

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Avir at Rose Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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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 observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions for 1 of 1 main facility kitchen. The facility failed to ensure a stainless steel sheet pan was clean and free of heavy carbon build-up. The facility failed to ensure food packaging in the dry pantry was sealed after opening. The facility failed to ensure the microwave was clean. The facility failed to ensure food items were labeled or dated. The facility failed to ensure scoops were not present in the bulk sugar container. These failures could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During observations and an interview on 12/01/25 of the kitchen the following was noted: *at 11:50 AM on the pan rack next to the prep sink a half-size stainless steel sheet pan was heavily caked with black carbon and the surface was burned black. The DM said at that time it was the emergency pan and it should be thrown away. He said it could be used for baking potatoes, *at 11:55 AM in the dry pantry a 16 oz. bag of potato chips was open and placed inside an opened zippered bag, *at 11:57 AM the microwave was soiled inside with food splatters and food debris, *at 12:12 PM the bulk sugar bin contained a 4 oz. plastic dessert cup in the sugar, *at 12:16 PM in the walk in cooler one 46-oz. container of nectar thick sweetened tea was opened and the container was not marked with an open date. The packaging indicated After opening may be kept up to 7 days under refrigeration. During a return visit to the kitchen on 12/02/2025 observations and an interview the following was noted: *at 11:37 AM in the dry pantry a 16 oz. bag of potato chips was open and placed inside an opened zippered bag, *at 11:38 AM the bulk sugar bin contained a 4 oz. plastic dessert cup in the sugar, *at 11:39 AM in the walk in cooler one 46-oz. container of nectar thick sweetened tea was opened and the container was not marked with an open date. The packaging indicated After opening may be kept up to 7 days under refrigeration. During an interview on 12/02/2024 at 12:45 AM, the DM said staff were to make sure the food packages placed in zippered bags were re-closed and sealed. He said staff were not leave scoops inside the products in the bulk bins. He said staff had been told to always date items when they are opened because that would keep insects, bugs, and other contaminants from getting into the foods. He said all staff should be aware but he was responsible to make sure it was done. Review of a facility policy, revised November 2022, on Sanitization indicated .2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corruptions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Review of a facility policy, revised November 2022, on Food Receiving and Storage indicated .Foods shall be received and stored in a manner that complies with safe food handling practices. 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) .7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. The Texas Food Establishment Rules, dated October 2015, revealed: S228.68. Preventing Contamination From Equipment, Utensils, and Linens. (a) Food shall only contact surfaces of: (1) equipment and utensils that are cleaned as specified under SS228.113, 228.114 and 228.115 of this title and sanitized as specified under SS228.116, 228.117 and 228.118 of (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455429	Facility ID: 455429 If continuation sheet Page 1 of 16

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this title; . S228.114. Frequency of Cleaning.(c) Nonfood-contact surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues Food and Drug Administration Code, Dated, 2013, indicated the following: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (B)The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations 3-305.11 Food StorageFood shall be protected from contamination by storing the food:(1) In a clean, dry location;(2) Where it is not exposed to slash, dust or other contamination .4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents (Resident #5, Resident #62, and Resident #72) reviewed for infection control. The facility failed to ensure CNAs E and F wore PPE when providing ADL care to Resident #72. The facility failed to ensure RN D wore PPE when providing tracheostomy care to Resident #5. The facility failed to ensure RN D wore PPE when providing enteral feeding to Resident #62. These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirements. Findings included: In an observation on 12/3/2025 at approximately 9:35 AM, Resident #72 had EBP signage in place and PPE (Personal protective equipment) was noted at the entrance to the resident room. In an observation on 12/3/2025 at approximately 9:35 AM CNA E and F entered Resident #72's room to perform ADL care and failed to sanitize their hands before entering. Both failed to don (put on) a gown to perform the ADLs. During an interview on 12/3/2025 at approximately 10:00 AM with CNA's E and F both stated they both failed to put on a gown to do ADLs with Resident #72 only resident in room and room had sign indicating EBP, they said, the residents doesn't like it when they wear gown. Both CNAs had been trained with evidence of signature on, Staff - Enhanced Barrier Questionnaire dated 10/3/2025. During an interview on 12/3/2025 at 10:30 AM Resident #72 said, 'she never told any CNA not to wear a gown when taking care of her, she said she rarely sees them wear gowns and she was not ok with them not wearing a gown. In an observation on 12/3/2025 at 1:00 PM RN D was noted in Resident #5's room who was on isolation/EBP. She was cleaning around the tracheostomy site; RN (D) was not wearing a mask or gown. There was signage indicating EBP was to be used and PPE was present at the room entrance area. In an observation on 12/3/2025 at 4:15 PM RN (D) was observed in Resident #62's room doing an enteral feeding and not wearing a mask or gown. There was signage indicating EBP was to be used and PPE was present at the room entrance area. In an interview on 12/4/2025 at 8:45 am with RN(D) she said she didn't notice that she had not put on a gown for both Resident #5 and Resident #62, but was aware of the EBP and what she should have done when doing care for both of the residents; The EBP signage states: When providing care for Dressing, bathing/Showering, transferring, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care any skin opening requiring a dressing. In an interview on 12/4/2025 at 9:00 AM, with RN D and IP (Infection Preventionist Nurse) both were able to state a potential negative outcome for failure to observe EBP on at-risk residents. These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirements. In an interview on 12/4/2025 at 10 AM with the Administrator, VP of Operations and the Director of Regulatory Services who all stated the staff in the building have all been trained and retrained on EBP (Enhanced Barrier Precautions), all three were able to state a potential negative outcome for failure to observe EBP on at-risk residents. These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirements. Record Review on 12/04/2025 of EBP Enhanced Barrier Precautions Policy dated 03/2024 indicated, EBP employs targeted gown, and gloves use in addition to standard precaution during high contact residents care activities when contact precaution do not otherwise apply .		

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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 interviews and record review, the facility failed to treat each resident with respect and dignity and cared for in a manner and environment that promoted the maintenance and /or enhancement of quality of life for 1 of 5 residents (Resident #6) reviewed for dignity and respect. LVN-H handled the Resident # 6's oxygen nasal cannula in a rough and abrupt manner, slapped it against the bed, and displayed frustration, demonstrating unprofessional conduct that did not promote the resident's quality of life. This failure has the potential to impact on the dignity of residents in the facility by causing residents to feel intimidated, threatened, or degraded. Findings included: Resident #6's face sheet dated 12/1/2025 revealed she was a [AGE] year-old female admitted [DATE], diagnosis of atrial fibrillation, vasomotor rhinitis, muscle weakness, monoplegia (paralysis affecting a single limb or body part) of lower left limb, acute respiratory failure with hypoxia (insufficient supply of oxygen), schizophrenia, mood disorders, acute kidney failure, and hypertension. A review of Resident #6's, quarterly MDS dated [DATE], revealed a BIMS score of 11 which indicated she was moderately impaired. Reviewed Resident #6 Care Plans dated 10/15/2025 indicated Resident will be cared for with dignity, intervention provide the resident with supportive care and services to promote a sense of safety well-being and positive self-image. On 12/1/2025 at 11:24AM Resident #6 and Resident #2 were interviewed regarding an incident that occurred on the weekend early Sunday morning 11/31/2025. Resident #6 stated she said the charge nurse came into my room to change my nasal cannula, abruptly she hit the bed with the nasal cannula tubing, she coincidentally hit me on the nose above her lip with the end of the nasal cannula tubing. Resident #6 said LVN-H looked frustrated when she did it and said, it hurt and made her feel like the nurse did not want to take care of her. Resident #6 said CNA-G, and her roommate (Resident #2), both witnessed the incident and both residents said they reported the incident to the RN weekend supervisor. Resident #6 said, later that morning LVN-H returned to the room to apologize and said she had been stressed, and very busy. Resident #6 denied having any injury beyond momentary discomfort but stated the incident made her feel disrespected. Residents #6, and Resident #2 said they felt safe in the facility. Reviewed Resident #2's Face sheet dated 12/4/2025 revealed she was a [AGE] year-old female admitted [DATE], diagnosis of sepsis, insomnia, cognitive communication deficit, alcoholic cirrhosis of liver, hypertension, major depressive disorder, anxiety disorder, and heart disease. A review of Resident #2, quarterly MDS reviewed a BIMS score of 12 dated 11/17/2025, which indicated she was moderately impaired. On 12/1/2025 at 11:30AM Resident #2 was interviewed on initial survey rounds said she was unsure if the nasal cannula hit Resident #6 but confirmed the interaction between LVN-H described by Resident #6, stated the incident was reported to the RN weekend supervisor. A review of the facility's statements dated 12/01/25 were as follows: A review of CNA-G statement dated 12/1/2025 indicated on 11/30/2025 CNA-G had notified LVN-H, Resident #6 had requested a nasal cannula. CNA-G stated he went to central supply and found a small nasal cannula. LVN-H said the nasal cannula was not the right size. Resident #6 said she had wanted a nasal cannula to hook behind her ears. CNA-G said he notified LVN-H, Resident #6 requested a new nasal cannula and stated LVN-H responded by she can get it tonight. CNA-G said he went to the RN weekend supervisor, requested a new nasal cannula for Resident #6. The RN weekend supervisor said she would notify LVN-H to get another nasal cannula for Resident # 6. CNA-G said once he returned to the nursing station, LVN-H asked, why did I go and tell on her. CNA-G said once they got the new nasal cannula from central supply, LVN-H entered the resident's room, she snatched the old cannula off the o2 concentrator and flung it onto the bed, then placed the new nasal cannula on Resident # 6 and walked out of the room. A review of the RN weekend supervisor statement dated 12/1/2025 indicated on 11/30/2025, LVN-H refused to give the resident the nasal canula, voicing the night shift nurse is going to give the resident that. She indicated (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she immediately went to talk with Resident #6. The RN weekend supervisor stated Resident #6 complained of LVN-H and had refused to care for her and give her another replacement cannula. She further said LVN-H was mean, rude, and she was tired of her attitude. The RN weekend supervisor stated, Resident #6 did not mention the nasal cannula hitting her. A review of the LVN-H statement dated 12/1/2025 indicated on 11/30/2025, Resident #6 requested a nasal cannula. She followed CNA-G into the room, and the resident stated she no longer wanted the nasal cannula. LVN-H stated later that day, Resident #6 requested a new nasal cannula. She instructed CNA-G to explain that it was scheduled to be replaced on Sunday night. Afterward LVN-H said she received a text message from the RN weekend supervisor stating that we needed to ensure Resident #6 had what she needed. LVN-H said she went to the Central supply, retrieved a new nasal cannula and went into the resident's room. She removed the old nasal cannula and placed it on the bed, placed the new one on the resident's face, and left the room and threw the old one away. On 12/1/2025 at 11:35A.M., interviewed CNA-G said Resident #6 requested a replacement nasal cannula. CNA-G stated he notified LVN-H, who responded, The resident can get the nasal cannula tonight. CNA-G reported he informed Resident #6 of the nurse's response. The resident told him I want it now. CNA-G stated, he attempted to locate the correct size nasal cannula but could not find one, so he notified the night weekend supervisor. The RN weekend supervisor told him she would ask LVN-H to obtain the nasal cannula. CNA-G said when LVN-H was informed to find a nasal cannula, she became upset and asked him Why did you go and tell on me? CNA-G stated, when LVN-H entered the resident's room, she snatched the old cannula off the o2 concentrator and flung it onto the bed, then placed the new nasal cannula on the resident and walked out of the room. CNA-G further states he was unsure if the nasal cannula hit the resident. On 12/1/2025 at 11: 36A.M., an attempt was made to contact RN supervisor, however there was no answer. A message was left requesting a return call to the State Surveyor phone number, but no return call was received during investigation. It was reported by the Administrator the RN supervisor only worked on the weekends. On 12/1/2025 at 11:37A.M., two attempts were made to contact LVN-H, however the attempts made was unsuccessful. The Administrator reported LVN-H denies allegations. On 12/1/2025 at 11:38A.M., interviewed the day shift RN-D said, she had morning report with the RN weekend supervisor, but the incident between Resident #6 and the weekend LVN-H was not reported. RN-D further stated that staff should never appear frustrated or irritated during residents' care. And the interaction between Resident # 6 and LVN-H should have been reported during morning report and to the abuse coordinator who was the Administrator. On 12/1/2025 at 11:40A.M., interviewed the ADON said this was the first time she had heard of the incident reported by Resident #6. ADON further said the LVN-H should never appear rushed during care and should have reported the incident to the Administrator, the abuse coordinator. On 12/1/2025 at 11:43A.M., interviewed the Administrator. said this was the first time she had learned of the incident between Resident #6 and LVN-H. She further stated she expects the facility staff to report any complaint or incident to her; she was the Abuse coordinator. The Administrator stated that the abuse policy was reviewed with the staff at least once a month. The Administrator said that a facility investigation immediately will be initiated. On 12/1/2025 at 12:15P.M., Administrator said on 12/1/2025 staff that were named in the allegations were suspended pending investigation. The Administrator further said during a phone interview with LVN-H she denied the allegations of the nasal cannula hitting Resident #6. On 12/04/2025 at 1:30 p.m., interviewed the DON said the facility administration team had conducted and completed abuse, neglect, exploitation, and dignity in-services training with staff's members. Re-educated staff on reporting and investigating in-services training with staff members, all had verbalized understanding of policies and in-services, and who to report to, which is the Abuse Coordinators. Review of the facility's Resident rights Policy states, Staff must not display anger, irritation, or disrespectful behavior during the provision of care. All staff must provide care in a manner that upholds dignity, respect, and resident preference.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure individuals with a diagnosis of mental illness were provided an accurate Preadmission Screening and Resident Review Level 1 (PASARR) Screening for 1 of 5 residents reviewed for PASARR (Resident #71). The facility failed to ensure that Resident #71 had an accurate PASARR Level 1 Screening indicating a diagnosis of mental illness on 06/24/2025. This failure could place residents at risk of not receiving needed assessments (PASARR Evaluation), individualized care, and specialized services to meet their needs. The findings included: Record review of an undated face sheet indicated Resident #71 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including schizophrenia (a psychiatric diagnosis usually characterized by psychotic behavior including delusions, hallucinations, withdrawal from reality, and disorganized patterns of thinking and speech) and depression (a mood disorder characterized by extreme sadness, poor concentration, sleep problems, and loss of appetite). Record review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #71 had a BIMS score of 0 (zero) indicating severely impaired cognition. The MDS section for PASARR indicated Resident #71 did not have a serious mental illness. The MDS section for active diagnoses indicated that Resident #71 had the psychiatric/mood disorders of depression and schizophrenia. Section B0100 indicated that Resident #71 was rarely/never understood, usually understands others, and has unclear speech. Record review of psychoactive medication consents for Resident #71 include consents for Depakote (an anticonvulsant used to treat mood disorders including mania, a state of abnormally elevated mood and energy) and Sertraline (an antidepressant used to regulate mood and emotions) dated 06/23/2025 and a nursing facility consent for antipsychotic or neuroleptic medication treatment for Olanzapine (an antipsychotic used to treat schizophrenia) dated 06/26/2025. Record review of physician's orders current as of 12/03/2025 indicated an order dated 10/28/2025 for 3 oral tablets of Sertraline 25 mg given daily for depression and an order dated 10/28/2025 for 1 oral tablet of Olanzapine 15 mg for schizophrenia. Record Review of Resident #71's PASARR Level 1 Screening completed by the referring entity on 06/24/2025 indicated in section C0100 this resident did not have evidence of having a mental illness. During an interview on 12/03/2024 at 3:19 PM, the MDS nurse stated she was responsible for tasks related to PASARR and MDS processes. The MDS nurse stated that Resident #71's PASARR Level 1 Screening should have indicated the diagnoses of depression and schizophrenia. She stated the potential negative outcome for not having accurate PASSAR screenings included the residents not getting the services they were entitled to. During an interview on 12/03/2025 at 2:00 PM, the ADM stated that residents who have a psychiatric diagnosis should have a completed PASSAR Level 1 Screening indicating these diagnoses. During an interview on 12/03/2025 at 3:45 PM, the [NAME] President of Clinical Operations acting as the interim DON stated that the facility did not have a policy on the PASSAR screening process and that they follow federal and state guidelines.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission and provide the resident and or the resident representative with a summary of the baseline care plan for 1 of 5 residents reviewed for the base line care plans. (Resident #90) The facility did not complete a baseline care plan within 48 hours of admission and provide a written summary of the baseline care plan to Resident #90 or their responsible party. This failure could place newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission. Findings included: A review of Resident #90's face sheet and physician's orders for December 2025 indicated the resident was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), mild neurocognitive (neurological disorders that affect cognitive functions) disorder, and cognitive communication disorder. A review of the electronic record on 12/01/2025 for Resident #90 indicated no documentation of a baseline care plan. During an interview on 12/03/2025 at 11:10 AM, the VP of Clinical Operations said the baseline care plan was not present in the clinical record for Resident #90. She said it was not done. She said the baseline care plan should have been initiated when Resident #90 admitted to the facility on [DATE] and completed on 11/28/2025. She said the RN in charge, usually the DON, should initiate the baseline care plan and the interdisciplinary team add to it and then it was presented to the resident and/or their responsible party and reviewed together. She said then the resident or the responsible party would sign they had received and reviewed the baseline care plan, and it would be indicated in the clinical record. A facility policy Care Plans - Baseline revised March 2022 indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. 4. The resident and/or representative are provided a written summary of the baseline care plan. 5. Provision of the summary is documented in the medical record.		

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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 observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 2 of 4 residents (Resident #34 and Resident #71) reviewed for care plans. 1. The facility failed to ensure that Resident #34's care plan included interventions for sexually inappropriate behavior. 2. The facility failed to ensure that Resident #71's care plan reflected the physician's order and intervention of enteral feedings. These failures could place residents at an increased risk of decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed/implemented to address their needs. The findings included: 1. A record review of an undated face sheet indicated Resident #34 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses of senile degeneration of brain (a decline in cognitive function associated with aging, characterized by memory loss, impaired judgement, and changes in behavior), weakness, and unspecified lack of coordination. A record review of the quarterly Minimum Data Set (MDS) dated [DATE] reflected Resident #34 had a BIMS score of 10 which indicated mild cognitive impairment. The MDS indicated Resident #34 utilized a cane or wheelchair for ambulation, was continent of bowel and bladder, and was able to voice concerns and needs. The MDS did not indicate any physical, verbal, or other behavioral symptoms. A record review of Resident #34's comprehensive care plan dated 8/14/2024 and revised 10/17/2025 did not include any indication of Resident #34's sexually inappropriate behavior nor did it identify any interventions. A record review of a progress note dated 11/26/2024 at 7:53 AM written by LVN J stated Resident #34 was noted with multiple complaints of sexual inappropriateness. A record review of progress note dated 11/03/2025 at 9:13 AM written by SW stated she spoke with Resident #34 about inappropriate touching of staff and provided education to Resident #34. During an interview on 12/02/2025 at 1:21 PM, LVN C stated that she was aware of Resident #34 having a history of inappropriate behavior. She stated it happens and it should not happen. During an interview on 12/03/2025 at 9:05 AM, RN D stated that Resident #34 has behaved inappropriately towards her and that he goes behind me and rubs up against my butt. RN D stated that the interventions she was aware of for Resident #34's behavior was to just keep a really close eye on him. During an interview on 12/03/2025 at 9:11 AM, the ADON stated that Resident #34 was the first resident she has had that exhibited sexually inappropriate behavior. She stated interventions included notifying the physician, notifying family, and providing Resident #34 with education on appropriate behavior. The ADON stated Resident #34's inappropriate behaviors should have been care planned. She stated any behaviors should be care planned. During an interview on 12/03/2025 at 9:15 AM, SW stated she was aware of Resident #34's inappropriate behavior. SW stated interventions included speaking with the family and educating Resident #34 on appropriate behavior. SW stated that Resident #34 had a history of inappropriate behaviors because he had two incidents. SW stated everyone was responsible for developing a care plan for Resident #34's inappropriate behavior. During an interview on 12/03/2025 at 9:21 AM, the ADM stated that she was aware of Resident #34's inappropriate behavior and that they intervened through redirection, contacting family, and providing education. The ADM stated that Resident #34's inappropriate behavior should have been care planned. During an interview on 12/03/2025 at 3:19 PM, the MDS nurse stated that she was responsible for updating care plans. The MDS nurse stated that Resident #34's inappropriate behavior was not and should have been included in the care plan. 2. A record review of an undated face sheet indicated Resident #71 was a [AGE] year-old male who was admitted on [DATE] and readmitted to the facility on [DATE] after a hospital stay. Resident #71 has diagnoses of gastro-esophageal reflux disease without esophagitis (a medical illness where stomach acid flows back into the esophagus without (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	causing inflammation or damage to its lining) and dysphagia oropharyngeal phase (a medical illness causing difficulty swallowing that occurs in the mouth and throat). A record review of the quarterly MDS dated [DATE] reflected Resident #71 had a BIMS score of 0, indicating severely impaired cognition. The MDS reflected Resident #71 was dependent of all functional abilities and used a feeding tube for nutritional approaches. A record review of Resident #71's physician's orders indicated an order for enteral feed every shift related to encounter for attention to gastrostomy. A record review of the Medication Administration Record dated 12/01/2025 through 12/03/2025 indicated Resident #71 received enteral feedings of Jevity 1.5 at 70 milliliters per hour via gastrostomy tube stationary pump with a down time of 2 hours at 50 cubic centimeter flushes per hour and receiving enteral site care each shift. A record review of Resident #71's comprehensive care plan dated 06/24/2025 and revised 10/16/2025 did not indicate Resident #71's enteral feeding status. During observation on 12/01/2025 at 11:31 AM, Resident #71 was observed lying in bed with the head rest propped up and enteral feeding on a continuous hang. During an interview on 12/03/2025 at 1:40 PM, the treatment nurse recognized that Resident #71 was on enteral feeding status. The treatment nurse was aware of Resident #71's enteral feeding status and physician order. The treatment nurse stated Resident #71's enteral feeding status should have been care planned. During an interview on 12/03/2025 at 1:50 PM, [NAME] President of Clinical Operations, acting as the DON, stated the MDS coordinator was responsible for care plans. She stated Resident #71's enteral feeding status should have been included in the care plans. During an interview on 12/03/2025 at 3:19 PM, the MDS nurse stated she was responsible for updating care plans. The MDS nurse stated Resident #71's enteral feeding status was not and should have been included in the care plan. A record review of the facility's policy dated March 2022 titled Care Plans, Comprehensive Person-Centered indicated the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being including: 1. services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.; 2. which professional services are responsible for each element of care.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and the residents goals and preferences for 1 of 2 residents (Resident #60) reviewed for oxygen therapy, in that: Resident #60's oxygen was set to 3.5 LPM on 3 consecutive days instead of 2 LPM as ordered by the physician. Resident #60's medical record did not include documentation of oxygen saturation checks and oxygen administration. These failures could place residents who receive oxygen therapy at risk for respiratory distress and incomplete medical records. Findings included: A review of a face sheet dated 12/03/2025 indicated Resident #60 was admitted to the facility on [DATE] with a diagnosis of respiratory failure. A review of a quarterly MDS assessment dated [DATE] noted Resident #60 had a BIMS score of 15 which indicated her cognition was intact. A review of Resident #60's physician orders dated 12/03/2025 reflected an order dated 07/08/2019 for Resident #60 to receive oxygen at 2 LPM as needed for shortness of breath to keep oxygen saturation above 92%. A review of Resident #60's undated care plan indicated Resident #60 had difficulty breathing and included directions to administer oxygen at 2LPM as needed to keep oxygen saturation above 92%. Resident #60 was observed receiving oxygen via a nasal cannula at 3.5 LPM on the following dates and times:- 12/01/2025 at 09:50 AM, - 12/01/2025 at 04:00 PM,- 12/02/2025 at 09:40 AM, and- 12/02/2025 at 04:30 PM, - 12/03/2025 at 09:30 AM. During an interview and observation on 12/03/2025 at 09:30 AM, Resident #60 said she wore oxygen all the time. She said she had been receiving oxygen therapy for years. She said she did not adjust the settings. She said she could not reach the oxygen concentrator from the bed to adjust the setting controls. Resident #60 reached her arm out toward the oxygen concentrator to demonstrate she could not reach it. Resident #60 said she depended on the nurses to regulate the oxygen settings. A review of Resident #60's December 2025 NMAR reflected a section designated for documentation of Resident #60's oxygen saturation and administration of oxygen. The section was blank and had no documentation to reflect oxygen saturation checks nor oxygen usage. Review of October 2025 and November 2025 NMARs indicated there was no documentation of oxygen saturation levels being checked nor any administration of oxygen therapy for those months. During an interview on 12/03/2025 at 09:36 AM, MA-A said she had been administering medications for a year at the facility and was a nurse aide at the facility prior to that. She said she knew Resident #60 had been receiving oxygen therapy for as long as she had been a medication aide and believed Resident #60 was receiving oxygen when MA-A was a nurse aide. During an interview and observation on 12/04/2025 at 09:41 AM, the Treatment Nurse said she was the nurse responsible for residents in the area where Resident #60 resided. She said the nurses were responsible for monitoring oxygen therapy to ensure flow rates were set as ordered by the physician. She said the nurses make rounds at the beginning of their shifts and throughout the day and check oxygen settings during those rounds. The Treatment Nurse said Resident #60's physician orders included an order for Resident #60 to receive oxygen at 2 LPM as needed. She said the nurses would have to check Resident #60's oxygen saturation to determine if oxygen therapy was needed. She said there were no instructions or orders regarding when or how often Resident #60's oxygen saturation was to be checked. She said she had not made it to Resident #60's room yet and did not know if Resident's was receiving oxygen at the physician ordered flow rate. The Treatment Nurse went to Resident #60's room, inspected the oxygen setting, and said it was set at 3.5 LPM. The nurse lowered the setting to 2 LPM. The Treatment Nurse said Resident #60 had been receiving oxygen therapy as long as she could remember. She said she did not know why Resident #60's oxygen therapy had not been documented in the medical record and could not identify any risks for a resident receiving oxygen at a rate higher than what is ordered by the physician. During an interview with the [NAME] (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	President of Clinical Operations (who was also an RN) on 12/03/2025 at 10:05 AM, she said the charge nurses were responsible for monitoring oxygen administration and documentation of oxygen therapy. She said the nurses were supposed to document oxygen saturation checks and oxygen administration on the NMAR. A review of the facility's Oxygen Administration Policy dated 03/14/2019 indicated the following: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation1. Verify that there is a physician's order for this procedure. Review the physician's orders, facility protocol, for oxygen administration. Assessment Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 3. Signs of oxygen toxicity 4. Vital signs 5. Lung sounds 6. Arterial blood gases or oxygen saturation, if applicable .Steps I procedure 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Documentation After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for the p.r.n. treatment.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 5 residents (Resident #61 and Resident #74) reviewed for pharmacy services. MA-A failed to take action to acquire Resident #61's scheduled dose of Pantoprazole when she did not have it available for administration. MA-A failed to take action to acquire Resident #74's scheduled dose of Tegretol when she did not have it available for administration. MA-A incorrectly documented she administered a dose of Pantoprazole to Resident #61 and a dose of Tegretol to Resident #74 when she did not have the 2 (two) medications available for administration. These failures could place residents at risk of not receiving their medications as ordered, having adverse consequences due to inconsistent levels of medication in the body, and having incorrect medication administration records. Findings included: 1. A review of a face sheet and physician orders dated 12/02/2025 indicated Resident #61 admitted to the facility on [DATE] with diagnoses which included end stage kidney disease and GERD (gastroesophageal reflux disease, a condition where stomach acid flows back up into the esophagus). A review of the annual MDS assessment dated [DATE] noted Resident #61 had a BIMS score of 11 indicating her cognition was moderately impaired. The same MDS indicated Resident #61 was ambulatory with a rolling walker and was continent of bowel and bladder. A review of Resident #61's physician orders dated 12/02/2025 indicated Resident #61 had an order dated 05/06/2025 for 1 (one) tablet of Pantoprazole 40 MG to be administered two times a day. During observation and interview of medication administration on 12/02/2025 at 08:40 AM, MA-A said Resident #61 did not have any Pantoprazole 40 MG tablets available in the medication cart. MA-A was then observed to check the medication overflow cart for the Pantoprazole tablets. She said she did not find any Pantoprazole tablets in the overflow cart. When MA-A did not locate any Pantoprazole tablets in the overflow cart, she went back to her medication cart and began preparation of medications for Resident #74. 2. A review of a face sheet and physician orders dated 12/02/2025 indicated Resident #74 admitted to the facility on [DATE] with diagnoses which included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures). A review of a quarterly MDS assessment dated [DATE] noted Resident #74 had a BIMS score of 5 indicating his cognition was severely impaired. The same MDS indicated Resident #74 was non-ambulatory and dependent on staff for most activities of daily living. A review of Resident #74's physician orders dated 12/02/2025 indicated Resident #74 had an order dated 01/11/2023 for 1 (one) tablet of Tegretol 300 MG to be administered two times a day related to the diagnosis of epilepsy. During observation and interview of medication administration on 12/02/2025 at 08:49 AM, MA-A said Resident #74 did not have any Tegretol 300 MG tablets available in the medication cart. MA-A was then observed to check the medication overflow cart for the Tegretol tablets. She said she did not find any Tegretol tablets in the overflow cart. When MA-A did not locate any Tegretol tablets in the overflow cart, she went back to her medication cart and began preparation of medications for other residents. She said when she did not have a needed medication on the medication cart, she would check the medication overflow cart for the medication first. If the medication was not in the overflow cart, she said she would notify the nurse, and the nurse could check the secure medication dispenser cart for the needed medication. MA-A said she was finished with medication administration tasks for Residents # 61 and Resident #74 and had nothing else to do for them. A review of the Medication Administration Records for Resident #61 and Resident #74 on 12/02/2025 at 10:15 AM indicated MA-A had administered 1 (one) Pantoprazole 40 MG tablet to Resident #61 at 09:58 AM on 12/02/2025. Further review indicated MA-A had administered 1 (one) Tegretol 300 MG tablet to Resident #74 at 10:01 AM on 12/02/2025. During an interview with LVN-C on 12/02/2025 at 10:31 AM, she said she had not been informed of (continued on next page)		

Department of Health & Human Services
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any resident not receiving their scheduled medications. LVN-C said it was important for Resident #64 to receive the physician ordered Pantoprazole medication because the medication helped to neutralize stomach acid and prevent damage to the lining of the esophagus. LVN-C said it was important for Resident #74 to receive his physician ordered Tegretol medication because it helped to prevent seizures. LVN-C said the medication aide was supposed to let the charge know when a medication was not available for administration. She said the medication aide was supposed to check the overflow cart for the needed medication first and if it was not there, the medication aide was supposed to check the medication room to see if the medication was there. She said the charge nurse would then check the emergency supply in the secure medication cabinet in the medication room to see if the needed medication was available. She said if the needed medication was not available, the charge nurse would notify the pharmacy who would either deliver the medication or obtain it from a local pharmacy for immediate delivery to the facility. During an interview with MA-A on 12/02/2025 at 10:35 AM, she said she did not tell the nurse that she did not have the Pantoprazole 40 MG tablets to give Resident #61 and could not explain why she documented that she had administered the medication. MA-A said she did not tell the nurse that she did not have the Tegretol 300 mg tablet to give to Resident #74 and did not know why she documented that she had administered it to Resident #74. MA-A said it was her responsibility to inform the charge nurse when a needed medication was not available. She said she forgot to inform the nurse. During an interview with LVN-C on 12/02/2025 at 11:30 AM, she said she had just found Resident #74's Tegretol medication in the medication room. She said the pharmacy delivered it last night. She said the nurse who received the pharmacy delivery was supposed to put the medication on the medication cart but did not. LVN-C said she obtained Resident #61's Pantoprazole medication from the emergency supply. LVN-C was noted to have both residents' medications in her hands. She said she informed the physician and she was instructed to administer them. During an interview with the [NAME] President of Clinical Operations (RN) on 12/03/2025 at 10:45 AM, she said she expected the medication aides to notify the charge nurse when a medication was not available for administration. She said she expected the nursing staff to document medication administration correctly. A review of the facility's policy dated as revised April 2019 and titled Administering Medications included the following: 4.Medications are administered in accordance with prescriber orders, including any required time frame.22.The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5 percent. There were 2 errors out of 27 opportunities, resulting in a 7 percent medication error rate involving 2 of 5 residents (Resident #61 and Resident #74). MA-A failed to administer a scheduled medication, pantoprazole 40 MG tablet, to Resident #61 as ordered by the physician. MA-A failed to administer a scheduled medication, Tegretol 300 MG tablet, to Resident #74 as ordered by the physician. These failures could place residents at risk of not receiving the therapeutic effects of the medications and could result in a decline in health status. Findings included: 1. A review of a face sheet and physician orders dated 12/02/2025 indicated Resident #61 admitted to the facility on [DATE] with diagnoses which included end stage kidney disease and GERD (gastroesophageal reflux disease, a condition where stomach acid flows back up into the esophagus). A review of the annual MDS assessment dated [DATE] noted Resident #61 had a BIMS score of 11 indicating her cognition was moderately impaired. The same MDS indicated Resident #61 was ambulatory with a rolling walker and was continent of bowel and bladder. A review of Resident #61's physician orders dated 12/02/2025 indicated Resident #61 had an order dated 05/06/2025 for 1 (one) tablet of Pantoprazole 40 MG to be administered two times a day. During observation of medication administration on 12/02/2025 at 08:40 AM, MA-A said Resident #61 did not have any Pantoprazole 40 MG tablets available in the medication cart. MA-A was observed to obtain the remainder of Resident #61's scheduled medications and administer them to Resident #61 as ordered. MA-A was then observed to check the medication overflow cart for the Pantoprazole tablets. She said she did not find any Pantoprazole tablets in the overflow cart. When MA-A did not locate any Pantoprazole tablets in the overflow cart, she went back to her medication cart, and began preparation of medications for Resident #74. 2. A review of a face sheet and physician orders dated 12/02/2025 indicated Resident #74 admitted to the facility on [DATE] with diagnoses which included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures). A review of a quarterly MDS assessment dated [DATE] noted Resident #74 had a BIMS score of 5 indicating his cognition was severely impaired. The same MDS indicated Resident #74 was non-ambulatory and dependent on staff for most activities of daily living. A review of Resident #74's physician orders dated 12/02/2025 indicated Resident #74 had an order dated 01/11/2023 for 1 (one) tablet of Tegretol 300 MG to be administered two times a day related to the diagnosis of epilepsy. During observation of medication administration on 12/02/2025 at 08:49 AM, MA-A said Resident #74 did not have any Tegretol 300 MG tablets available in the medication cart. MA-A was observed to obtain the remainder of Resident #74's scheduled medications and administer them to Resident #74 as ordered. MA-A was then observed to check the medication overflow cart for the Tegretol tablets. She said she did not find any Tegretol tablets in the overflow cart. When MA-A did not locate any Tegretol tablets in the overflow cart, she went back to her medication cart and began preparation of medications for other residents. During an interview with LVN-C on 12/02/2025 at 10:31 AM, she said she had not been informed of any resident not receiving their scheduled medications. LVN-C said it was important for Resident #64 to receive the physician ordered Pantoprazole medication because the medication helped to neutralize stomach acid and prevent damage to the lining of the esophagus. LVN-C said it was important for Resident #74 to receive his physician ordered Tegretol medication because it helped to prevent seizures. After surveyor intervention, LVN-C obtained the 2 medications and administered them accordingly. During an interview with MA-A on 12/02/2025 at 10:35 AM, she said she forgot to tell the nurse that she did not have the Pantoprazole 40 MG tablets to give Resident #61. MA-A said she forgot to tell the nurse that she did not have the Tegretol 300 mg tablet to give to Resident #74. During an interview with the [NAME] President of Clinical Operations (who was also a RN) on 12/03/2025 at 10:45 AM, she said she expected the medication aides to notify the charge nurse when a medication was not available for (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration. A review of the facility's policy dated as revised April 2019 and titled Administering Medications included the following: 4. Medications are administered in accordance with prescriber orders, including any required time frame.		

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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 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 observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 5 residents (Resident #74) reviewed for significant medication errors. MA-A failed to take action to acquire and administer a scheduled medication, Tegretol (to prevent seizures related to diagnosis of epilepsy). This failure could place resident at risk of not receiving the therapeutic effect of medications and could result in a decline in health status. Findings included: A review of a face sheet and physician orders dated 12/02/2025 indicated Resident #74 admitted to the facility on [DATE] with diagnoses which included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures). A review of a quarterly MDS assessment dated [DATE] noted Resident #74 had a BIMS score of 5 indicating his cognition was severely impaired. The same MDS indicated Resident #74 was non-ambulatory and dependent on staff for most activities of daily living. A review of Resident #74's physician orders dated 12/02/2025 indicated Resident #74 had an order dated 01/11/2023 for 1 (one) tablet of Tegretol 300 MG to be administered two times a day at 09:00 AM and 05:00 PM related to the diagnosis of epilepsy. A review of The Epilepsy Foundation's instructions on 12/3/25 indicated taking medications to treat epilepsy or seizures indicated these medications were to be consistently taken at the same time daily to maintain a therapeutic level in the bloodstream. During observation of medication administration on 12/02/2025 at 08:49 AM, MA-A said Resident #74 did not have any Tegretol 300 MG tablets available in the medication cart. MA-A was then observed to check the medication overflow cart for the Tegretol tablets. She said she did not find any Tegretol tablets in the overflow cart. When MA-A did not locate any Tegretol tablets in the overflow cart, she went back to her medication cart, said she didn't have any Tegretol, and began preparation of medications for other residents. During an interview with LVN-C on 12/02/2025 at 10:31 AM, she said she had not been informed of any resident not receiving their scheduled medications. LVN-C said it was important for Resident #74 to receive his physician ordered Tegretol medication because it helped to prevent seizures. LVN-C said the medication aide was supposed to let the charge know when a medication was not available for administration. She said the medication aide was supposed to check the overflow cart for the needed medication first and if it was not there, the medication aide was supposed to check the medication room to see if the medication was there. She said the charge nurse would then check the emergency supply in the secure medication cabinet in the medication room to see if the needed medication was available. She said if the needed medication was not available, the charge nurse would notify the pharmacy who would either deliver the medication or obtain it from a local pharmacy for immediate delivery to the facility. After surveyor intervention, LVN-C obtained the Tegretol medication and administered it on 12/02/2025 at 11:50 AM which was 2 hours and 50 minutes after the scheduled time of 09:00 AM. LVN-C said if the surveyor had not intervened, Resident #74 would most likely not have received the morning dose of Tegretol. During an interview with the [NAME] President of Clinical Operations (RN) on 12/03/2025 at 10:45 AM, she said she expected the medication aides to follow the rules of medication administration and notify the charge nurse when a medication was not available for administration. A review of the facility's policy dated as revised April 2019 and titled Administering Medications included the following: 4. Medications are administered in accordance with prescriber orders, including any required time frame.		