STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Rose Trail	930 S Baxter Tyler, TX 75701

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 4 residents (Resident #1) reviewed for significant medication errors. The facility failed to ensure Resident #1 was administered his evening dose of apixaban (also known under the brand name Eliquis, an anticoagulant medication used to treat and prevent blood clots) on 1/1/26 and his morning dose (of apixaban) on 1/2/26. This failure could place residents at risk of not receiving the therapeutic effect of medications used to treat significant medical diagnosis and could result in significant health complications. Findings included: Record review of Resident #1's face sheet dated 03/05/26, reflected he was a [AGE] year old male admitted to the facility on [DATE] with diagnoses which included, unspecified multiple injuries, driver injured in collision with other motor vehicles, nondisplaced fracture of base of neck right femur (a crack in the upper thighbone near the hip joint where the bone remains in proper alignment), displaced segmental fracture of shaft of ulna, right arm (fracture to the forearm bone where it breaks in at least two distinct places, creating a completely separated intermediate bone segment), fracture of the lower end of the right radius (break in the larger forearm bone near the wrist), nondisplaced bicondylar fracture of the right tibia (the top of the right shinbone is cracked on both the inner and outer sides, but the bone pieces remain in proper alignment), nondisplaced bicondylar fracture of the left tibia (the top of the left shinbone is cracked on both the inner and outer sides, but the bone pieces remain in proper alignment), displaced [NAME] fracture of the right tibia (bottom of the right shinbone is broken into multiple, misaligned pieces, extending into the ankle joint), displaced intraarticular fracture of unspecified calcaneus (fracture of heel bone), history of pulmonary embolism (blood clot in the lungs). The face sheet indicated he was discharged home with home health services on 01/30/26. Record review of the MDS dated [DATE] for Resident #1 reflected he was admitted to the facility on [DATE] after an acute hospital stay. The MDS indicated Resident #1 made himself understood and understood others. The MDS indicated Resident #1 did not have cognitive impairment (BIMS of 15). The MDS indicated Resident #1 had no behavior of rejecting care. The MDS indicated Resident #1 was dependent for all ADL care, and transfers. The MDS indicated Resident #1 was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS indicated Resident #1 had a history of pulmonary embolism. The MDS indicated Resident #1 had received anticoagulant therapy during the 7-day look back period. Record Review of Resident #1's care plan dated 1/5/26, did not address the administration of anticoagulant therapy. Record review of the hospital Discharge summary dated [DATE], reflected Resident #1 was to be administered, apixaban (also known as Eliquis) 5 mg by mouth twice a day. The hospital discharge summary reported Resident #1 had last been administered this medication at 8:59 a.m., on 1/1/26. Record review of physician order with a start date of 1/2/26, reflected Resident #1 was to be administered apixaban 5 mg twice a day. Record review of Resident #1's MAR for January 2026, reflected Resident #1 was not administered apixaban on the evening of 1/1/26 and his morning dose (of apixaban) on 1/2/26. Record review of the nursing progress notes for Resident #1 dated 1/1/26 did not document any administration of apixaban for the evening of 1/1/26. Record review of the nursing progress notes for Resident #1 dated 1/2/26 did not document any (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Rose Trail	930 S Baxter Tyler, TX 75701

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration of apixaban for morning dose of 1/1/26. During an interview on 2/25/26 at 2:55 p.m., Resident #1's family member said he (Resident #1) had not been administered his anticoagulant medication on 1/1/26 or 1/2/26 while at the nursing facility. Resident #1's family member said Resident #1 did not develop a blood clot while in the nursing facility. Resident #1's family member said Resident #1 was now at home. During an interview on 3/5/26 at 11:25 a.m., LVN A said she recalled caring for Resident #1 on 1/1/26 upon his admission. LVN A said she worked the 6:00 a.m.-6:00 p.m. shift on that date. LVN A said she had not administered apixaban to Resident #1 on 1/1/26 as he came late in the shift but did not know if the nurse taking care him on 6:00 p.m. on 1/1/26 to 6:00 a.m. (1/2/26) had administered the medication. LVN A said she cared for Resident #1 on 1/2/26 from 6:00 a.m. to 6:00 p.m. LVN A said she could not recall if she had administered apixaban during that shift (6:00 a.m. to 6:00 p.m. on 1/2/26). LVN A said if she had administered apixaban to Resident #1 it should be documented on the MAR. LVN A said she always handed her patients off to LVN B and would have been the nurse who cared for Resident #1 on the 6:00 p.m. to 6:00 a.m. shift on 1/1/26. A phone interview was attempted with LVN B on 3/5/26 at 11:44 a.m. and was unsuccessful.A phone interview was attempted with LVN C on 3/5/26 at 12:36 p.m. and was unsuccessful. During an interview on 3/5/26 at 11:10a.m., ADON D said with a new admission nurses can pull significant medications such as Eliquis once orders have been entered. The ADON said Eliquis was a medication in the E-kit medication dispensing system stocked by the contracted pharmacy (secured, pharmacy-supplied kit containing essential, pre-approved significant medications and supplies for immediate use. It enables nurses to administer significant medications, without waiting for pharmacy delivery, often during nights or weekends). Record review of the E-Kit medication inventory on 3/5/26, found the facility had ten doses of Eliquis 2.5 mg in stock. During an interview on 3/5/26 at 1:59 p.m., the DON said he expected nursing staff to administer medications as ordered by the physician and to follow the facility's policy and procedure with regard to medication administration. The DON said with a new admission from a hospital, after orders were entered by the nursing staff, significant medications such as apixaban, would be available in the E-Kit medication dispensing system. He explained the nurse must enter a code provided by the contracted pharmacy service in order to pull the medication for the resident. The DON explained the contracted pharmacy would not supply that code until the orders entered. The DON said the facility tried to put orders into the contracted pharmacy in advance in order to secure the code needed to pull any significant medications promptly upon the new admissions arrival but the pharmacy would not allow them to do so. The DON said the contracted pharmacy would not allow the orders to be put in until the new admission arrived to the facility. The DON said Eliquis was a medication in the E-kit medication dispensing system stocked by the contracted pharmacy. The DON said the facility requested a report from the contracted pharmacy for Eliquis dispensed on 1/1/26 and 1/2/26 and was told by the contracted pharmacy they could not run a report that would provide that information. The DON said it was important for residents to receive their ordered anticoagulant medications to prevent significant complications that could result from blood clots. During an interview on 3/5/26 at 2:20 p.m., the Administrator said she expected nursing staff to administer medications as ordered by the physician and to follow the facility's policy and procedure with regard to medication administration. During an interview on 3/6/26 at 10:27 a.m., the pharmacy consultant stated she reviewed the E-kit system information at the facility for the date 1/1/26 and the date of 1/2/26 and said no Eliquis was pulled form the facility's E-Kit on those dates. Record review of the E-Kit medication inventory on 3/5/26, found the facility had ten doses of Eliquis 2.5 mg in stock. Record review of the facility's staffing sheet for 1/1/26 indicated Resident #1 was cared for by LVN C on the 6:00 p.m. to 6:00 a.m. shift of 1/1/26. Record review of the facility's policy and procedure tiled, Administering Medications, revised April of 2019, stated Medications are administered in a safe and timely manner and as prescribed. Record review of the facility policy and procedure tiled. Medication Orders and Reorder, dated May of 2025, stated .4. Emergency Medication Ordering-Emergency or STAT medications may be obtained (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455429	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Rose Trail	930 S Baxter Tyler, TX 75701

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through emergency drug kits, Pyxis/Medbank, STAT pharmacy delivery, or provider STAT orders entered in EHR. Emergency medications must still be entered into EHR and documented on the eMAR.