STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676486	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Johnson City	206 Haley Rd. Johnson City, TX 78636

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - 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 ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 4 residents reviewed for quality of care. The facility failed to ensure Resident #1 had orders in place to treat his heel abrasion from 11/14/2025 through 12/03/2025. The facility failed to ensure Resident #1 had a weekly skin assessment completed on 11/22/2025 and 11/29/2025. These failures could place residents at risk for unassessed changes in conditions and to not receive adequate care Findings included:Review of Resident #1 face sheet reflected a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified fracture of right femur (break in thigh bone), depression (mental health disorder characterized by persistent feelings of sadness), chronic embolism and thrombosis of unspecified deep veins (blood clots in deep veins that cause ongoing circulation problems), and restlessness and agitation. Review of Resident #1 admission MDS dated [DATE] reflected a BIMS of 11 which indicated moderate cognitive impairment. Review reflected Resident #1 had no pressure ulcers/injuries. Review of progress note dated 11/16/2025 by RN B reflected late entry for admission on [DATE] reflected whole body assessment done. bilateral buttock redness . no other skin breakdowns. Review of Resident #1 order summary reflected no orders to treat or monitor Resident #1's heel. Review of physician's orders dated 11/15/2025 reflected an order to for wound consult for skin and wound conditions/prevention. Further review reflected an order dated 11/15/2025 for pressure relieving mattress. Review of Resident #1 admission skin assessment dated [DATE] reflected right foot (heel): superficial abrasion noted. Review of Resident #1 assessment reflected there were no other skin assessments documented for Resident #1. Review of Resident #1 undated care plan reflected Resident #1 had a potential for impaired skin integrity with a goal for his skin to remain intact. Interventions included evaluate skin integrity and provide skin care per facility guidelines and as needed. Review of Resident #1's chart reflected no wound consult notes. Review of Resident #1's November 2025 TAR reflected no wound care was performed on Resident #1's heel. Review of Resident #1's December 2025 TAR reflected no wound care was performed on Resident #1's heel. Observation and attempted interview on 12/02/2025 at 11:24 AM revealed Resident #1 sat in his wheelchair at the nurses station. Resident #1 had socks on and a pillow on the footrest of his wheelchair that his right foot rested on. Resident did not respond to simple questions and did not indicate any nonverbal signs of pain or discomfort. Observation on 12/03/2025 at 9:36 AM revealed Resident #1's right heel had a circular area with flakey skin. Inside the circular area was a smaller circular area with a darker red area with a white center. Above the heel was a smaller circular area that appeared sunken in below the surface and dark black in color. During an interview on 12/02/2025 at 12:07 PM, RN E stated that she worked on 11/30/2025 as the weekend supervisor. She stated that she completed skin assessments for some residents on the weekends and RN F (another weekend supervisor) completed skin assessments for the other residents during her shift. RN E stated she believed there was new breakdown on Resident #1's heels. RN E stated that she was unsure if there were orders in place for Resident #1. RN E stated that she was unable to log into the facility computer on 11/30/2025 and unable to access the resident's charts. RN E stated that she reported the breakdown to RN B, who was the charge nurse this day, and did not report it to the DON/ADON/NP or MD. RN E stated since she did not have access to the computer or charting system she did not finish skin assessments and did not document the assessments she did complete anywhere. RN E stated she only completed a handful of skin assessments and did not complete any other assessments because she was unable to get into the charting system and was busy during her shift. During an interview on 12/02/2025 at 2:01 PM, CNA C stated that he provided care for Resident #1. CNA C stated that he recalled seeing blistering on Resident #1's right heel. CNA C stated sometimes when he arrived for his shift (6:00 am to 2:00 PM) he saw brown spots on Resident #1's sock or sheets from his heel. CNA C stated that he reported the change in Resident #1's heel to RN A the second day Resident #1 was at the facility. CNA C stated he was instructed to place a boot on Resident #1's foot, but he was not sure who instructed him to do so. CNA C stated he felt the area on Resident #1's heel was not smaller in size. CNA C stated any changes in skin are reported to the charge nurse and documented on the POC. During an interview on 12/02/2025 at 2:01 PM, CNA D stated that Resident #1 had a sore on his heel, but it looked better. CNA D stated the nurse put a bandage on Resident #1's heel sometimes and that a pillow was kept under his heel. CNA D stated that

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. (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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to use the services of a registered nurse of at least 8 consecutive hours a day, 7 days a week for 2 of 14 days reviewed (11/27/2025 and 11/28/2025) reviewed for RN coverage. The facility failed to ensure they had an RN charge nurse on duty on 11/27/2025 and 11/28/2025. This failure could place residents at risk of missed nursing assessments, interventions, care and treatment. Findings included: Review of November 2025 nurses schedule reflected zero hours worked by an RN on 11/27/2025 and 11/28/2025. Review of time sheets and scheduled reflected LVN H worked 11/26/2025 from 5:50 PM until 11/27/2027 at 6:54 PM (25 hours). Review of time sheet reflected LVN J relieved LVN H at 6:52 PM on 11/27/2025 and left the shift at 12:38 PM on 11/28/25. Further review of scheduled reflected LVN I worked on 11/28/2025 from 6:00 am to 6:00 pm and was relieved by LVN K who worked from 6:05 pm on 11/28/2025 to 6:47 AM on 11/29/2025. During an interview on 12/02/2025 at 11:42 AM, LVN H stated that she worked 25 hours straight from 11/27/2025 to 11/28/2025. LVN H stated that she was scheduled to work 11/26/2025 to 11/27/2026 from 6:00 pm to 6:00 am. She stated the morning of 11/27/2026 at 4:00 AM (two hours before her shift was scheduled to end) LVN I called in with a family emergency. LVN H stated that the staffing coordinator (CNA D) was on the shift with her and she called other staff to come in to relive LVN H. LVN H stated she was told at 10:37 AM on 11/27/2025 that RNC was going to relieve her but that she was then told at 1:00 pm on 11/27/2025 that RNC was not in the area to relieve her. RNC stated that no one showed up to relieve her until 11/27/2025 at 6:15 PM which was LVN J. LVN H stated that she had to step out twice because she was in tears and felt she did not feel comfortable to pass medication after 16 hours due to being tired and stated she was not sure medications were on time. During an interview on 12/02/2025 at 12:57 PM, CNA D stated she was the staffing coordinator and scheduled staff. She stated that call-ins go through her and the former DON used to handle nursing call-ins. She stated that for any call-ins she sends out a message in the group chat and asks if any nurses are available to pick up a shift. CNA D stated that LVN L never called in but she had a family emergency and called in early morning on 11/27/2025. CNA D stated that RN M was scheduled to work on 11/27/2025 with LVN L, but she called in after she found out LVN L would not be working. CNA D stated that RN M stated she would not come in if there was not going to be a nurse working the floor. CNA D stated when she received word from RN M that she was not going to come in she reached out to the ADM and RNC. CNA D stated she worked from 11/26/2025 at 10:00 pm to 11/27/2025 at 6:00 AM as a CNA. CNA D stated the facility tried to hire more nurses and they just hired RN G. CNA D stated that the LVN J relieved LVN H on 11/27/2025 and LVN I received LVN J on 11/28/2025 both of whom are agency staff. During an interview on 12/03/2025 at 12:30 PM, RN M stated that she was scheduled to work on 11/27/2025 and did not come to the facility because she did not feel safe. RN M stated that on 11/27/2025 at 2:00 AM LVN L called in due to a family emergency. RN M stated that she did not feel comfortable passing medications and had never passed medications to the residents at the facility and did not feel comfortable taking responsibility for 31 residents with 2 CNAs working. RN M stated she was a registered nurse and retired nurse practitioner and she has given medication before. RN M stated she normally worked as a weekend RN supervisor on Saturdays. During an interview on 12/03/2025 at 2:23 PM, RNC stated that he was not aware of an ongoing issue with no RNs being at the facility. RNC stated that the facility was supposed to have at least one RN working 8 consecutive hours and the facility should schedule an RN even if they have to get agency staff or ask the weekend RN supervisor to come in. RNC stated that he has interviewed DON candidates on 12/2/2025 and 12/3/2025. RNC stated DON position is posted on job sites. RNC stated that residents were not admitted to the facility that required treatment only an RN could provide. RNC stated that he was made aware that LVN L called in at 4:30 AM on 11/27/2025 and that the other scheduled nurse (RN M) decided she was not going to come into work. RNC stated that there were originally two nurses (LVN L and RN M) scheduled to work on 11/27/2025. RNC stated that CNA D handled staffing. RNC stated he was not sure why RN M did not come to work. RNC stated he expected RN supervisors to help with whatever was needed during their shifts and to pass medications if needed. RNC stated efforts were made to relieve LVN H. RNC stated that the maximum amount of hours a nurse could work the floor was 20 hours. RNC stated that a potential risk to working longer than 20 hours was that the nurse may not be as alert working so long. During an interview on 12/03/2025 at 3:06 PM, the ADM stated that LVN H worked the night of 11/26/2025 and started at 6:00 PM and was scheduled to work until 6:00 am on 11/27/2025. The ADM stated on 11/27/2025 LVN L and RN M

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing and administering of all routine and emergency drugs and biologicals for 3 of 4 (Resident #1, Resident #2, and Resident #3) reviewed for pharmacy services. The facility failed to ensure that all of Resident #1's, Resident #2's, and Resident #3's medications were administered on time as indicated by physician's orders on 11/27/2026. These failures could place residents at risk of exacerbation and/or deterioration of their health conditions, and delayed relief or treatment of symptoms which could result in decreased quality of life, discomfort or hospitalization. Findings included: Review of Resident #1 face sheet dated 12/02/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified fracture of right femur (break in thigh bone), depression (mental health disorder characterized by persistent feelings of sadness), chronic embolism and thrombosis of unspecified deep veins (blood clots in deep veins that cause ongoing circulation problems), and restlessness and agitation. Review of Resident #1 physician orders reflected an order dated 11/15/2025 for Divalproex Sodium Oral Capsule Delayed Release 125 MG with instructions to give 2 capsules by mouth every morning and at bedtime. Review also reflected an order dated 11/15/2025 for Sacubitril-Valsartan Oral tablet 24-26 MG with instructions to give 1 tablet by mouth every morning and at bedtime. Review of Resident #1's MAR reflected Divalproex was scheduled for 7:00 am and 7:00 PM. Review reflected LVN H administered Resident #1's first dose of Divalproex on 11/27/2025. Review also reflected Sacubitril-valsartan was scheduled for 7:00 AM and 7:00 PM. Review reflected LVN H administered Resident #1's first dose of Sacubitril-valsartan on 11/27/2025. Review of Resident #1's medication admin audit report reflected on 11/27/2025 LVN H administered Resident #1's Divalproex at 9:25 AM, two hours and twenty five minutes after scheduled administration time of 7:00 AM. Further review of the medication admin audit report reflected on 11/27/2025, LVN H administered Resident #1's Sacubitril-valsartan at 9:35 AM, two hours and thirty-five minutes after the scheduled administration time of 7:00 AM. Review of Resident #1 admission MDS dated [DATE] reflected a BIMS of 11, which indicated moderate cognitive impairment. Review of Resident #2's face sheet dated 12/02/2025 reflected a [AGE] year old woman admitted on [DATE] with diagnoses of immobility syndrome (paraplegic), hypokalemia (condition where blood potassium levels are too low and impact muscles, nerves, heart and kidneys), major depressive disorder (serious mood disorder causing persistent sadness and loss of interest that impacts daily life), and other chronic pain (persistent pain not tied to specific injuries). Review of Resident #2's physician orders reflected an order dated 11/19/2025 for Aspirin Oral tablet Chewable 81 MG with instructions to give by mouth every morning and bedtime. Review reflected an order with a start date of 11/19/2025 for baclofen Oral tablet 10 MG with instructions to give by mouth three times a day. Review reflected an order with a start date of 11/19/2025 for buspirone HCL Oral Tablet 5 MG with instructions to give 2 tablets by mouth every morning and at bedtime. Further review reflected an order dated 11/19/2025 for Potassium Chloride ER Oral tablet Extended Release 10 MEQ with instructions to give 2 tablets by mouth two times a day. Review of Resident #2's MAR reflected Aspirin was scheduled for 7:00 AM and 7:00 PM. Review reflected LVN H administered Resident #2's first dose of Aspirin on 11/27/2025. Review reflected Resident #2's buspirone was scheduled for 7:00 am and 7:00 pm and the first dose was administered by LVN H on 11/27/2025. Review reflected Resident #2's Baclofen was scheduled for 6:00 am, 11:00 am and 7:00 pm. Review reflected LVN H administered Resident #2's first and second dose of Baclofen on 11/27/2025. Review reflected Resident #2's Potassium was scheduled to be administered at 7:00 am and 7:00 pm. Review reflected LVN H administered Resident #2's first dose on 11/27/2025.Review of Resident #2's medication audit report reflected on 11/27/2025 LVN H administered Resident #2's 6:00 Am dose of Baclofen at 10:43 AM, four hours and forty-three minutes after scheduled administration time. Review reflected LVN H administered Resident #2's 7:00 am dose of aspirin at 10:42 AM, three hours and forty-two minutes after the scheduled administration time on 11/27/2025. Review reflected on 11/27/2025 LVN H administered Resident #2's 7:00 AM dose of buspirone at 10:43 AM, three hours and forty-three minutes after scheduled administration time. Review reflected on 11/27/2025, LVN H administered Resident #2's 7:00 AM dose of Potassium at 10:43 AM, three hours and forty-three minutes after scheduled administration time. Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS of 15, which indicated cognitively intact. Review of Resident #2's care plan dated 05/29/2025 reflected Resident #2 was