STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455485	A. Building B. Wing	11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Petal Hill	900 S Baxter Ave 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to ensure residents were free from physical abuse for 2 of 8 residents reviewed for abuse. (Resident #s 1 and 2) The facility failed to ensure Resident #2 was free from physical abuse when Resident #1 threw Resident #2 against the wall in the hallway of the secured unit causing Resident #2 to hit her head on the corner of the wall and fall onto the floor resulting in a closed head injury and a fractured lumbar vertebra on 5/13/25. The noncompliance was identified as past noncompliance (PNC). The IJ began on 5/13/25 and ended on 5/14/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for physical abuse, mental abuse, emotional abuse, and harm. Findings included: 1. Record review of an admission record dated 11/8/25 indicated Resident #1 was an [AGE] year-old female who initially admitted to the facility on [DATE] onto the secured unit and readmitted on [DATE] and was discharged on 5/13/25 with diagnoses including Cerebral palsy (caused by abnormal development or damage to the parts of the brain that control movement, balance, and posture), paranoid schizophrenia (a severe mental health condition characterized by persistent delusions and hallucinations), mood disorder (a mental health condition that primarily affects your emotional state. It can cause persistent and intense sadness, elation and/or anger), major depressive disorder (Clinical depression causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy.), and TBI (an injury to the brain caused by an external force. TBI can result in physical, cognitive, social, emotional and behavioral symptoms, and outcomes can range from complete recovery to permanent disability or death.) Record review of annual MDS assessment dated [DATE] indicated Resident #1 was considered by the state to have a level II PASRR condition due to her serious mental illness diagnosis and other related conditions. Section A indicated Resident #1's most recent 3/12/25 admission was from an inpatient psychiatric hospital. She had clear speech but had difficulty communicating some words or finishing thought but was able if prompted or given time; and comprehend most conversations. She was independent with most ADLs and no DME required. She had BIMS score of 6 out of 15 indicating she had severe cognitive impairment with thinking and memory. Section E - Behaviors was marked none of the above indicating no hallucinations nor delusions and no physical, no verbal and no other behavioral symptoms directed towards other; Section E1100 indicated Resident #1 behavior status remained the same when compared with the prior MDS Section E assessment. Record review of Resident #1's undated revised care plan indicated the following:-Focus: Problematic manner in which [Resident #1] acted characterized by ineffective coping; verbal/ physical Aggression related to: Cognitive impairment/phys.-Goal: For [Resident #1] to cope with the current situation; [Resident #1] will not strike others; [Resident #1] will not verbally abuse others; Staff will recognize and avoid behaviors that provoke aggressive [Resident #1]; to minimize disruptive behavior during recreation programs; to reduce incidents of aggression and angry outbursts.-Interventions: Allow [Resident #1] time to respond to directions or requests (due to dementia more time is required to absorb instructions); approach [Resident #1] slowly and from the front; be cognizant of not invading [Resident #1's] personal space; Do not argue or condemn resident; do not express [facility employee] anger or impatience verbally or with physical movements (i.e shaking head, pointing finger). These responses are likely to increase confusion and agitation; Document summary of each episode. Note cause & successful interventions, include frequency and duration; Give [Resident #1clear, concise explanation of anything about to occur; avoid information overload since the angry aggressive resident cannot assimilate many details; Help [Resident #1] identify activities that tend to decrease angry behavior and encourage their utilization; If aggressive, try and remove from recreational program, and provide individualized program; Initiate behavior charting to identify why the [Resident #1] became angry or agitated(note time of day, who was present, & what proceeded the incident).Record review of Resident #1's Progress notes indicated the following:-On 5/13/25 at 10:02pm (Late Entry); completed by MDS RN: [The local] PD was called to facility due to assault. [Two] officers arrived and interviewed [Resident #1] and witnesses. [Resident#1] was arrested for assault/injury of the elderly and walked out of facility with [the two] officers to patrol vehicle.-On 5/13/25 at 7:50pm; completed by LVN B: [Resident #1] came out of her room walking down the hallway. [LVN B] called out to [Resident#1] asking her to come back. [Resident #1] continued to walk down the hallway. The resident then stopped and grabbed both arms of [Resident #2] standing in the hallway and threw her into the wall. [Resident #1] was redirected back to her room at that time. Dr. notified, RN/DON notified, and Resident's