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	06/11/2026

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 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 observations, interviews, and record review. The facility failed to provide maintenance services necessary to maintain a comfortable interior for 3 of 16 Residents (Resident #6, Resident #21, and Resident #35) who were reviewed for a home-like environment. The facility failed to ensure that the walls of Residents #6, #21, and #35 rooms were free of scuff marks and paint damage.The deficient practice could place residents at risk of a clean and comfortable home-like environment Findings include: 1.Review of Resident #6's face sheet revealed she was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis, including Active primary, progressive, multiple sclerosis, dysphasia, Parkinson's disease, anxiety disorder, and muscle weakness. Review of Resident #6?s quarterly MDS, dated [DATE], revealed the score of 12, reflecting she had moderate cognitive impairment. Resident #2 was functional and able to perform some of her ADLs. Review of Resident #6's care plan, dated 4/01/2026, revealed that the resident was at risk for falls with limited mobility. Interventions included the resident being totally dependent on one staff member to provide baths and showers. 2.Review of Resident #21's face sheet revealed she was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a diagnosis, including Legal blindness, Type two diabetes, and morbid obesity. Review of Resident #21?s quarterly MDS, dated [DATE], revealed the score of 15, reflecting her cognition is fully intact. Resident #21 was functional and able to perform some of her ADLs with limited assistance. Review of Resident #21's care plan, dated 5/08/2026, revealed that resident was at risk for falls with impaired mobility. Interventions included observing the environment to identify any potential factors that could contribute to a fall, such as lighting, uneven/slippery/cluttered floor surfaces, improper footwear, and failure to use assistive devices. 3.Review of Resident #35's face sheet revealed she was admitted to the facility on [DATE] with a diagnosis, including: Cerebrovascular Disease, Morbid (Severe) Obesity, and Alzheimer's Disease with late onset. Review of resident #35?s quarterly MDS, dated [DATE], revealed the score of 15, reflecting that her cognition is fully intact. Resident #35 needs assistance with all of her ADLs. Review of resident #35's care plan, dated 2/24/2026, revealed that the resident #35 was The resident has an ADL self-care performance deficit. Resident #35 will receive assistance with bathing/showering, bed mobility, dressing, eating, toileting, and transfers. An interview and observation with Resident #21 on 06/09/2026 @ 8:57 AM. Resident #21 had several scuff marks and repairs in the room that have not been painted. Resident #21 stated that he has reported and nothing has changed. He stated that it bothers him and he would like the walls to be fixed. An Interview and observation with Resident #6 on 06/09/2026 at 9:20 AM - Resident #6 Walls are scuffed up and repaired behind the bed that was not painted. Resident #6 stated that the walls have been scuffed up for a while. He stated that he had told someone, but nothing was done. Resident #6 stated that the walls have been like that for a month. An interview and observation with Resident #35 on 06/10/2026 11:56 PM and daughter was in the room at the time. The daughter stated that the walls have a lot of damage. The daughter stated that she has mentioned this to the facility and nothing has been done, she stated that she does not feel like it is a homelike environment for the resident. The daughter (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that she wants the facility to address this issue. An interview on 6/11/2026 at 2:58 PM the MD stated that if there are any concerns with a residence room, there's an app they use to request things like painting or bathroom issues. She stated that once the request was made, maintenance will receive it and was responsible for fixing the issues. She stated she has not had any residents complain about the scuffed-up walls. She stated she had previously requested the walls be repaired. She stated if multiple requests are not completed, they are forwarded to the administrator. She stated residents with scuffed-up balls are not in a home-like environment. An interview on 6/11/2026 at 3:03 PM ADON stated if there was a maintenance request, she will go into the computer and enter it into the application. She stated the requests were sometimes made verbally. She stated that maintenance keeps track of all maintenance issues. She stated she has not heard any residents complain about the scuff marks on the paint in their rooms. She stated these should be repaired by maintenance. She stated if repairs are not made, residents would want to move to another room. She stated that having scuffed-up walls was not a home-like environment for the residents. An interview on 6/11/2026 at 3:24 PM the MD. She stated there are times when the floor staff does not make those requests, so they do not know what needs to be fixed. He stated that floor staff should make rounds in the rooms to ensure there are no issues and, if there are, submit those requests via the app. He stated it was either his responsibility or the maintenance assistant's responsibility to complete the repairs and residence rooms. He stated if repairs are not done for the residence, it will not have a home-like environment. An interview on 6/11/2026 3:40 PM with ADM. She stated there was an online portal where staff can submit maintenance and repair requests. She stated repairs are expected to be made in a timely manner. She stated staff should make rounds in the morning and, if repairs are needed, enter them into the online maintenance portal for completion. She stated a residence with scuffed-up walls was not a home-like environment. Record review of the facilities home like environment policy revise February 2021 reflected the following: The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:a. clean, sanitary, and orderly environment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure the Pre-admission Screening and Resident Review (PASARR) Level I assessment accurately reflected the resident's status for 2 of 5 residents (Resident #12 and Resident #11) reviewed for PASARR Level I screenings. 1. The facility failed to ensure the accuracy of the PASARR Level 1 screening for Resident #11 and Resident #12. The PASARR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis PTSD (post-traumatic stress disorder) with an onset was present upon Resident #12 and Resident #11's admission. 2. The facility did not complete a 1012 form to update Resident #12 and Resident #11's PASARR Level 1 with the new diagnosis. These failures could place residents who had a mental illness at risk of not receiving a needed assessment (PASARR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Resident #12Record review of Resident #12's face sheet indicated a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of bipolar disorder, current episode depressed, severe with psychotic features. On 4/27/2026, Resident #12 was diagnosed with bipolar type. Record review of Resident #12's MDS record dated 04/19/2026 revealed a BIMS score of 14, reflecting she had moderate cognitive impairment. Resident #12 had a diagnosis of bipolar disorder triggered at that time. Record review of Resident #12's care plan does not reveal Resident #12's mental illness. Record review of Resident #12's level 1 PASARR dated 04/21/2026 indicated that Resident #1 had no evidence of a primary diagnosis for this individual, individual had no mental illness, no intellectual disability and/or evidence that this individual has a developmental disability. Resident #11Review of Resident #11's face sheet revealed she was admitted to the facility on [DATE] and a readmission on [DATE] with a diagnosis, including: Progressive Multiple Sclerosis, Dysphagia, Oropharyngeal Phase, and Major Depressive Disorder, Recurrent Severe Without Psychotic Features dated 10/06/2025. Review of Resident #11?s quarterly MDS, dated [DATE], revealed a BIMS score of 12, reflecting she had moderate cognitive impairment. MDS showed that Resident had Resident #11 has little interest or pleasure in doing things The MDS did not address her mental illness. Review of Resident #11's care plan, dated 3/03/2026, revealed that the resident was The resident has little or no activity involvement. The resident wishes not to Participate. The care plan did not address the mental illness. Establish and record the residents' prior level of activity involvement and interests by talking with the residents, caregivers, and family on admission and as necessary. Record review of Resident #11's level 1 PASARR dated 04/11/2026 indicated that Resident #1 had no evidence of a primary diagnosis for this individual, individual had no mental illness, no intellectual disability and/or evidence that this individual has a developmental disability. An interview on 6/11/2026 at 3:45 PM the MDS coordinator stated that residents get a PASRR prior to admission to the facility. She stated that if a resident were to have a new diagnosis, that would trigger a new PASARR assessment. She stated that after a positive PASARR assessment, someone from outside the facility would come to administer a PASARR 2 assessment. She stated that if a resident does not get an updated PASARR assessment, then they could miss out on services. She stated that Resident #11 should have received another PASARR assessment after her diagnosis of major depressive disorder on 10/06/2026. An interview on 6/11/2026 at 4:08 PM the DON stated that the MDS coordinator was the one responsible for updating the PASRR Screenings. She stated that residents with a new diagnosis should receive a new PASRR screening to determine eligibility for services. She stated that they conduct a PASARR assessment to ensure they are all up to date. She stated that if the PASRR is not up to date then a resident misses out on services. She stated that Resident #11 should have had a new assessment after the diagnosis on 10/06/2026. An interview on 6/11/2026 the ADM said the MDS coordinators are responsible for updating the PASARR screenings. She stated that if the PASARR screenings are not up to date, then a (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident could go without services. She stated that if a resident was diagnosed on [DATE], then the resident should have had a new PASARR screening after the new diagnosis. Record review of facility provided policy titled PASARR dated 01/20/2026 indicated the following: Purpose: The aim of the PASARR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID) or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in the community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR) Level I assessment accurately reflected the resident's status for 2 of 5 residents (Resident #81 and Resident #67) reviewed for PASARR Level I screenings. 1. The facility failed to ensure the accuracy of the PASARR Level 1 screening for Resident #81 and Resident #67. The PASARR Level 1 screening indicated a negative level 1 despite the resident had a diagnosis prior to the PASARR being completed. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASARR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Resident #81Record review of Resident #81's face sheet indicated a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of bipolar disorder and depression. Record review of Resident #81's care plan dated 06/24/2025 revealed that Resident#81 was at risk for depression and takes an antidepressant. Resident #81's care plan indicated resident had a diagnosis of bipolar disorder and depression. Record review of Resident #81's level 1 PASARR dated 03/01/2025 indicated that Resident #81 had no evidence of a primary diagnosis for mental illness. Resident #67Review of Resident #67's face sheet indicated an [AGE] year-old man admitted to the facility on [DATE] with diagnoses of schizophrenia. Review of resident #67's care plan dated 06/26/2025 revealed that Resident #67 had diagnoses of major depressive disorder and schizophrenia.Record review of Resident #67's level 1 PASARR dated 01/11/2022 indicated that Resident #67 had no evidence of a primary diagnosis for mental illness.An interview on 6/11/2026 at 3:45 PM the MDS coordinator stated that MDS was responsible for the PASARR screenings. MDS coordinator stated that a diagnosis such as schizophrenia would indicate a positive level 1 screening. MDS coordinator stated that if the PASARR screen was inaccurate, the residents could miss out on needed person-centered services. MDS coordinator stated that the PASARR screening for both Resident #81 a Resident #67 should have triggered positive due to the diagnosis of schizophrenia and bipolar disorder and would be considered inaccurate. An interview on 6/11/2026 at 4:08 PM with the DON stated that the MDS coordinator was the one responsible for updating the PASARR Screenings. The DON stated that PASARR level 1 should be completed upon admission to the facility. The DON stated that bipolar disorder and schizophrenia are diagnoses that would trigger a positive level 1. The DON stated that if the PASARR screen was inaccurate, the residents could miss needed mental health services or experience a delay in receiving specialized services. The DON indicated that the screen was inaccurate. An interview on 6/11/2026 at 4:30PM the ADM stated that the MDS coordinators are responsible for updating the PASARR screenings. The ADM stated that diagnosis of bipolar schizophrenia would indicate a positive Level 1 screen. The ADM stated that if the PASARR was inaccurate, the residents may not have had the appropriate screening completed. The ADM stated that both Resident #81 and Resident #67's diagnosis would indicate a positive level 1 diagnosis and was an inaccurate screen. Record review of facility provided policy titled PASARR dated 01/20/2026 indicated the following: Purpose: The aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID) or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in the community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD.

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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. Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food Service safety, for one of one kitchen reviewed for food storage. The facility failed to label and date food correctly. These failures could place residents at risk for foodborne illnesses. The findings include: An Observation on 06/09/2026 at 6:50 AM of the walk-in refrigerator revealed the following: Cubed raw potatoes in a Ziploc bag with an open date 6/3/2026 and no use-by date. Chicken tenders in a Ziploc bag with no open date and no use-by date Daily milkshake in a serving jug with an open date of 6/8/2026 with no use-by date. An observation on 06/09/2026 at 6:55 AM of the walk-in freezer revealed the following: Sugar cookies in a Ziploc bag with an open date of 5/19/2026 and no use-by date. An observation on 6/9/2026 at 6:59 AM of the pantry revealed the following: Black Eyed Peas in a Ziploc bag with an open date of 5/24/2026 with no use-by date. Fritos chips and a Ziploc bag with no open date or use by date on the bag. An interview on 6/11/2026 at 2:05 PM CK stated she has been working at the facility for seven months as the cook. She stated it was everybody's responsibility to label and date food items in the kitchen. She stated that food items in the kitchen should be checked daily for dating. She stated all food items should have an open date and be used by the day. She stated they use the first-in, first-out method, which means all the old items go in front and the new items go back. She stated they usually have a daily huddle to discuss labeling and dating food items in the kitchen. She stated that if residents were served out-of-date food, they could get sick. An interview on 6/11/2026 at 2:13 PM DA stated she has been working at a facility for seven months. She stated that everybody in the kitchen was responsible for labeling and dating food items. She stated that she labels and dates certain items in the kitchen, and the cook labels certain items there. She stated the cooks normally label leftovers. She said she usually labels and dates juices and items to be served the same day. She stated they use the first-in, first-out method, where when they get a truck, the old items go in front, and the new items go back. She stated she has had in-service training on labeling and dating. She stated her last in-service training was on 6/9/2026. She stated that if residents are served out-of-date food, they could get sick. An interview on 6/11/2026 at 2:20 PM DM stated that everyone in the kitchen was required to label and date all food items they handle. She stated that she and the cooks should be checking daily for out-of-date food items. She stated they use the first-in, first-out method, where they place old items at the front and new items at the back, so the old items are used first. She stated they do not check the dry goods daily, mainly the food in the walk-in cooler. She stated she has been in service on labeling and dating. She stated the last time she had in-service training was two days ago. She stated that residents could get sick if they ate out-of-date food. An interview on 6/11/2026 at 4:26 PM ADM stated it was the responsibility of the whole dietary team to label and date food items in the kitchen. She stated that food items should be checked daily for out-of-date items and to make sure all items are labeled and dated. She stated an in-service was done two days ago for labeling and dating. She stated in-service training should be done with staff regularly so they are aware that all food items should be labeled and dated. She stated if residents were to eat at a date food they could get sick. Record review of the facilities, food, and storage policy updated November 2022 Reflected the following: All food items to be kept at or below 41 F are placed in the refrigerator located at the nurses' station and labeled with a use by date. 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. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).