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	04/11/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' right to formulate an advance directive for 1 of 6 residents (Resident #1) reviewed for advanced directives, in that:The facility failed to ensure Resident #1's OOH-DNR was valid with a physician signature which resulted in Resident #1 receiving life saving measures including CPR when Resident #1 was found unresponsive. This failure places residents at risk of having their end-of-life wishes dishonored, and of having CPR performed against their wishes. The findings included: Record review of Resident of #1's face sheet, dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of SEPSIS, UNSPECIFIED ORGANISM, (condition that occurs when the body's response to an infection causes injury to its own tissues and organs), PNEUMONIA, (an infection that inflames the air sacs in one or both lungs) and PRESENCE OF PROSTHETIC HEART VALVE (Pacemaker), (a medical device designed to replace a diseased native valve). Record review of an OOH DNR form, dated [DATE], revealed RP and BM/HR's signatures were both on the form. The OOH DNR did not have a doctor's signatures on the form. Record Review on [DATE] of Resident #1 's Orders revealed Code Status: (Advance Directive) *** FULL CODE***. Record review of Resident #1's comprehensive care plan, initiated on [DATE], revealed there was no code status mentioned. During an interview on [DATE] at 3:31 p.m., the BM/HR revealed her responsibilities included performing financial assessments and obtaining paperwork for new admissions. The BM/HR stated, ?I was told by the Regional Trainer that when the family comes in, have them fill out the OOH form. She said the RP signed the new admission forms that included the OOH form. She said she looked it over and signed it. She stated, ?the DON took the OHH off my desk, it was in his office for a while, and I was responsible to upload it to Resident # 1's file.' BM/HR has received training regarding her responsibility to obtain the required signatures on OOH DNR form, and she understands the form is not valid unless a physician's signature has been included on the form. During an interview on [DATE] at 10:37 a.m., LVN A revealed on [DATE] at 6 a.m., CNA B had alerted her that Resident #1 was found unresponsive. LVN A stated she went to Resident # 1s room, he looked pale. She said, she checked his pulse on his neck and his left wrist, she then used the blood pressure cuff and she checked his oxygen; there were no readings on either device. She stated the CNA remained with Resident # 1 in his room while she went to the nurse's station to check the computer to find an Advance Directive for Resident # 1. Resident # 1's Advance Directive was, full code. She contacted the NP. Next, she connected the leads from the Automatic compression machine on Resident # 1 while he was on the bed and she performed CPR. She stated, CNA B called EMS. She stated, Resident # 1 passed away on [DATE] at 6:59 a.m. During an interview on [DATE] at 1:02 p.m., CNA B revealed on [DATE] at 6 a.m. she found Resident # 1, lying in his bed and he was unresponsive. CNA B stated, she notified LVN A of Resident # 1s condition and she checked Residents # 1's file for an Advanced Directive. She stated Resident # 1's file showed the Advance Directive was ?full code'. She said, I accompanied LVN A in Resident # 1's room and I brought the Automatic compression machine over to Resident # 1s bed. During an interview on [DATE] at 1:05 p.m., the DON revealed BM/HR was responsible for obtaining all required signatures (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on all the admission paperwork. The DON stated, BM/ HR didn't speak with the clinical staff regarding the family's wishes for DNR. The DON stated BM/ HR didn't get the physician's signature on the OOH DNR form. The DON stated, on Monday ([DATE]), the day following Resident # 1's death, DON discovered that Resident # 1's RP had signed and dated a OOH DNR form. The DON stated that the corporate office advised him that the document was not valid if the physician's signature was not on the form. The DON stated he contacted Resident #1's RP regarding Resident # 1's Advanced Directive. The DON said RP told him that he signed the OOH DNR document on [DATE] and he had discussed Resident #1's wishes for a DNR with BM/ HR. The DON said RP told him, he believed that was all he needed to do regarding the Advanced Directive. During an interview on [DATE] at 3:00 p.m., the Administrator stated the staff member who did the admission paperwork for Resident #1 was BM/HR. The ADM stated handling new admission paperwork was in the job description for BM/ HR. The ADM stated it was BM/ HR's responsibility to let the staff know Resident #1's wishes. The ADM stated an Advanced Directive for DNR was valid if a Physicians signature has been obtained on the form. Record review of the facility document titled Advance Directives, dated 09/2022, stated Policy Statement The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. a. Advance care planning - a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. b. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated . Do Not Resuscitate (DNR)- indicates that, in a case of respiratory or cardiac failure, their resident, legal guardian, healthcare proxy, or representative ad directed that no cardiopulmonary resuscitation (CPR) or other life -sustaining treatments or methods are to be used.