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	06/04/2026

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 0730 Level of Harm - Actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to properly complete a performance review of every nurse aide at least once every 12 months, for 2 of 4 (CNA A and CNA C) reviewed for nursing services.The facility failed to provide a completed competency checklist for the mechanical lifting device (assists staff with transferring a resident from the bed to a wheelchair and back to the bed) for CNA A and CNA C.This deficient practice resulted in an injury to the Resident #27 and could place other residents at risk of falls and injury.The findings included: Review of Resident #27's face sheet, dated 06/02/2026, revealed she was admitted to the facility on [DATE] with history of Atherosclerotic heart disease of the native coronary artery without angina pectoris (Plaque has built up in the heart's original arteries, restricting blood flow without causing chest pain), Violent behavior, Dementia (Decline in mental ability severe enough to interfere with daily life), Depression (It causes persistent feelings of sadness, emptiness, and a loss of interest in activities), Abnormalities of gait and mobility (Irregular, unsteady, or inefficient walking patterns), A lack of coordination (Inability to control smooth, precise muscle movements), Cognitive communication deficit (Communication challenges caused by underlying disruptions in mental processes), and need for assistance with personal care. Code status: Review of Resident #27's quarterly MDS assessment dated [DATE] reflected that Resident #27 was assessed to have a BIMS score of 00, indicating severe cognitive impairment.Review of Resident #27's Care Plan, dated on 01/30/2026, revealed Resident #27 required assistance by 2 staff with Mechanical lift transfer assistance and dated on 01/31/2026, revealed Resident #27 required assistance by staff with bathing/showering.Review of the competency assessment titled Lifting Machine, Using a Mechanical, showed that the assessment was done by ADON in March 2026. However, there were no employee-associated names, titles, employee signatures, IDs, initials, or completed dates of the employee recorded in the assessment records. The facility did not provide any properly completed documents showing that any of its employees took the competency assessment and in-services on the Lifting Machine, using a Mechanical lift prior to 06/02/2026.Review of video evidence recorded on 06/01/2026 revealed that Resident #27 fell from the mechanical lift due to improper placement of the sling strap.Review of the email statement on 06/04/2026 at 01:14 p.m. revealed that DOC A found Resident #27's injury was serious. DOC A stated that Resident #27's head trauma, requiring stitches to close a wound, was a significant injury. Given her age, there is potential for such trauma to cause intracranial bleeding, which can lead to death or permanent disability, although DOC A did not see evidence of such a more serious injury. DOC A stated Resident #27's head wound was repaired with stitches after being washed out and obtaining CT imaging of her brain and neck to rule out brain bleeding or skull or spine fracture.Interview on 06/02/2026 at 01:31 p.m. with CNA C stated that he had been working at the facility for about four months. CNA C stated he had been trained in abuse, neglect, and exploitation. CNA C stated that around 2 in the afternoon, after lunch, CNA C was helping CNA A with transferring Resident 27 with a mechanical lift from the bed to the shower chair. CNA C stated CNA A was using a sling in the mechanical lift, and CNA C was just behind the shower chair next to the bedside. CNA C stated that two individuals operate a mechanical lift. CNA C stated Resident #27 fell while putting on the shower (continued on next page)

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 0730 Level of Harm - Actual harm Residents Affected - Some	chair. CNA C stated that the sling was improperly placed, and Resident #27's aggression occurred during the lift. CNA C stated Resident #27 was yelling and moving in the sling. CNA C stated that Resident #27 was yelling in Spanish, and while Resident #27 was in bed, she was trying to hit CNA A. CNA C stated that when Resident #27 was on the sling, she was moving and yelling. CNA C stated that Resident #27 was moving her whole body, and it was very difficult for CNA C to put her on the shower chair in a sitting position. CNA C stated that CNA C did not notice the sling was in the wrong position until Resident #27 fell. CNA C stated that after the fall, CNA C thought the placement of the sling was probably wrong, because the sling came off from the top right corner of the mechanical lift. CNA C stated Resident #27 was on the side of the mechanical lift rather than directly in the middle during transfer from the bed to the mechanical lift. CNA C stated that it is both people's responsibility to ensure the resident is in the proper position during a mechanical lift transfer. CNA C stated he had been trained on the mechanical lift before the incident and had been serviced on a mechanical lift transfer after the incident. CNA C stated that after the fall, CNA C immediately told CNA A to get the nurse and placed a pillow under Resident #27's head. CNA C stated he stayed with the resident until the nurse (ADON) arrived. CNA C stated ADON brought a stronger sling and then put the Resident #27 back to bed so the nurse could properly assess Resident #27. CNA C stated the nurse assessed Resident #27 and sent Resident #27 to the hospital. Interview on 06/02/2026 at 01:42 p.m. with CNA A revealed that she had been working at the facility for almost 5 months. CNA A stated she had been trained in abuse, neglect, and exploitation. CNA A stated she had been trained in the mechanical lift 1-2 months ago. CNA A stated Resident #27 was fighting in the mechanical and moving Resident #27's legs up and down, then Resident #27 came to one side of the mechanical and fell. CNA A stated Resident #27 was in the right position because CNA A helped Resident #27 position on the front by fixing Resident #27's legs, and CNA A's partner, CNA C, helped CNA A to put Resident #27 in the middle from the back. CNA A stated she did not ask for help while Resident #27 was moving too fast in the Hoyer. CNA A stated nothing to Resident #27 this time, and everything happened so fast. CNA A stated she did not ask for help or pause during the transfer because Resident #27 acted the same way throughout. CNA A stated that after the fall, CNA C saw the resident was bleeding, and her partner, CNA C, told CNA A to get the nurse, and CNA A went to get the nurse. CNA A stated that this kind of incident had not happened before. Interview on 06/04/2026 at 01:50 p.m., LVN A stated that a negative outcome of not properly or safely using the mechanical lift could cause a fall, which could cause serious injury. LVN A stated that the prevention measures were: Ensuring loops were properly secured, that two people perform the transfer safely, and double-checking hooks and loops to ensure they were secure and properly in place. Interview on 06/04/2026 at 02:18 p.m. ADON stated that failing to properly evaluate or use an in-service competency checklist can lead to injury, create a paper trail, and leave them without proof. ADON stated that a prevention measure not evaluating the competency checklist was: Every person must be watched while the trainee gives their signature. ADON stated that a proper evaluation of the checklist requires a signature, full name, and date and time; all check boxes need to be filled in and covered for the assessment.Interview on 06/04/2026 at 02:32 p.m. DON stated that failure to properly evaluate or use an in-service competency checklist can lead to incidents involving serious injury. DON stated prevention measures for improper evaluation of the competency checklist, including in-services on videotaping proper procedures during training, watching the video, performing the techniques, and teaching back the process. DON stated he will try to simulate the weight during training. DON stated that the checklist requires a proper signature, full name, and date and time. DON stated that the documents must be completed in full and that there must be no missing data in the boxes. Interview on 06/04/2026 at 03:16 p.m. the ADM stated that failing to properly evaluate or use an in-service competency checklist can result in them not receiving their training. ADM stated it was important for them to receive the training on time and to re-educate them. ADM stated that prevention measures, such as not evaluating in-services and competency checklists, had another set of eyes on them and that they were reviewed after completion. ADM (continued on next page)

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Avir at Johnson City	206 Haley Rd. Johnson City, TX 78636

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F 0730 Level of Harm - Actual harm Residents Affected - Some	stated that it was typically reviewed by HR. ADM stated that a proper evaluation of the checklist required a proper signature, full name, date, and time. ADM stated CNA A's Hoyer lift competency checklist was completed, but not filled out correctly, because CNA A was upset during the signature. Review of the facility's policy titled Lifting Machine, Using a Mechanical, revision date July 2017, revealed under the Purpose section: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for the manufacturer's training or instructions.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the residents' environment remained free from accidents and hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents, for 4 of 11 residents (Resident #20, Resident #27, Resident #28 and Resident #34,) reviewed for quality of life. The facility failed to ensure Resident #27's mechanical lift sling was securely attached to the sling bar. The facility failed to ensure that the call light was within reach for Resident #34 and Resident #20. The facility failed to serve Resident #28 a mechanically altered diet on 6/1/2026. This deficient practice resulted in an injury to Resident #27 and could have placed Resident #34 and #20 at risk of falls, pain, anxiety, and injuries, and could have placed Resident #28 at risk of choking, reduced intake, and weight loss. Findings included: Resident#27Review of Resident #27's face sheet, dated 06/02/2026, revealed she was admitted to the facility on [DATE] with history of Atherosclerotic heart disease of the native coronary artery without angina pectoris (Plaque has built up in the heart's original arteries, restricting blood flow without causing chest pain), Violent behavior, Dementia (Decline in mental ability severe enough to interfere with daily life), Depression (It causes persistent feelings of sadness, emptiness, and a loss of interest in activities), Abnormalities of gait and mobility (Irregular, unsteady, or inefficient walking patterns), A lack of coordination (Inability to control smooth, precise muscle movements), Cognitive communication deficit (Communication challenges caused by underlying disruptions in mental processes), and need for assistance with personal care. Code status: Full Code (Full code means that if a person's heart stopped beating, all resuscitation procedures will be provided to keep them alive).Review of Resident #27's quarterly MDS assessment dated [DATE] reflected that Resident #27 was assessed to have a BIMS score of 00, indicates severe cognitive impairment. Review of Resident #27's Care Plan, dated on 01/30/2026, revealed Resident #27 required assistance by 2 staff with mechanical lift transfer assistance and dated on 01/31/2026, revealed Resident #27 required assistance by staff with bathing/showering.Review on 06/02/2026 of video evidence recorded on 06/01/2026 revealed that Resident #27 fell from the mechanical lift due to improper placement of the sling strap. Review of the email statement on 06/04/2026 at 01:14 p.m. revealed that DOC A found Resident #27's injury was serious. DOC A stated that Resident #27's head trauma, requiring stitches to close a wound, was a significant injury. Given her age, there is potential for such trauma to cause intracranial bleeding, which can lead to death or permanent disability, although DOC A did not see evidence of such a more serious injury. DOC A stated Resident #27's head wound was repaired with stitches after being washed out and obtaining CT imaging of her brain and neck to rule out brain bleeding or skull or spine fracture. An observation and interview on 06/02/2026 at 11:46 a.m. revealed Resident #27 was in her wheelchair, and Resident #27's FAM A was caring Resident #27. Resident #27 had an above the left eyebrow laceration, and bruises on her left arm. FAM A mentioned, Resident #27 had fallen from the mechanical lift and hit the floor. FAM A stated Resident #27 could not express pain, but if she gets angry, that shows her pain. FAM A stated Resident #27 no longer communicates the way she used to. FAM A stated she had video evidence of one female staff was getting Resident #27 ready without any (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	clothing on, and Resident #27 was on the side lying in the mechanical Lift and Resident #27 fell from it. FAM A stated she was very disappointed about the situation. Interview on 06/02/2026 at 01:31 p.m. with CNA C revealed he had been working at the facility for about four months. CNA C stated he had been trained in abuse, neglect, and exploitation. CNA C stated that around 2 in the afternoon, after lunch on 06/01/2026, CNA C was helping CNA A with transferring Resident #27 with a mechanical lift from the bed to the shower chair. CNA C stated CNA A was using a sling in the mechanical lift, and CNA C was just behind the shower chair next to the bedside. CNA C stated that two individuals operate a mechanical lift. CNA C stated Resident #27 fell from the mechanical lift while putting on the shower chair on 06/01/2026. CNA C stated that the sling was improperly placed, and Resident #27's aggression occurred during the lift. CNA C stated Resident #27 was yelling and moving in the sling. CNA C stated that Resident #27 was yelling in Spanish, and while Resident #27 was in bed, she was trying to hit CNA A. CNA C stated that Resident #27 was moving her whole body, and it was very difficult for CNA C to put her on the shower chair in a sitting position. CNA C stated that CNA C did not notice the sling was in the wrong position until Resident #27 fell. CNA C stated that after the fall, CNA C thought the placement of the sling was probably wrong, because the sling came off from the top right corner of the mechanical lift. CNA C stated Resident #27 was on the side of the mechanical lift rather than directly in the middle during transfer from the bed to the mechanical lift. CNA C stated that it was both people's responsibility to ensure the resident is in the proper position during a mechanical lift transfer. CNA C stated he had been trained on a mechanical lift before the incident and had been in-serviced on a mechanical lift transfer after the incident. CNA C stated that after the fall, CNA C immediately told CNA A to get the nurse and placed a pillow under Resident #27's head. CNA C stated he stayed with the resident until the nurse (ADON) arrived. CNA C stated ADON brought a stronger sling and then put the Resident #27 back to bed so the nurse could properly assess Resident #27. CNA C stated the nurse assessed Resident #27 and sent Resident #27 to the hospital. In an interview on 06/02/2026 at 01:42 p.m. with CNA A revealed that she had been working at the facility for almost 5 months. CNA A stated she had been trained in abuse, neglect, and exploitation. CNA A stated she had been trained on the mechanical lift 1-2 months ago. CNA A stated Resident #27 was fighting in the mechanical and moving Resident #27's legs up and down, then Resident #27 came to one side of the mechanical and fell. CNA A stated Resident #27 was in the right position because CNA A helped Resident #27 position on the front by fixing Resident #27's legs, and CNA A's partner, CNA C, helped CNA A to put Resident #27 in the middle from the back. CNA A stated she did not ask for help while Resident #27 was moving too fast in the Hoyer. CNA A stated nothing to Resident #27 this time because Resident #27 always acted the same during transfer, and everything happened so fast. CNA A stated she did not ask for help or pause during the transfer because Resident #27 acted the same way throughout. CNA A stated that after the fall, CNA C saw the resident was bleeding, and her partner, CNA C, told CNA A to get the nurse, and CNA A went to get the nurse. CNA A stated that this kind of incident had not happened before. In an interview on 06/04/2026 at 01:02 p.m., DOC B stated he saw Resident #27 on 06/04/2026. DOC B stated the laceration of the left eyebrow was superficial with some bruising. He stated the stitches were healing appropriately, and they would be removed in 10 days. DOC B stated Resident #27 denied a headache or pain. DOC B stated Resident #27 was speaking in Spanish. In an interview on 06/04/2026 at 01:50 p.m., LVN A stated that a negative outcome of not properly or safely using the mechanical lift could cause a fall, which could cause serious injury. LVN A stated prevention measures were: Ensuring loops were properly secured, that two people perform the transfer safely, and double-checking hooks and loops to ensure they were secure and properly in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 06/04/2026 at 02:18 p.m. ADON stated that a negative outcome of not properly or safely using the mechanical lift could cause injury. ADON stated prevention measures to stop the injury, such as ensuring slings were properly placed, using proper body mechanics, using a two-person assist, and evaluating the competency checklist. In an interview on 06/04/2026 at 02:32 p.m. DON stated that a negative outcome of improper or unsafe use of the mechanical lift includes injuries and falls. DON stated the prevention measures for improper use of the mechanical lift were stop and check, and that two aides verify every single step of the transfer. In an interview on 06/04/2026 at 03:16 p.m. ADM stated negative outcomes of improper or unsafe use of the mechanical lift could include harm. ADM stated prevention measures of improper use of the mechanical Lift were re-education, consistent education, and training. Resident #28: Record review of Resident #28's face sheet printed on 6/4/2026 reflected an [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses including encephalopathy (brain dysfunction which appears as confusion, memory loss, and personality changes), Type 2 Diabetes (metabolic disorder that occurs when the body becomes resistant to insulin), and dysphasia (difficulty swallowing), oropharyngeal phase (earliest and fastest stage of swallowing involving both voluntary and involuntary actions). Record review of Resident #28's quarterly MDS assessment dated [DATE], reflected a BIMS score of 7, indicating severe cognitive impairment. Resident #28's quarterly assessment also indicated the resident was on a mechanically altered diet while a resident at the facility. Record review of Resident #28's care plan initiated on 5/8/2026 and revised on 5/21/2026 reflected a focus stating, The resident has a nutritional problem r/t mechanical soft diet, and intervention/tasks stating, Provide, serve diet as ordered. Monitor intake and record q meal. Record review of Resident #28's order summary printed 6/4/2026, reflected an order started on 12/3/2025 that stated, Regular diet mechanical soft texture, regular consistency. During observation of lunch service on 6/2/2026 at 12:30 PM, Resident #28 was observed to be served spaghetti with mechanically softened meatballs by CNA A. Another resident sitting next to Resident #28, who was not on a mechanically softened diet, was served spaghetti with full-size meatballs by CNA A. When Resident #28 saw the full-size meatballs on her neighbor's tray she complained to CNA A that she had not received any meatballs. The neighboring resident offered Resident #28 her meatballs from her plate and Resident #28 accepted. CNA A stood by watching. CNA B immediately intervened and told CNA A that Resident #27 could not had the meatballs and attempted to replace the resident's tray with new one. Resident #28 refused. CNA B immediately sought out the DON who was in the dining room and informed him of the occurrence. The DON attempted to reason with Resident #28 and offered to get her another tray. Resident #28 again refused. The DON continued to explain to the resident that she could not had whole meatballs, but she refused to listen and put the whole meatball in her mouth. The DON stood by monitoring the resident's consumption to ensure it was properly chewed and swallowed. In an interview on 6/2/2026 at 1230PM, CNA A confirmed Resident #28 was not to have had full (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	meatballs, but she was unsure what to do if the resident insisted. In an interview on 6/4/2026 at 2:50 PM, the DON stated that he and all staff were oriented, trained and regularly in-serviced on topics relevant to their roles and responsibilities, including diets. The DON stated that dietary restrictions were communicated to staff through orders and hand-off reports. The DON stated if a resident refused their served meal, he would educate them on why the meal style was necessary. If they still refused, he would consult with the therapy department, doctor, and care plan team for recommendations. The DON stated that residents were not allowed to share food. He stated that potential negative outcomes from consuming food not prepared for them could be aspiration. The DON stated that CNA A should had immediately intervened and not allowed Resident #28 to accept food from another resident's plate. In an interview on 6/4/2026 at 3:00 PM, CNA D stated that she had been trained and in-serviced on diets and proper diet consumption by residents. She said if she was unsure of a resident's dietary restrictions, she would ask questions. CNA D stated that she was familiar with Resident #28 and her non-compliance with her dietary restrictions. She stated that Resident #27 often questioned why she was not served bacon when everyone else was. CNA D stated that she explained the reasoning to the resident every time. CNA D stated that correct diets were important because if served the wrong item, residents who had swallowing difficulties may choke. She stated it was also important for the resident's best overall health and safety. CNA D stated that Resident #27 was often not accepting of explanations and reasoning regarding her diet, and that she had seen the resident take food or accept food from others, even when instructed not to do so. In an interview on 6/4/2026 at 3:05 PM, CNA B stated that she had been oriented, trained, and regularly in-serviced on resident diets and consumption. She stated the facility's policy regarding diets stated that staff should look at the resident's care record and follow it. CNA B stated that menus and tickets should also be reviewed for accuracy regarding resident dietary restrictions. In regard to the observed incident regarding Resident #28, CNA D stated she would have immediately intervened and not allowed the residents to share food and would had explained the reason to the residents in a way they could understand. In an interview on 6/4/2026 at 3:15 PM, the ADM stated that all staff were properly oriented, trained and regularly in-serviced on topics relevant to their positions and responsibilities. The ADM stated that dietary restrictions for residents were communicated by nursing staff in conjunction with the dietary staff. Crucial information, such as dietary restrictions, were communicated in morning meetings and clinical meetings. The ADM stated if residents were non-compliant with their diet, the nurse was to be immediately notified. The ADM stated that non-compliance with dietary restrictions could lead to choking, allergic reactions, or weight loss. Resident #341. Record review of Resident #34's admission face sheet dated 06/04/26 reflected she was a [AGE] year-old male admitted to the facility on [DATE] with active diagnoses that included: Respiratory Failure, Chronic Obstructive Pulmonary Disease (lung diseases), Sepsis (life-threatening response to an infection), Acute Bronchitis, Enterovirus Infection (inflammation of the breathing tubes), and Depression. Record review of Resident #34's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 15, indicating the individual's cognition was intact. Resident #34's MDS Assessment reflected that she was incontinent of bowl and bladder and required assistance with daily care.Record review of Resident #34's Care Plan dated 05/06/2026 indicated that the resident needed assistance with his (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 0689 Level of Harm - Actual harm Residents Affected - Few	ADLs. In an observation on 6/2/2026 at 10:24 AM in Resident #34's room, the call light was in the drawer and not within reach. An interview on 6/2/2026 at 10:26 AM with Resident #34 revealed he did not know how the call light ended up in the drawer. Resident #34 stated that he had not had any falls at the facility due to being unable to reach the call light and not receiving help. Resident #34 stated that he did not think about the call light that often. Resident #34 stated that the staff were the ones who helped him with his ADLs. Resident #20 2. Record review of Resident #20's admission face sheet dated 06/04/26 reflected she was an [AGE] year-old male admitted to the facility on [DATE] with active diagnoses that included: Metabolic Encephalopathy (altered mental status), Behavioral Disturbance (sudden changes in personality), Psychotic Disturbance (loses touch with reality), Mood Disturbance (Severe shifts in emotional state), Anxiety, Dysphagia Oropharyngeal (Difficulty swallowing), And Muscle Wasting And Atrophy (deterioration, shrinking, or loss of muscle mass). Record review of Resident #20's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 15, indicating the individual's cognition was intact. Resident #20's MDS Assessment reflected that she was incontinent of bowel and bladder and required assistance with ADL care. Record review of Resident #20's Care Plan dated 05/05/2026 indicated that the resident needed assistance with his ADLs. In an observation on 6/2/2026 at 10:30 AM in Resident #20's room, the call light was hanging on the wall behind the bed while Resident #20 was in the recliner and unable to reach the call light. An interview on 6/2/2026 at 10:32 AM with Resident #20, revealed he had put the call light on the wall when he moved to the recliner. Resident #20 stated that he could not reach the call light because it was behind him. Resident #20 stated that he had not had any falls at the facility because he was not able to reach the call lights. An interview on 06/04/2026 at 1:06 PM with CNA D revealed she stated that the residents' call lights should have been next to them or on their outfits, so they were within reach. She stated that they checked on residents regularly to make sure the call light was within reach. She stated that if the call light was not close to the resident, she would move it back close to the resident. She stated that she would remind the residents of the importance of keeping the call light within reach and that they needed to use it in an emergency. She stated she had had in-service training, and the last time was a couple of months ago. She stated that residents could have been injured if the call light was not close. An interview on 06/04/2026 at 1:24 PM with CNA B revealed she stated that the call light should have been placed close to the resident. She stated that she would place the call light on the bed, so it was within reach. She stated that she checked on the residents often to make sure the call light was within reach. She stated that if a resident moved or left the room, when they returned, she would make sure the call light was close to the resident. She stated that if the residents did not like the call light being close to them, she would remind them that it needed to be close for their safety. She stated that she had had in-service training for about a month. (continued on next page)

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	676486	A. Building B. Wing	06/04/2026

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 06/04/2026 at 1:42 PM [SH1] LVN E. He stated that call lights should have been within the resident's reach. He stated there had been a clip on the call light so that it could be kept close to the residents. If the resident moved to a chair, then the call light would have been close to the resident. He stated that residents were checked every couple of hours to ensure the call lights were in place. He stated that he had reinforced to the residents the need to keep the call light within reach for their safety. He stated that his in-service training had been 3 months ago, when he was hired. He stated that the resident could have been injured if the call light was not within reach. An interview on 06/04/2026 at 2:13 PM with the ADON, she stated that call lights should have been within the resident's reach. She stated if a resident moved to a recliner, the call light should have been moved with the resident. She stated that if the resident's call light was not within reach, the resident could have been injured. She stated that she talked to the residents about the importance of the call light being close. She stated that the resident could have fallen and not gotten help. She stated that call lights were talked about daily with the staff. An interview on 06/04/2026 at 3:09 PM with the ADM, she stated the call light should be within reach of the resident when the resident was in the room. She stated the call light should be moved if the resident goes to a recliner. She stated that the call light should always be within the resident's reach while the resident is in the room. She stated that all staff meet every month to remind staff about the call lights. Record Review of the facility's policy titled Lifting Machine, Using a Mechanical revised July 2017 revealed:1.Before using a lifting device, assess the resident's current condition, including:a.Physical:i.Can the resident assist with transfer?ii.Is the resident's weight and medical condition appropriate for the use of a lift?b.Cognitive/Emotional:i.Can the resident understand and follow instructions?ii.Does the resident express fear or appear anxious about the use of a lift?iii.Is the resident agitated, resistant, or combative?2. Measure the resident for proper sling size and purpose, according to the manufacturer's instructions.3. Select a sling bar that is appropriate for the resident's size and the task.12. Attach sling straps to sling bar, according to manufacturer's instructions.a. Make sure the sling is securely attached to the clips and that it is properly balanced.b. Check to make sure the resident's head, neck, and back are supported.c. Before resident is lifted, double check the security of the sling attachment.d. Examine all hooks, clips or fasteners.e. Check the stability of the straps.f. Ensure that the sling bar is securely attached and sound. Record review of the call light policy dated January 2025 reflected the following. Policy:Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. 1.Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities, and from the floor. Record review of the facility's policy and procedures entitled Dining Room Service dated 2023 stated: Dining room staff should check the individual name and diet on the meal identification (ID) card/ticket to verify that the meal was served to the correct person, check items on the plate/tray to ensure accuracy for food preferences, therapeutic or modified consistency diets.

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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 in the 1 of 1 kitchen reviewed for food and nutrition services. The facility failed to consistently monitor and discard expired food The facility failed to maintain a sanitary kitchen by keeping the ice scoop in the ice machine. The facility did not label and date food items in the kitchen. The facility failed to keep employee's food items away from residents' food items. These failures can place residents at risk for foodborne illness. Findings included:An observation of Refrigerator #1 on 6-2-2026 at 9:22 AM revealed the following. Individual Butter and jelly were in containers that were not labeled with a date. There was a staff member's cup in the refrigerator. Herbs in a zip top bag that was not labeled with what was in it and had no dates on it. Cut bell pepper in a sealed bag that was not labeled with an open and use-by date. Blueberries in the original container with no date on the package. An Observation of Refrigerator #2 on 6-2-2026 at 9:27 AM revealed the following. Frosting in a sealed bag only the date of 5-27-2026. A tray with Juice that was not labeled with a date. Plastic bag containing lettuce was neither labeled nor dated. Jello in a clear container not labeled with only a date of 6-1-2026 . Bowl of an unknown food item labeled with only the date 5-25-2026. Sandwich bag with a cut red onion that was not labeled, dated, or sealed. Sealed bag with cut tomatoes that had no open date and no use-by date. Lettuce in its original packaging, which had no date on the package. An observation of Freezer #1 on 06/01/2026 9:30 AM revealed the following. Plastic bag containing frozen egg rolls that were not labeled with what was in the bag, or an open or use-by date. Plastic bag containing frozen chicken nuggets that were not labeled with what was in the bag, or an open or use-by date. Plastic bag containing frozen garlic that was not labeled with what was in the bag, or an open or use-by date. An observation of Ice Machine #1 on 06/01/2026 9:34 AM revealed the following. The scope was being stored inside the ice machine on a hook. The ice scope was being stored in an open Ziplock bag on top of the ice machine. An observation of the kitchen on 06/02/2026 9:37 AM revealed the following. The drawer in the kitchen containing serving utensils had food debris at the bottom of the drawer. The tray holding the coffee cups had debris. An interview on 6/02/2026 9:37 AM with the DM revealed the following. DM stated that personal food items should not have been in the kitchen refrigerator. The DM stated that everyone in the kitchen had been responsible for labeling and dating food in the kitchen. The DM stated that dates in the kitchen were checked weekly. The DM stated that if he saw staff not labeling and dating food items, then he would have reminded them to do that. The DM stated that all food items should have been labeled and dated. The DM stated that all staff had been responsible for cleaning the kitchen. The DM stated that the kitchen drawers should have been cleaned 2 times a month. The DM stated that he had not been sure why the drawers were not cleaned. The DM stated that the staff had followed a cleaning schedule. The DM stated that if residents had eaten out-of-date food or food served on dirty utensils, they could have gotten sick.An interview on 6/02/2026 at 11:15 AM with the CK revealed she stated that personal items should not have been left in the fridge. She stated that it had been everybody's responsibility to label and take food items into the kitchen. She said that it had been everybody's responsibility to clean the kitchen. She stated their residents could have gotten sick if they were served out-of-date food or food from dirty utensils.An interview on 06/04/2026 at 2:54 PM with DA revealed she stated that it had been everybody's responsibility in the kitchen to clean. She stated that everyone had been supposed to clean their own area. She stated that everybody in the kitchen had been responsible for labeling and dating food items. She stated that the DM had been the one who checked for dates in the refrigerator. She stated that she had not been aware that no personal food items were to be left on the counter or in the refrigerator. She stated that there had been an ice scoop in the ice machine, but that was not the one that they used. She stated that it had been her drink that was in the refrigerator. She stated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that they had had monthly in-service training. She stated that if these things had not been done, then it had been an infection control issue, and residents could have gotten sick.An interview on 06/04/2026 at 3:09 PM with the ADM revealed that she stated that everybody in the kitchen had been responsible for labeling and dating food items. She stated that everybody in the kitchen had been responsible for cleaning. She stated that the ice machine scoop had not belonged in the ice machine. She stated that kitchen staff had not been allowed to have their personal food items in the refrigerator or the kitchen area. She stated that doing these things could have put residents at risk by spreading an infection. She stated that the dietary manager had been responsible for in-service training for all kitchen staff. She stated that she would have reviewed all in-service training with the dietary manager to ensure staff had been updated on policies for labeling, dating, and kitchen cleaning. She stated that if these things had not been done then items could have been contaminated and caused the residents to get sick.Record review of the Labeling and Dating Policy dated November 2022 reflected the following. 2. Foods belonging to residents are labeled with the resident's name, the item, and the use by date.3.Food code was reviewed. Record review of the Sanitation Policy that was not dated reflected the following. Food and nutrition services staff will maintain kitchen sanitation by complying with a comprehensive written cleaning schedule.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to treat Resident #27 with dignity and respect in a manner and environment that promoted the maintenance or enhancement of his or her quality of life for 1 of 11 (Resident #27) residents reviewed for resident rights.The facility failed to ensure Resident #27's private area was covered while staff transferred the resident via a mechanical lift (assists staff with transferring a resident from the bed to a wheelchair and from the wheelchair back to the bed) from the bed to a chair.This deficient practice could place residents at risk for unnecessary exposure, embarrassment, and diminished quality of life. The findings were:Review of Resident #27's face sheet, dated 06/02/2026, revealed she was admitted to the facility on [DATE] with history of Atherosclerotic heart disease of the native coronary artery without angina pectoris (Plaque has built up in the heart's original arteries, restricting blood flow without causing chest pain), Violent behavior, Dementia (Decline in mental ability severe enough to interfere with daily life), Depression (It causes persistent feelings of sadness, emptiness, and a loss of interest in activities), Abnormalities of gait and mobility (Irregular, unsteady, or inefficient walking patterns), A lack of coordination (Inability to control smooth, precise muscle movements), Cognitive communication deficit (Communication challenges caused by underlying disruptions in mental processes), and need for assistance with personal care. Review of Resident #27's quarterly MDS assessment dated [DATE] reflected that Resident #27 was assessed to have a BIMS score of 00, indicating severe cognitive impairment.Review of Resident #27's Care Plan, dated 01/30/2026, revealed a focus that Resident #27 required assistance by 2 staff with mechanical lift transfer assistance, and a focus dated 01/31/2026, revealed Resident #27 required assistance by staff with bathing/showering.Observation and interview on 06/02/2026 at 11:46 a.m. revealed Resident #27 was in her wheelchair, and Resident #27's FAM A was caring for Resident #27. Resident #27 had an above the left eyebrow laceration, and bruises on her left arm. FAM A mentioned, Resident #27 had fallen from the mechanical lift and hit the floor. FAM A stated Resident #27 cannot express pain, but if she gets angry, that shows her pain. FAM A stated Resident #27 no longer communicates the way she used to. FAM A stated she had video evidence that one girl getting Resident #27 ready without any clothing on, and Resident #27 was on the side lying in the mechanical Lift and Resident #27 fell from it. FAM A stated she is very disappointed about the situation. Review of video evidence recorded on 06/01/2026 at 01:15 p.m. revealed that Resident #27's body was fully uncovered on the bed and during transfer from the bed to the mechanical lift. Interview on 06/02/2026 at 01:31 p.m. with CNA C revealed that he had been working in the facility for about four months. CNA C was helping CNA A during transfer of Resident 27 for shower. CNA C was in-serviced on abuse, neglect, and exploitation. CNA C stated that it was both people's responsibility to ensure the resident is in the proper position during a mechanical lift transfer. CNA C had been trained in a mechanical lift. Interview on 06/02/2026 at 01:42 p.m. with CNA A revealed that she had been working at the facility for almost 5 months. CNA A stated she had been trained in abuse, neglect, and exploitation. CNA A stated she had been trained in the mechanical lift 1-2 months ago. CNA A stated Resident #27 was fighting in the mechanical and moving Resident #27's legs up and down, then Resident #27 came to one side of the mechanical and fell. CNA A stated Resident #27 was in the right position because CNA A helped Resident #27 position on the front by fixing Resident #27's legs, and CNA A's partner, CNA C, helped CNA A to put Resident #27 in the middle from the back. CNA A stated she did not ask for help while Resident #27 was moving too fast in the Hoyer. CNA A stated nothing to Resident #27 this time, and everything happened so fast. CNA A stated she did not ask for help or pause during the transfer because Resident #27 acted the same way throughout. CNA A stated that after the fall, CNA C saw the resident was bleeding, and her partner, CNA C, told CNA A to get the nurse, and CNA A went to get the nurse. CNA A stated that this kind of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident had not happened before.In an interview on 06/04/2026 at 01:50 p.m., LVN A stated a negative outcome of transferring a resident without covering private parts from the bed to the mechanical lift can cause skin injury and dignity issues. LVN A stated that some prevention measures include ensuring all pressure points and private areas were covered, preventing skin tears, and maintaining residents' dignity. In an interview on 06/04/2026 at 02:32 p.m., DON stated a negative outcome of transferring a resident totally not covering private parts, from the bed to the mechanical lift, was just dignity. DON stated you didn't want your body to be exposed that's why Resident's body needs to be covered. DON stated some prevention measures to avoid exposing residents include covering the patient, providing privacy, putting them in a gown, and covering them with a loose-fitting garment until they were in the shower. In an interview on 06/04/2026 at 03:16 p.m. ADM stated she did not know the negative outcome of failing to cover a resident's private area during a transfer and would refer to her clinical staff. Review of the facility's policy titled Dignity with a revised date of February 2021 revealed that:1. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.12. Demanding practices and standards of care that compromise dignity are prohibited.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 residents (Resident #14) reviewed for care plans.1.The facility failed to develop a comprehensive care plan to reflect Resident #14's diagnoses.2.The facility failed to develop a comprehensive care plan to reflect Resident #14's preferences.These failures could place residents at risk of not receiving appropriate interventions to meet their psychosocial and medical needs. Record review of Resident #14's face sheet printed on [DATE], reflected a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses which included Parkinson's Disease with dyskinesia, with fluctuations (progressive neurological disorder with involuntary, abnormal movements due to changes in dopamine levels), unresolved, onset date of [DATE], muscle weakness, unresolved, onset date of [DATE], lack of coordination, unresolved, onset date of [DATE], aphasia (language disorder that affects an individual's ability to communicate effectively), unresolved, onset date [DATE], pneumonia, unresolved, onset [DATE], and urinary tract infection (UTI), unresolved, onset date [DATE]. Record review of Resident #14's Quarterly MDS assessment dated [DATE], reflected Resident #14 had a BIMS score of 3, indicating severe cognitive impairment. The MDS assessment stated Resident #14 needed substantial/maximal assistance with eating, oral hygiene, upper body dressing, and personal hygiene. The MDS assessment reflected Resident #14 was dependent on a helper to do all the effort regarding toileting hygiene, shower/bathing, lower body dressing, and putting on and taking off footwear. The MDS assessment reflected Resident #14 needed substantial/maximal assistance rolling left to right, moving from sitting to lying, moving from lying to sitting on the side of the bed, sitting to standing, and chair/bed-to-chair transfer. The MDS assessment reflected that the resident was totally dependent on a helper for tub/shower transfers. The MDS assessment reflected Resident #14 was always incontinent (bowel and bladder). The MDS assessment reflected that Resident #14 had a condition or chronic disease that may had resulted in a life expectancy of less than 6 months. The MDS assessment reflected Resident #14 had been on a mechanically altered diet while a resident and was at risk of developing pressure ulcers/injuries. The MDS assessment reflected Resident #14 was taking an antidepressant, a diuretic, oxygen therapy, and receiving hospice care. Record review of Resident #14's Comprehensive Care Plan initiated on [DATE] and revised on [DATE] reflected 1 Focus as follows: DNR Resident Choice, with a Goal of [Residents] wishes will be honored. The Interventions/Tasks for this focus were: Educate the resident/family of the meaning of the current code status. Ensure the current code status was in the medical record. If arrest occurs CPR will not be given. Notify receiving facility of the current code status. Place DNR in [resident's] record. Residents have right to be a DNR. Review quarterly. No other focus, goal, and/or intervention/tasks listed.In an interview on [DATE] at 2:00 PM, the ADON stated she had been working at the facility since [DATE]. She stated that she had been oriented, trained, and in-serviced on relevant topics to her position. The ADON stated the purpose of care plans was for staff to know how to properly care for the residents and their needs. The ADON confirmed focus were as such as hospice services should be included in a resident's care plan. The ADON stated that a possible negative outcome from an incomplete care plan would be a lack of knowledge of the residents' needs and necessary services. The ADON agreed Resident #14's care plan was incomplete and incorrect. She stated there were several essential focuses were missing that could lead to the resident not getting the services needed.In an interview on [DATE] at 2:50 PM, the DON stated he had been in his position since [DATE]. The DON stated that he left the accuracy and completion of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the comprehensive care plans system and monitoring to their MDS nurse which resulted in Resident #14's incomplete care plan. The DON stated care plans should include services and interventions necessary to provide appropriate treatment for identified problems. The DON stated if there was no clear pathway to treat the residents' problem were as, harm may be caused. The DON stated that triggered care were as in the MDS assessment should be carried over to the care plan. The DON agreed that Resident #14's care plan was not complete.In an interview on [DATE] at 2:55 PM, CNA D stated she worked for the facility for almost 4 years. She confirmed she had been appropriately oriented, trained, and in-serviced on relevant topics for her position. CNA D stated the importance of care plans was to determine residents' needs. She stated if she saw an incomplete service plan, she would ask the appropriate staff member or bring it to their attention.In an interview on [DATE] at 3:05 PM, LVN A stated he had worked for the facility for 3 months. He stated that he had been oriented, trained, and in-serviced on relevant topics for his position, including care plans. He stated that care plans needed to be complete to provide the residents with the best therapeutic care possible. He stated that focus were as such as hospice and pneumonia should be included in a resident's care plan. He stated a possible negative outcome of an incomplete care plan would be decreased health.In an interview on [DATE] at 3:15 PM, the ADM stated that she could not speak directly to the contents of a comprehensive care plan and would defer to the facility's MDS nurse. The ADM stated that a possible negative outcome of an incomplete comprehensive care plan was that the resident would not receive adequate care.Record review of the facility's policy entitled, Care Plans, Comprehensive Person-Centered states:A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident.Furthermore, the policy interpretation and implementation states:1.The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7.The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes;b. describes the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.c. includes the resident's stated goals upon admission and desired outcomes.d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem were and conditions.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure the safe storage of medications and medical supplies within the medication cart for 1 of 2 medication carts (medication cart on 100 hall) reviewed for pharmacy services. The facility failed to prevent the storage of expired medication and supplies in the medication cart on 100 hall. This deficient practice could place residents at risk of the medications and supplies not being as effective and dealing with the symptoms that the meds were supposed to treat.The findings included: Observation on 06/03/2026 at 02:20 pm showed that the following medication and supplies were expired in the medication cart of the 100 Hall: 1. OCuSoft Lid Scrub Plus, which was used as an Eyelid Cleanser for moderate-severe conditions, expired on 12/2025.2. Nystop. Nystatin Topical Powder, USP 100,000 USP Units Per Gram (Treat fungal infections) expired on 05/31/2026.In an interview on 06/03/2026 at 02:51 p.m., LVN B stated she had been working at the facility for about 3 months. LVN B stated she checked expired medication every couple of weeks. LVN B stated that expired medication can affect its potency, becoming either stronger or weaker in its effects. LVN B stated that she will check more promptly, at least once a week, to prevent expired medication from being in the medication cart. LVN B stated she had been trained to check for expired medication and immediately removed the found expired medications from the medication cart. In an interview on 06/04/2026 at 02:18 p.m., ADON stated that the negative outcome of expired medication was: Expired medication cannot get the full chemicals of the medication and not fully absorbed, which can cause a negative reaction. ADON stated that interventions could be implemented to prevent expired medication from being administered to residents, such as regularly checking stock levels. ADON stated it was the responsibility of the nursing staff to check the expired medication, and anyone assigned to the medication cart. ADON stated she checks the medication cart every month. In an interview on 06/04/2026 at 02:32 p.m., DON stated that a negative outcome of expired medication could be a medication error because one could mistakenly pass that medication and potentially cause patient harm, or the medication may not be therapeutic. DON stated that an intervention can be taken to prevent expired medication from being administered to residents, which includes the following: cart checks being performed in mid-month, not only by the ADON, but also by nurses, who should check the expiration date with each medication administration. In an interview on 06/04/2026 at 03:16 p.m., ADM stated that she would refer to her clinical staff regarding the negative outcomes associated with expired medications. ADM stated that interventions could be taken to prevent expired medication from being administered to residents by checking the medication cart monthly. ADM stated that it is the responsibility of the nursing staff and the ADON to check for expired medication. Review of the facility's policy titled Medication Labeling and Storage, revision date February 2023, revealed under the Medication Storage: 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding resuming or destroying items.