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	04/01/2026

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 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 observation, 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 for one of seven residents (Resident #1) reviewed for abuse. The facility failed to report an allegation of abuse to HHSC until approximately 5 hours after the incident occurred. This failure could place residents at risk of not receiving timely investigation into allegations of abuse. The findings included: 1. A record review of Resident #1's facesheet dated 04/01/2026 indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included encephalopathy (a brain condition that can manifest as altered mental state, confusion, or memory loss) and dementia (a decline in cognitive abilities that interferes with memory, thinking, reasoning, and behavior). Resident #1's most recent Quarterly MDS dated [DATE] indicated Resident #1 had a BIMS of 3, which indicated severe cognitive impairment. Record review of progress notes for Resident #1 indicated the following:A nurse note dated 03/26/2026 at 4:30 PM indicated Resident #1 was sitting in the dining area when another resident walked by and hit her in the face with a sneaker that she was carrying in her hand. The note indicated Resident #1 showed no signs of physical or emotional distress and had no redness, pinkness, or bruising to her face or complaint of pain. Record review of a social services note dated 03/26/2026 at 6:44 PM indicated Resident #1 appeared without distress, was pleasant and calm, and unable to recall any event. The social services note indicated that the SW contacted Resident #1's family to inform them of the incident. A record review of neurological evaluation checklists dated 03/26/2026 at 4:00 PM, 4:30 PM, 5:15 PM, 5:30 PM, 6:00 PM, 6:30 PM, and 7:30 PM indicated Resident #1 was alert, was able to move all extremities, pupils were equal and reactive to light, and she had an appropriate response to pain. Record review of an IDT Care Conference note dated 03/27/2026 at 8:13 PM indicated neuro checks were initiated, psych NP was contacted for assessment, and nursing staff were to continue to monitor Resident #1 for signs and symptoms of delayed injury and physical/emotional distress. An observation of Resident #1 on 04/01/2026 at 9:16 AM indicated no bruising or redness to her face or other indicators of abuse. An attempt was made to interview Resident #1, but she was unable to answer questions appropriately. 2. A record review of Resident #2's facesheet dated 04/01/2026, indicated she was a [AGE] year-old female who was initially admitted on [DATE]. Resident #2 had diagnoses which included cerebral ischemia (a condition in which insufficient blood flow to the brain leads to reduced oxygen supply) and dementia (a decline in cognitive abilities that interferes with memory, thinking, reasoning, and behavior). Resident #2's discharge MDS dated [DATE] indicated a BIMS of 3, which indicated severe cognitive impairment. Record review of progress notes for Resident #2 indicated the following:A nurse noted dated 03/26/2026 at 4:30 PM indicated Resident #2 walked by another resident seated in the dining area and hit her in the face with a sneaker she was carrying in her hand, then sat at the table and put the sneaker on her foot. The note indicated Resident #2 had no anxiety or aggressive behavior (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and had nothing to say about the incident. The note indicated Resident #2 was immediately placed on one to one supervision and separated from the other resident. Record review of a social services behavior note dated 03/26/2026 at 5:50 PM indicated referrals were sent to multiple behavioral health hospitals for Resident #2 following the event. The social services note indicated the SW contacted Resident #2's family to inform them of the incident. Record review of an IDT Care Conference note dated 03/27/2026 at 11:07 AM indicated Resident #2 had no signs or symptoms of aggression that day, would continue to be on one-to-one monitoring, and a referral would be placed for the psych NP to assess Resident #2. Record review of a nurse note dated 03/27/2026 at 3:00 PM indicated Resident #2 was transferred to a behavioral health hospital. Record review of an encounter by the psych NP dated 03/27/2026 at 10:16 PM, with date of service 03/26/2026, indicated Resident #2 reported she moved her shoe to ward off Resident #1's hand that was out and that it was not an intentional provocation. Attempted observation and interview on 04/01/2026 at 9:20 AM revealed the resident was unavailable due to hospitalization. During an interview on 04/01/2026 at 9:32 AM, LVN A indicated she was not working when the event occurred, but she worked the following day. LVN A indicated Resident #2 often paced the halls. LVN A indicated she did not observe any redness or bruising to Resident #1 the following day. LVN A indicated she did not believe Resident #2 was acting intentionally to harm Resident #1. During an interview on 04/01/2026 at 9:36 AM, CNA A indicated she was a witness to the event. CNA A indicated Resident #1 was sitting with her hand extended and Resident #2 then walked by and hit Resident #1 with her shoe that she was holding. CNA A indicated she separated the residents, made sure Resident #1 was okay, and told the nurse. CNA A indicated the ADM was the abuse coordinator and staff were to inform him of allegations of abuse. During an interview on 04/01/2026 at 9:41 AM, CNA B indicated she was a witness to the event. CNA B indicated Resident #2 was walking the halls. Resident #1 had her hand extended in a comfortable position for her, and Resident #2 walked by Resident #1 and hit her with the shoe. CNA B denied Resident #1 had redness. CNA B denied this event could have been anticipated as Resident #2 liked to walk the halls and had been throughout the day. CNA B indicated the nurse was notified and completed assessments on both residents. CNA B indicated she was aware the abuse coordinator was the ADM and stated if she witnessed any abuse she was to tell the charge nurse. During a telephone interview on 04/01/2026 at 9:48 AM, RN A indicated she did not see the event occur but was notified by a CNA Resident #2 had hit Resident #1 in the face with a sneaker. RN A indicated Resident #1 had no redness and would not grimace when touched. RN A indicated they immediately separated the residents, placed Resident #2 on one-to-one supervision, and assessed Resident #1's skin, emotional state, and vital signs. RN A indicated she immediately notified the DON, ADON, physician, and family. During an interview on 04/01/2026 at 12:33 PM, the SW indicated she followed up with Resident #1 and Resident #2 that same day. The SW indicated Resident #2 denied being angry or upset. The SW indicated Resident #1 did not recall the event occurring. The SW indicated she was aware that the ADM was the abuse coordinator and stated the DON communicated to the ADM when there was an allegation of abuse. During an interview on 04/01/2026 at 12:57 PM, the ADON indicated she was at the facility in her office when the event occurred and immediately went to the secured unit to assist. The ADON indicated she was told Resident #1 was stretching out her arm when Resident #2 was passing by and was when Resident #1 was hit with the shoe. The ADON indicated Resident #2 had never been physically aggressive before. The ADON indicated she was on the secured unit and she contacted the DON by phone who gave instructions to the nursing staff. The ADON indicated she was aware the ADM was the abuse coordinator and she believed he was notified within an hour of the event occurring. During an interview on 04/01/2026 at 1:04 PM, the DON indicated she was contacted by the ADON and notified Resident #2 hit Resident #1 with her shoe. The DON indicated she had never known Resident #2 to be physically aggressive. The DON indicated she was aware the ADM was the abuse coordinator and she contacted him around 6:20 PM that evening. The DON indicated there was an estimated hour and a half to two hours between when she learned of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident and when she contacted the ADM. The DON indicated she was not at the facility at the time of the event but returned after she contacted the ADM. The DON indicated she understood the policy on reporting suspected abuse to be within 24 hours if there was no bodily injury. The DON indicated she did not believe this to be an instance of abuse as Resident #2 did not know what she was doing. The DON indicated if she had not known the residents' cognitive status she would have considered the event abuse, but since she knew the residents she did not think Resident #2 would harm another resident willfully. The DON indicated if she could go back she would report the event earlier. During an interview on 04/01/2026 at 1:38 PM, the ADM indicated he did not feel the event should have been reported within 2 hours because he did not believe there was willful intent. The ADM indicated he understood the residents to be interviewed after the event and claimed they did not have knowledge of what happened. The ADM agreed abuse can occur regardless of cognitive status. The ADM indicated there was a delay reporting as he had to arrive at the facility and obtain information and indicated the TULIP system will often kick him out. The ADM indicated he was notified of the event at 6:51 PM on 03/26/2026. A record review of TULIP case details on 04/01/2026 at 8:50 AM indicated the report of alleged abuse was received by HHSC on 03/26/2026 at 9:16 PM. A record review indicated an in-service on abuse and neglect was held on 03/26/2026 and was instructed by the DON. A record review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation dated April 2021 indicated the following: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to.physical abuse.The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to:.b. other residents A record review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated September 2022 indicated the following: Reporting Allegations to the Administrator and AuthoritiesIf 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.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:The state licensing/certification agency responsible for surveying/licensing the facility;. Immediately is defined as:Within two hours of an allegation involving abuse.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary and comfortable environment for one of one rooms (the primary therapy room) reviewed for environment. The facility failed to ensure residents were not exposed to mold growing in the air vents in the primary therapy room. This failure could place residents at risk for respiratory infections and allergic reactions. The findings included: During an observation on 04/01/2026 at 8:56 AM, revealed a black, spotty substance observed on four air vents and the surrounding ceiling area located in the primary therapy room. 1. A record review of Resident #3's face sheet, dated 04/01/2026, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included spinal stenosis, cervical region (the narrowing of the spinal canal in the neck area), weakness, unsteadiness on feet, other abnormalities of gait and mobility, and hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side (paralysis and weakness following a stroke). Record review of Resident #3's most recent Quarterly MDS dated [DATE] indicated a BIMS of 15, which indicated normal cognitive function. Resident #3 received therapy services for at least 15 minutes a day on one or more days in the last 7 days. During an observation and interview on 04/01/2026 at 9:00 AM, Resident #3 was observed utilizing the SciFit machine in the primary therapy room directly underneath the vent and ceiling area that had the black, spotty substance. Resident #3 indicated he had a history of strokes and had been at the facility for about two and a half years. Resident #3 indicated he often utilized the primary therapy room and entered it at least once a day. Resident #3 indicated he had not noticed the substance on the air vents and surrounding ceiling as he did not often look up. Resident #3 indicated he had not experienced any adverse effects including respiratory illness or skin irritation. Resident #3 did not have any observable skin irritation or respiratory issues. 2. A record review of Resident #4's facesheet, dated 04/01/2026, indicated a [AGE] year-old male admitted [DATE]. Resident #4 had diagnoses which included other nontraumatic intracerebral hemorrhage (bleeding in the brain tissue), hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side (paralysis and weakness following a stroke), muscle weakness, and unsteadiness on feet. Record review of Resident #4's most recent Quarterly MDS dated [DATE] indicated a BIMS of 13, which indicated normal cognitive function. Resident #4 received therapy services for at least 15 minutes a day on one or more days in the last 7 days. During an observation and interview on 04/01/2026 at 10:38 AM, Resident #4 was observed completing a puzzle at a table directly underneath a vent and ceiling area that had a black, spotty substance. Resident #4 indicated he entered the primary therapy room daily. Resident #4 indicated he never looked up to see the black substance. Resident #4 indicated he had not experienced any adverse effects including respiratory illness or skin irritation. Resident #4 did not have any observable skin irritation or respiratory issues. During a record review on 04/01/2026 at 10:24 AM, a list of residents who had pneumonia in the last 6 months was cross referenced with a roster of residents receiving therapy services. These records indicated no residents who had received therapy services in the front therapy room had been diagnosed with pneumonia. During an interview on 04/01/2026 at 10:41 AM, the Director of Rehab indicated he was not sure what specifically was on the vents and ceiling. The Director of Rehab indicated somebody had come to the facility about 3 or 4 months ago. The Director of Rehab indicated they were instructed not to use the air conditioning or heat in that room and to bring residents to a separate therapy area when it was too hot or too cold. The Director of Rehab indicated they now had a wall unit to regulate the temperature. The Director of Rehab indicated he felt it was safe as no air was going through the vents. During an interview on 04/01/2026 at 12:43 PM, the PT indicated she had worked at the facility part time for about a year and a half. The PT indicated they were using a separate therapy area and she was instructed not to (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bring residents to the primary therapy area when it was too hot or too cold as they could not use the vented air system. The PT indicated it was around Christmas time that she had been instructed this. The PT indicated she was it was okay to bring residents to the primary therapy area full time now that there was a wall unit to regulate the temperature even with the black substance on the vents and ceiling. During an interview on 04/01/2026 at 12:52 PM, the PTA indicated she had worked at the facility for about 7 months. The PTA indicated in December she was told not to use the main air system in the therapy room and that there had been a water leak in the ceiling. The PTA indicated they got a new window unit last week to regulate the temperature. The PTA indicated she thought the vents looked black, brown, and dusty and the appearance of the vents had not changed since December 2025. The PTA declined to answer if she felt it was safe to bring residents for therapy underneath these vents and ceiling areas. During an interview on 04/01/2026 at 12:57 PM, the ADON indicated she understood the air system was not working in the therapy area. The ADON indicated she was unaware of any further issues. During an interview on 04/01/2026 at 1:04 PM, the DON indicated the primary therapy area was supposed to receive updates soon. The DON indicated there was talk regarding mold so therapy was moved to a separate area. The DON indicated she believed the vents were recently cleaned. The DON indicated she was unsure if it was mold, but she thought it was suspected and that was why air flow was stopped in that room. During an interview on 04/01/2026 at 1:38 PM, the ADM indicated he was waiting on bids to be able to repair the primary therapy area. The ADM indicated they planned to remove and replace the venting system. The ADM indicated he did not have test results that showed what the substance was, but he knew it had been tested. The ADM indicated he was told to not use the central air in that room and it was safe as long as the system was not running. The ADM was unable to provide information on who stated it was safe for residents to utilize that room. The ADM did not answer when asked if he felt it was safe for residents to be using that room, instead he stated they could close it off and move the residents. The ADM indicated they attempted to move as much of the therapy services as possible to the separate therapy area that was not affected. During an interview on 04/01/2026 at 2:25 PM, the regional director of maintenance indicated he had a report regarding the issue in the vents and ceiling and would provide it. The regional director of maintenance indicated the testing sample indicated it was penicillin, aspergillus, and another fungus that he was unaware of. The regional director of maintenance indicated he would not want his family receiving therapy underneath the substance and it was not acceptable. During a telephone interview on 04/07/2026 at 10:35 AM, the mold assessment consultant indicated the majority of the typical mold spores throughout the area were low, with the air duct being the exception. The mold assessment consultant indicated he was contacted by 2 remediation companies for clarification on his report, which indicated the facility was getting quotes for the work to be done. The mold assessment consultant indicated if the facility followed the recommendation for use of the primary rehab room found in the report there was no significant health risk to anyone who used the area. A record review of the report provided by the regional director of maintenance titled Physical Therapy Room Mold Report & Protocol dated 12/17/2925 indicated the following: Project SummaryThis is an assisted living residence that requested a mold inspection with associated testing be done to determine the risk of mold exposure to residents. The physical therapy (PT) room had mold growth evident around the vents on the ceiling. The ductwork was also tested and showed heavy mold spore populations. Employees working in that room reported irritation to skin and other symptoms that may be caused by mold exposure. General Remediation Methods.Secure the work area(s) from access by building occupants, employees, other contractors, and other nonessential traffic prior to the start of remediation activities. Only Texas licensed, or registered mold contractor, consultant, and worker personnel are allowed to enter the remediation containment area(s) between the start date specified on the Texas notification and the date written clearance is achieved. Accomplish this, where possible, by locking doors, windows, or other means of access to the work area(s); by scheduling work for periods of time that the building is unoccupied or by constructing (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temporary wood stud and plywood barriers where necessary. Periodically re-inspect the perimeter for any breaches that may allow for work area entry. In addition, post signs advising that a mold remediation project is in progress at all accessible entrances to remediation area of the building in according with TDLR mold regulations. Special Considerations & Protocol Measures for Remediation of the Physical Therapy RoomThis Remediation Work Area is being conducted adjacent to a main entrance where heavy foot traffic is expected. To protect the guests, employees and residents, a sheet of 6-mil polyethylene film shall be draped and sealed across the main doorway to the PT Room with access from that doorway being completely blocked off while contaminated materials are being removed, demolished, or remediated and while any construction activities that generate dust are being performed in the PT room. This will protect the people entering and leaving the building from mold, construction debris, and other potentially harmful airborne particles. Lab Data The following lab data shows relatively low levels of spores in the PT Room's air, similar to the fungal diversity of the Outside Control Sample. Summary & Recommendations.The HVAC system should not be operated until the ductwork is cleaned and remediated. A record review of the facility's policy entitled Homelike Environment, dated February 2021 indicated the following: Policy Statement Residents are provided with a safe, clean, comfortable, and homelike environment.Policy Interpretation and Implementation.2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:a. clean, sanitary and orderly environment