound cleaner, apply betadine moistened gauze to base of the wound, secure with dry dressing, and change daily and PRN; wound #6 right leg venous ulcer to cleanse with wound cleaner, apply betadine moistened gauze to base of the wound, secure with ABD, Kerlix, ace bandage, and change daily and PRN. The orders did not reflect the stages of the wounds. During an interview with Resident #1 on 3/31/2026 at 4:10 pm, Resident #1 stated the nurse provided wound care to her legs daily. During an interview on 3/31/2026 at 2:13 PM with Wound Care Nurse, she stated she provided wound care to Resident #1 Monday through Friday. She stated Resident #1's leg started as a blister and the NP came and gave orders to put betadine (put in a gauze to make it moist and place it on the leg. They were to change the dressing daily and PRN. When the resident takes a shower, the staff can wrap it using gauze, ABD, Kerlix, and an ace bandage. Her last changing was yesterday 3/30/2026 and she stated Resident #1 went to an appointment and she was waiting for her to return to change it. The WCN stated she will change her dressing before she leaves for the day. She stated Resident #1 was noncompliant with the doctors' orders. The WCN stated if it was not changed properly, it could get infected but as of now it was healing and there were no oozing or blisters on the wound. Surveyor reviewed Resident #1 electronic health record and revealed there was no care provided on 3/28/2026. Record review did not reveal what stage the wound was. Observation on 3/31/2026 at 3:45 PM, the wound care nurse was observed providing wound care to Resident #1 legs per the physicians' orders. During an interview on 4/1/2026 at 1:53 PM with the ADM, she stated her expectation for her nurses was to follow the MD or NP orders they have put in place for the staff to care for the residents. They were to also follow what the policy stated. During an interview on 4/1/2026 at 2:25 PM with the DON, she stated it was the responsibility of the nurse to provide wound care to the residents when the wound care nurse was not on duty. She stated if the wound care was not performed, it could worsen, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	more drainage can occur, pain and discomfort. She did not know why wound care was not performed on the resident. The last wound care was done 3/30/2026. The wound care was not done on 3/28/2026. The one change did not worsen the wound. Record review of facility policy titled Wound Care updated July 2019, revealed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing,

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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 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 observation, interview, and record review the facility failed to ensure food and drink that is palatable, attractive, safe and appetizing temperature for residents in the 1 kitchen of 1. The facility failed to ensure residents received food that tasted good. The facility failed to ensure residents did not receive cold food. The facility failed to prepare enough food to ensure all residents received the meals offered. These failures could place residents on regular diet and puree diet at risk of receiving inadequate diet that could affect their health and unwanted weight loss. Findings included: Observation on 3/31/2026 at 11:30 am, the Surveyor entered the kitchen and observed staff preparing meal trays for residents in the facility. The Surveyor asked the [NAME] where the temperatures were, she had taken prior to beginning to prepare lunch trays, and she said she had not gotten around to writing them down, but she remembered them for all the meals. The Surveyor observed the lunch meal for the of 3/31/2026 was beef stroganoff over egg noodles, green beans with pimento, dinner roll and gooey butter bar. During the observation, Surveyor observed the cook came to the last 5 trays and there was no more food prepared to complete the trays. The dietary manager and other staff in the kitchen chopped up some hamburger patties and mixed some gravy in it and placed it over the noodles to complete the remaining 5 meal trays. Surveyor observed there were not enough dinner rolls for all residents. The staff cut bread in half to substitute for the residents missing a dinner roll. A test tray was not requested as there was not enough food prepared for the residents. A test tray would have been the made-up meal they put together at the last minute. Record review of the grievances revealed resident had complained about the food being cold and the kitchen does not prepare enough food. Interview on 3/31/2026 at 2:03 PM, the DM stated more food should have been cooked. She stated it was not often they do not prepare enough food. She stated she will educate on portion size to prevent shortage of food. The DM stated to prevent shortage, she will have them prepare additional food by increasing the recipe. The DM stated the temperatures for the hot plates should be at least 130. The hot plates were not warm/hot to touch. She stated the staff should take the temperature on the food line about 15 minutes before serving. The DM stated the residents were given slips of what will be served for the different meals. The residents determine if they want what was prepared or if they want an alternative meal. She stated she expected her staff to follow guidelines. Interview on 3/31/2026 at 2:46 PM, CK A stated her responsibility was to prepare the meals for the different diets and maintain the temperatures of the food once it was prepared. CK A stated she takes the temperatures when she puts the food on the stem table. She stated she measures the amount of food needed based on what the packaging tells her. She stated they followed the recipe according to what the book tells her. CK A stated she believed they received the menus from corporate. CK A denied running out of food. She stated she had hamburger meat to add to what she had already prepared. She stated she normally has leftovers. She stated about twenty of the residents will choose the alternate menu and she tries to accommodate them. CK A stated no resident will ever go to bed hungry. She stated her rule was if someone comes to the door and asked for something, she will offer them something until they leave with something. Interview on 3/31/2026 at 1:53 PM, the ADM stated she expected the resident to get what they asked for and not the alternative meal unless they asked for it. She stated to her understanding; they were able to make more. The ADM stated they normally had the base of the meal already prepared and if they need to, they can just make up the meal. As of 3/31/2026, the DM or ADM could not provide a policy regarding not preparing enough food for the residents.