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	06/26/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property and exploitation for 2 of 10 residents (Resident #1 and Resident #2) reviewed for misappropriation of funds. The facility failed to ensure CNA/Staffing Coordinator B did not take money from Resident #1 and Resident #2 for her personal use. This failure could place residents at risk for decreased quality of life and misappropriation of funds. The findings include: 1. A record review of Resident #1's face sheet dated 06/25/2026 indicated a [AGE] year-old male who was originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic obstructive pulmonary disease with (acute) lower respiratory infection (a condition characterized by obstructed airflow due to inflammation and damage in the airways), cognitive communication deficit, unspecified lack of coordination, muscle weakness, and atherosclerotic heart disease of native coronary artery with unstable angina pectoris (a condition in which plaque buildup in the heart's arteries cause narrowing or blockage, leading to chest pain). A record review of Resident #1's most recent Quarterly MDS, dated [DATE], indicated a BIMS of 12, which indicated moderate cognitive impairment. Section GG of Resident #1's MDS indicated he was dependent on staff for toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. 2. A record review of Resident #2's face sheet dated 06/25/2026 indicated a [AGE] year-old female who was originally admitted to the facility on [DATE]. Resident #2 had diagnoses which included paraplegia, incomplete (partial paralysis of the lower body where some sensation or movement remains below the spinal cord injury), unspecified lack of coordination, muscle weakness, disorder of the autonomic nervous system (dysfunction in the nervous system that controls involuntary bodily functions such as heart rate, blood pressure, and sweating), and sickle-cell disease without crisis (an inherited blood disorder that causes red blood cells to become rigid and sticky which can block blood flow, cause pain, and damage organs). A record review of Resident #2's most recent Annual MDS, dated [DATE], indicated a BIMS of 15, which indicated intact cognitive function with minimal or no impairment. Resident #2's was dependent on staff for toileting hygiene, lower body dressing, and putting on/taking off footwear. Resident #2 required substantial/maximum assistance for showering/bathing herself and upper body dressing. Resident #2 required partial/moderate assistance with personal hygiene. A record review of a witness statement dated 06/23/2026, signed by the ADM, indicated on 06/23/2026 a staff member notified her a resident alleged CNA/Staffing Coordinator B had borrowed money from him and failed to repay it. The ADM indicated the resident alleged CNA/Staffing Coordinator B withdrew $270.00 from his account; $150.00 which was permitted by the resident for CNA/Staffing Coordinator B to repay another staff member from whom CNA/Staffing Coordinator B had previously borrowed from and another unauthorized $120.00. A record review of a witness statement dated 06/23/2026, signed by the DON, indicated Resident #1 alleged CNA/Staffing Coordinator B informed him she needed $150.00, he provided her with his bank card, and she withdrew $270.00. Resident #1 alleged CNA/Staffing Coordinator B advised him she would pay him on her next payday, though she did not repay the money and four pay periods had passed. A record review of a witness statement dated 06/23/2026, signed (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by CNA/Staffing Coordinator B, indicated she denied she took money from Resident #1's account but did have his bank card to shop for Resident #1. CNA/Staffing Coordinator B indicated she notified the BOM and was told if it was over a certain amount to obtain a receipt. A record review of a witness statement dated 06/24/2026, signed by the ADM, indicated RN A notified the ADM during the investigation process CNA/Staffing Coordinator B borrowed money from herself and two residents. The ADM indicated she asked who the residents were and why RN A did not report this. RN A indicated the residents included Resident #1 and Resident #2. The ADM indicated she interviewed Resident #2 and she stated she loaned CNA/Staffing Coordinator B $200.00 and was paid back. A record review of a witness statement dated 06/24/2026 signed by RN A indicated she was told by Resident #2 CNA/Staffing Coordinator B borrowed money from her and paid her back later that day. RN A indicated she was told by Resident #1 CNA/Staffing Coordinator B borrowed money from him and had not paid him back. During an interview on 06/25/2026 at 9:46 AM, Resident #1 stated CNA/Staffing Coordinator B asked him for $150.00 an estimated 3 months prior. Resident #1 stated he gave CNA/Staffing Coordinator B his bank card and permitted her to withdraw the $150.00 and CNA/Staffing Coordinator B took another unauthorized $120.00. Resident #1 stated he did not know how to obtain these records and was aware because he got a notification from the bank on his phone. Resident #1 indicated he had not been repaid these funds. Resident #1 stated this event made him feel disappointed in CNA/Staffing Coordinator B and disappointed in himself for lending her the money. Resident #1 stated CNA B told him she took the extra $120.00 to play a gambling game on her phone. Resident #1 stated he did not want CNA/Staffing Coordinator B to lose her job and he did not want to press charges. During an interview on 06/25/2026 at 10:06 AM, Resident #2 declined to answer when asked if staff had ever asked for money. Resident #2 declined to identify how much money she had given staff but stated she was repaid. Resident #2 stated you already know her name when asked who the staff member was that borrowed money from her. Resident #2 nodded up and down when she was asked if the staff member that borrowed money from her was CNA/Staffing Coordinator B. Resident #2 declined to answer any further questions regarding this matter. During an interview on 06/25/2026 at 1:37 PM, CNA/Staffing Coordinator B denied she took money from Resident #1 and Resident #2. CNA/Staffing Coordinator B stated she would often obtain Resident #1's bank card to get him food, tobacco products, or items from the store. CNA/Staffing Coordinator B stated she also took Resident #2's bank card to run errands for her. CNA/Staffing Coordinator B stated she did not keep any receipts and gave them to the residents when she obtained them from the stores. CNA/Staffing Coordinator B stated she notified the BOM Resident #1 gave her his card and stated the BOM told her it was fine as long as it was not over a certain amount because she would need a receipt. CNA/Staffing Coordinator B stated an estimated month ago Resident #1 began making her feel uncomfortable with his requests and she stopped going to the store for him. CNA/Staffing Coordinator B stated she was assigned as his aide on 06/23/2026, he requested she not provide care, she notified RN C, RN C went to speak with Resident #1, and then she learned of the allegation that she took his money. During an interview on 06/25/2026 at 2:10 PM, Resident #1 stated he provided CNA/Staffing Coordinator B with his bank card for her to go to the store and buy him items. Resident #1 stated CNA/Staffing Coordinator B came to him one day and asked for $150.00 because she had lent money to RN A and RN A was requesting it from her and that was when he permitted her to use his bank card to withdraw $150.00. During an interview on 06/25/2026 at 2:15 PM, RN A stated she had recently learned CNA/Staffing Coordinator B borrowed money from Resident #1 and Resident #2. RN A stated she reported this to the ADM on 06/24/2026. RN A stated the ADM was the Abuse Coordinator. RN A stated CNA/Staffing Coordinator B owed her $400.00. RN A stated staff were educated that they were not to obtain money from residents for any reason. During an interview on 06/25/2026 at 3:21 PM, the BOM stated she was unaware of any staff members using any resident's cards aside from the activity director as part of the activities program. The BOM stated Resident #1 and Resident #2 were their own payee's and managed their own funds. The BOM stated she was (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unaware of any staff members asking residents for money. During an interview on 06/25/2026 at 3:35 PM, the SW stated Resident #1 confirmed to her that CNA/Staffing Coordinator B had taken his money. The SW stated Resident #1 did not want his money returned and he felt sorry for her. The SW stated it was plausible CNA/Staffing Coordinator B was taking money from residents as she had borrowed from multiple staff members. The SW stated Resident #1 stated CNA/Staffing Coordinator B took the money approximately in May. The SW stated Resident #2 denied to her CNA/Staffing Coordinator B ever asked her for money, but when asked by the ADM Resident #2 stated she took $200.00. During an interview on 06/26/2026 at 8:17 AM, RN C stated Resident #1 told her on Tuesday, 06/23/2026, he had given his bank card to CNA/Staffing Coordinator B to get money out of the ATM and was notified by his phone that CNA/Staffing Coordinator B took more out than he told her to. RN C stated she notified the ADM immediately. RN C stated there were no other residents she knew of that alleged misappropriation and no other staff members who knew of the allegations at that time. During an interview on 06/26/2026 at 10:19 AM, the DON stated the ADM notified him Tuesday, 06/23/2026, of the allegation of misappropriation. The DON stated CNA/Staffing Coordinator B was suspended immediately. The DON stated it was determined CNA/Staffing Coordinator B took the money from Resident #1 due to resident statement and multiple employee's reporting she borrowed money from them and had not repaid them. The DON stated CNA/Staffing Coordinator B had a trend of not repaying borrowed money. The DON stated he was unsure if CNA/Staffing Coordinator B received money from Resident #2 as she did not speak much about it. During a telephone interview on 06/26/2026 at 11:03 AM, the ADM stated RN C notified her of the allegation of misappropriation and it was immediately investigated. The ADM stated she did believe CNA/Staffing Coordinator B took Resident #1 and Resident #2's money. The ADM stated the SW completed safe surveys and no other residents were identified to have concerns regarding misappropriation. During an interview on 06/26/2026 at 12:10 PM, the DON stated he believed CNA/Staffing Coordinator B was a further risk to residents regarding misappropriation. The DON stated he would not allow CNA/Staffing Coordinator B to return to providing care to the residents as he felt she could do it again. A record review of an in-service training report, dated 01/12/2026, signed by CNA/Staffing Coordinator B, indicated CNA/Staffing Coordinator B was provided in-service training on the subject of abuse, neglect, exploitation, and misappropriation prevention program/reporting. A record review of a police report, dated 06/23/2026, indicated the police department was made aware a nurse had taken more than an agreed amount out of a residents banking account. The police report indicated the resident did not wish to make a report, but the ADM requested a report. A record review of a Record of Employee Counseling, dated 06/23/2026, signed by CNA/Staffing Coordinator B and the ADM, indicated CNA/Staffing Coordinator B was suspended pending the outcome of the investigation. A record review of a facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, indicated the following: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than two hours after the allegations were made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for 2 of 10 residents (Resident #1 and Resident #2) reviewed for reporting misappropriation of property. The facility failed to ensure RN A immediately reported an allegation of misappropriation towards Resident #1 and Resident #2 by CNA/Staffing Coordinator B to the abuse coordinator. This failure could place residents at risk for financial exploitation, psychosocial harm, and unaddressed allegations of abuse. The findings included: 1. A record review of Resident #1's face sheet dated 06/25/2026 indicated a [AGE] year-old male who was originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic obstructive pulmonary disease with (acute) lower respiratory infection (a condition characterized by obstructed airflow due to inflammation and damage in the airways), cognitive communication deficit, unspecified lack of coordination, muscle weakness, and atherosclerotic heart disease of native coronary artery with unstable angina pectoris (a condition in which plaque buildup in the heart's arteries cause narrowing or blockage, leading to chest pain). A record review of Resident #1's most recent Quarterly MDS, dated [DATE], indicated a BIMS of 12, which indicated moderate cognitive impairment. Section GG of Resident #1's MDS indicated he was dependent on staff for toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. 2. A record review of Resident #2's face sheet dated 06/25/2026 indicated a [AGE] year-old female who was originally admitted to the facility on [DATE]. Resident #2 had diagnoses which included paraplegia, incomplete (partial paralysis of the lower body where some sensation or movement remains below the spinal cord injury), unspecified lack of coordination, muscle weakness, disorder of the autonomic nervous system (dysfunction in the nervous system that controls involuntary bodily functions such as heart rate, blood pressure, and sweating), and sickle-cell disease without crisis (an inherited blood disorder that causes red blood cells to become rigid and sticky which can block blood flow, cause pain, and damage organs). A record review of Resident #2's most recent Annual MDS, dated [DATE], indicated a BIMS of 15, which indicated intact cognitive function with minimal or no impairment. Resident #2's was dependent on staff for toileting hygiene, lower body dressing, and putting on/taking off footwear. Resident #2 required substantial/maximum assistance for showering/bathing herself and upper body dressing. Resident #2 required partial/moderate assistance with personal hygiene. A record review of a witness statement, dated 06/23/2026, signed by the ADM, indicated on 06/23/2026 a staff member notified her a resident alleged CNA/Staffing Coordinator B had borrowed money from him and failed to repay it. The ADM indicated the resident alleged CNA/Staffing Coordinator B withdrew $270.00 from his account; $150.00 which was permitted by the resident for CNA/Staffing Coordinator B to repay another staff member from whom CNA/Staffing Coordinator B had previously borrowed from and another unauthorized $120.00. A record review of a witness statement, dated 06/23/2026, signed by the DON, indicated Resident #1 alleged CNA/Staffing Coordinator B informed him she needed $150.00, he provided her with his bank card, and she withdrew $270.00. Resident #1 alleged CNA/Staffing Coordinator B advised him she would pay him on her next payday, though she did not repay the money and four pay periods had passed. A record review of a witness statement, dated 06/23/2026, signed by CNA/Staffing Coordinator B, indicated she denied she took money from Resident #1's account but (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did have his bank card to shop for Resident #1. CNA/Staffing Coordinator B indicated she notified the BOM and was told if it was over a certain amount to obtain a receipt. A record review of a witness statement, dated 06/24/2026, signed by the ADM, indicated RN A notified the ADM during the investigation process CNA/Staffing Coordinator B borrowed money from herself and two residents. The ADM indicated she asked who the residents were and why RN A did not report this. RN A indicated the residents included Resident #1 and Resident #2. The ADM indicated she interviewed Resident #2 and she stated she loaned CNA/Staffing Coordinator B $200.00 and was paid back. A record review of a witness statement, dated 06/24/2026, signed by RN A, indicated she was told by Resident #2 that CNA/Staffing Coordinator B borrowed money from her and paid her back later that day. RN A indicated she was told by Resident #1 CNA/Staffing Coordinator B borrowed money from him and had not paid him back. During an interview on 06/25/2026 at 9:46 AM, Resident #1 stated CNA/Staffing Coordinator B asked him for $150.00 an estimated 3 months prior. Resident #1 stated he gave CNA/Staffing Coordinator B his bank card and permitted her to withdraw the $150.00 and CNA/Staffing Coordinator B took another unauthorized $120.00. Resident #1 stated he did not know how to obtain these records and was aware because he got a notification from the bank on his phone. Resident #1 indicated he had not been repaid these funds. Resident #1 stated this event made him feel disappointed in CNA/Staffing Coordinator B and disappointed in himself for lending her the money. Resident #1 stated CNA B told him she took the extra $120.00 to play a gambling game on her phone. Resident #1 stated he did not want CNA/Staffing Coordinator B to lose her job and he did not want to press charges. During an interview on 06/25/2026 at 10:06 AM, Resident #2 declined to answer when asked if staff had ever asked for money. Resident #2 declined to identify how much money she had given staff but stated she was repaid. Resident #2 stated you already know her name when asked who the staff member was that borrowed money from her. Resident #2 nodded up and down when she was asked if the staff member who borrowed money from her was CNA/Staffing Coordinator B. Resident #2 declined to answer any further questions regarding this matter. During an interview on 06/25/2026 at 4:14 PM, RN A stated Resident #1 and Resident #2 notified her of the alleged misappropriation on Monday, 06/22/2026. RN A stated she did not report the allegation at that time, then was off for 2 days, when she returned there was a meeting regarding the issue and that was when she told the ADM. RN A stated she did not notify the ADM because she did not know it was such a big deal. RN A stated she was in-serviced on timely reporting of misappropriation. RN A stated she probably should have reported the allegations immediately. During an interview on 06/26/2026 at 10:19 AM, the DON stated he RN A did not work Monday. During an interview on 06/26/2026 at 10:40 AM, RN A stated she learned of the allegations of misappropriation on Sunday, 06/21/2026. RN A stated she did not inform the ADM until Wednesday, 06/24/2026. RN A stated she did not initially think it was a big deal because Resident #2 was repaid, then stated it was a big deal because staff should not take money from residents. RN A stated she was the weekend supervisor at the time she learned of the allegations. RN A stated that was probably poor judgement, but at the time she did not think it necessary to call the ADM. During an interview on 06/26/2026 at 10:43 AM, the DON stated RN A should have reported the allegations of misappropriation immediately. The DON stated RN A was in-serviced on timely reporting of allegations of misappropriation. The DON stated RN A should have reported this to the Abuse Coordinator, the ADM. The DON stated if misappropriation was not reported timely it left residents at risk for further harm. During a telephone interview on 06/26/2026 at 11:03 AM, the ADM stated she called the facility to speak with the weekend supervisor each Saturday and Sunday regarding general facility information. The ADM stated RN A did not inform her of the allegations of misappropriation during the phone call. The ADM stated RN A notified her while she and the DON were meeting with Resident #1 and RN A stated she knew and did not think it was a big deal. The ADM stated she expected staff to notify her immediately when they suspected any abuse, neglect, or exploitation. The ADM stated all staff were in-serviced on identifying and reporting abuse, neglect, and exploitation. The ADM stated the risk to residents for not reporting timely included (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further misappropriation and abuse to residents. A record review of RN A's personnel file indicated an Abuse, Neglect, and Exploitation Statement, dated 07/16/2025, signed by RN A, which indicated the following: Residents of the facility shall not be subject to abuse, neglect, or exploitation by company employees, and if a resident accuses an employee of abuse certain procedures will be followed (see Abuse Policy in the facility Policies and Procedures).Exploitation:The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary or personal benefit profit, or gain without the informed consent of the elderly of disabled person. A record review of RN A's personnel file indicated a Record of Employee Counseling, dated 12/30/2025, which indicated RN A had failed to inform the ADM of an allegation of abuse. The Record of Employee Counseling indicated RN A was in-serviced individually on abuse, neglect, and reporting. A record review of an in-service training report, dated 12/30/2025, signed by RN A indicated RN A was provided in-service training individually on the subject of abuse, neglect, exploitation and misappropriation prevention program - reporting. A record review of an in-service training report, dated 01/28/2026, signed by RN A indicated RN A was provided in-service training on the subject of abuse, neglect, exploitation, and misappropriation prevention program. A record review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, indicated the following: If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines.