STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745050	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kerrville	1555 Bandera Hwy Kerrville, TX 78028

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 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. (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 0656 Level of Harm - Minimal harm or potential for 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 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 5 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's comprehensive care plan included information on required ADL care and assistance, interventions for cardiac diet, or interventions for nutritional status with a weight management plan. This failure could place residents at risk for not having their needs and preferences met. The findings include:Record review of Resident #1's face sheet dated 9/30/2025 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: morbid (severe) obesity due to excess calories, Body mass index (BMI) [TF1] 50.0-59.9 (normal BMI for adult male was 18.5-24.9), and metabolic encephalopathy (brain disfunction with symptoms such as confusion, memory loss). Record review of Resident #1's admission MDS, dated [DATE], revealed a BIMs score of 15, which indicated the resident was cognitively intact. The assessment indicated the resident had impairment to the lower extremities with ADL requirements of total dependance for toileting, showering/bathing, lower body dressing and footwear and moderate assistance for oral hygiene, personal hygiene and upper body dressing. The assessment indicated the resident weighed 384 lbs[TF2] . Record review of Resident #1's physician orders revealed an order, dated 9/03/2025, for:Cardiac DietSemaglutide-Weight Management Subcutaneous Solution Auto-Injector 0. 25 mg[TF3] //0.5 ml[TF4] one time a day every Monday for weight loss Record review of Resident #1's Care Plan, initiated on 9/04/2025, revealed: Impaired Physical Mobility was added to the care plan on 9/04/2025 with an intervention to determine level of needed assistance based on ADL evaluation that had no follow up of required ADLs. Nutrition: Cardiac Diet was added to the care plan on 9/09/2025 with no interventions. Intake more than body requirements with an intervention to evaluate exact height and no mention of weight and monitor resident's nutritional intake but no direction on what ideal intake or other interventions should be in place. The care plan did not address obesity or semaglutide or weight management program. During an observation and interview on 10/01/2025 at 1:44 p.m., revealed Resident #1 was observed in his room in a bariatric bed. The resident was obese and positioned on his back and slightly to the left side. He was unable to move from that position and had limited ability to reach across him or behind him. The resident stated he needed the assistance of 3-4 staff members for bathing, turning and positioning in bed. He stated he was unable to maneuver in bed independently. He stated he had the ability to get out of bed with a lot of assistance but preferred to remain in bed. He stated he was unable to walk. Resident #1 stated he was on a diet which included eating what he wanted when he wanted. He stated he ate his normal facility provided diet and staff would give him snacks of crackers and other items depending on what they had on hand. During the interview Resident #1 pushed his call light, when staff responded he requested repositioning, three therapy staff and 1 CNA responded to reposition the resident. During an interview on 10/01/2025 at 4:00 p.m. , LVN A stated Resident #1 utilized his call light a lot and required staff assistance and attention frequently. LVN A stated Resident #1 was on Ozempic (Semaglutide) and they were trying to get him to lose weight so he would be healthier and could participate in his own care and in therapy. LVN A stated the resident could have snacks in addition to his prescribed diet. He stated staff should monitor his food intake and record it in the medical record. LVN A stated he did not have anything to do with the care plans and was not certain what should be contained in them. He stated he wasn't sure who was responsible for the care plans. During an interview on 10/01/2025 at 5:05 p.m., the MDS Coordinator stated Resident #1 was totally dependent on staff for his care and needed help with moving, sitting, etc[TF5] . She stated Resident #1's care plan did not specify what his bed mobility or other ADL requirements were, or the number of staff needed to provide his care. She stated a place holder was added to the care plan, but the care itself was not specified. The MDS Coordinator stated Resident #1's care plan also included spaces for cardiac diet with no interventions because that part of the care plan was not finished. She stated the part that indicated intake more than body requirements was created but an evaluation of the resident's weight and goals were not specified. The MDS Coordinator stated she was the only full-time MDS Coordinator at the facility. She stated care plans were primarily her responsibility. She stated they used to have weekly care plan meetings on Thursdays, and they had not occurred in one month. She stated she was new to the role of MDS Coordinator and needed more

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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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered by the State to for 72 of 72 residents reviewed for qualifications of activity professionals.The facility failed to have a qualified Activities Professional to direct their activities program. This deficient practice could place residents at risk of not receiving approaches that were individualized to match the skills, abilities, and interests/preferences of each resident for activities.The findings include: During an interview on 10/01/2025 at 3:40 p.m., the HR [TF1] Director stated the personnel file for the Activity Director did not have any proof of education. He stated it was his understanding, the Activity Director had a year to complete training. The HR Director stated the Administrator had intentions on enrolling the Activity Director in training but as of this interview she had not yet been enrolled. During an interview on 10/01/2025 at 4:46 p.m., the Activity Director stated she was the facility Activity Coordinator. She stated she had been in the position for the past 4-5 weeks. She stated she did not have any training right now and was not currently enrolled in any training for Activity Director. She stated she was not an OT[TF2] or OTA[TF3] , and she did not have any prior experience. She stated she was doing a little trial run to see if she was interested in the position. She stated she wanted to make sure she could take the job seriously and do the position justice and do it right. The Activity Director stated she loved the job. She stated she communicated to the Administrator within the first week that she wanted to do it full time. During an interview on 10/02/2025 at 1:03 p.m., the Administrator stated the Activity Director was hired as an assistant because she worked at as CNA. The Administrator stated the facility was working on getting her certified and she was going to be enrolled in one of the training courses for Activity Director. He stated she was not currently registered for the training. The Administrator stated he did not have anyone else who met the Activity Director requirements. He stated it was important to have an Activity Director on staff who met requirements to assist with cognition, so residents' had the opportunity to express themselves and so they could flourish in their home[TF4] [TF5] . Record review of the facility's, unsigned and undated, job description for the Activity Coordinator, revealed: Qualifications: previous office experience preferred, previous nursing home experience preferred, previous supervisory experience preferred. Record review of the facility's policy titled Activity Program, dated June 2018, revealed: The Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. The policy did not address the Activity Director.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medical records were maintained in accordance with accepted professional standards and practices for each resident, that were complete and accurately documented for 1 of 6 residents (Residents #2[TF1]) reviewed for accuracy of medical records. The facility failed to ensure Resident #2's progress notes were documented accurately and according to professional standards of practice when RN B documented under LVN A's profile. This deficient practice could place residents at risk for errors in care and treatment and inaccuracies in documentation. The findings include: Record review of Resident #2's face sheet dated 9/30/2025 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: retention of urine, type 2 diabetes mellitus and hypertension. [TF1] Record review of Resident #2's EMR revealed a progress note, dated 9/24/2025 at 18:10 (6:10 p.m.), of an assessment note, with RN B's typed name at the end of the note. The progress note, had a date and time stamp and electronic signature belonging to LVN A. During an interview on 10/01/2025 at 2:31 p.m., RN B stated she was a new RN, and this was her first job as a nurse. She stated she worked at the facility for two days on 9/24/2025-9/25/2025 before quitting. She stated on 9/24/2025 she was assigned LVN A to shadow and to learn the computer system. She stated she did not have her own log in to PCC. RN B stated she did not have her own assignment of patients to care for as she was supposed to be learning. RN B stated on 9/24/2025 she documented an assessment of Resident #1 using LVN A profile. She stated LVN A allowed her to use his profile to look around in the system to see how it worked. RN A stated LVN A was aware she was documenting under his profile. She stated he told her he would have to review and approve the note, but he was not with her when she entered it in the computer. RN B stated she had not been instructed to document in the EMR by any staff member. During an interview on 10/01/2025 at 4:00 p.m., LVN A stated he was training RN B on the system (PCC) on 9/24/2025. He stated she did not have any log in information, so he was training her how to use the system on his profile. LVN A stated RN B completed an assessment on Resident #2. LVN A stated RN B was doing stuff he didn't know she was doing. LVN A stated he did not know RN B had put the progress note in. He stated later that evening he saw it. He stated he did not realize she was actually writing a note in the medical record. LVN A stated RN B did not have his password. He stated he logged into PCC for her. He stated he thought she was just looking. LVN A stated after he saw the note he told the DON. He said the DON stated they were going to look over her notes. During an interview on 10/01/2025 at 5:32 p.m., the ADON stated she worked with RN B on day 1 (9/24/2025). She stated RN B would not stay with her trainer (LVN A) and was trying to do her own thing without direction of management. The ADON stated RN B had to be redirected multiple times. She stated RN B was making phone calls and charting things she was not authorized to chart. The ADON stated RN B was a new nurse and was very eager, but she was not fully trained. The ADON stated the next day, RN B called and said she would not be returning to the facility. The ADON stated she was not aware RN B had documented under LVN A's profile. She stated RN B should not have done that. The ADON stated the EMR was a permanent record of the resident. She stated another staff could not document under someone else's electronic signature because it had the appearance of something LVN A did. She stated if there was an error in documentation it would fall on LVN A[TF2] . During an interview on 10/01/2025 at 6:00 p.m., the DON stated RN B was a new nurse with no experience. She stated she was only at the facility for 12 hours and that was enough for her. She stated after the 12 hours she called and said she was not cut out for nursing and never came back. The DON stated when she found out RN B had documented under LVN A's credentials, she told RN B no that was not okay. She stated she told RN B it was never okay to document under someone else. The DON stated it was falsifying documentation and could get someone in trouble. The DON stated LVN A was not graining [TF3] RN B on any nursing skills. He was training her on the computer. She stated she told HR she did not want RN B back in the building after this occurred. Record review of the facility's policy titled Charting and Documentation, dated July 2017, revealed: 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 4. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g. RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy.