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	03/05/2026

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.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews and record review, the facility failed to provide a private space for resident group meetings for 6 of 6 confidential residents interviewed. The facility failed to ensure the resident group had a meeting space available that was private and uninvited staff were not present during the meetings. This failure could place residents at risk for reluctance to voice their concerns due to staff members being present.The findings included: During a confidential interview at an undisclosed date and time, 6 of 6 confidential residents indicated that they held resident group meetings in the facility dining room. The confidential residents indicated that they would prefer not to meet in the dining room as staff entered the dining room throughout their meetings. The confidential residents indicated that they had told staff not to enter during their meetings, but that they continue to do so. During an interview on 03/04/2026 at 10:30 AM, the AD indicated that staff had often entered the dining room during resident council meetings despite being asked not to and a sign on the door was placed to notify staff not to enter due to a resident group meeting in process. The AD indicated that she had asked the ADM to address the issue approximately 6 months prior and staff continued to enter the dining room during resident group meetings. During an interview on 03/05/2026 at 9:03 AM, CNA C indicated that she had worked at the facility for 3 years and was aware the resident group meetings were typically held in the dining room. CNA C indicated that CNAs were educated not to enter the dining room while resident group meetings were in process, but that some staff members did still enter the room as the vending machines and kitchen were located there. CNA C indicated that she was aware that signs were posted during resident group meetings to notify staff members not to enter. During an interview on 03/05/2026 at 9:16 AM, the DON indicated that she was unaware of staff entering the dining room during resident group meetings. The DON indicated that staff were told not to enter the dining room during resident group meetings. The DON indicated that there was an alternative meeting area, a common area where therapy occasionally provides treatment, that residents could use to hold resident group meetings that was private as staff would not have reason to enter. The DON indicated that the risk to residents for not having a private area to conduct resident group meetings would be that residents would not be able to feel as though they could voice their concerns due to staff presence. During an interview on 03/05/2026 at 9:50 AM, the ADM indicated that he was unaware of staff entering the dining room during resident group meetings and that he did not recall the AD mentioning it to him. The ADM indicated that the dining room also holds the staff breakroom, the kitchen, and the vending machines. The ADM indicated that there were alternative meeting areas including the conference room or the therapy room. The ADM indicated that the risk to residents for not having a private area to hold resident group meetings included not being able to communicate without staff hearing them and fear of retaliation. A record review of the sign posted during resident group meetings provided by the AD indicated the following: Do Not EnterResident Council Meeting in Session. A record review of an undated facility policy titled Resident Council indicated the following: 2. All residents are eligible to participate in the resident council. The facility staff encourages residents who are willing to participate. Staff, visitors, or other guests may attend resident council meetings if invited by the respective resident group.3. The resident council group is provided with space, privacy, and support to conduct meetings.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, 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 two of two residents (Resident # 1 and Resident # 81), two of four medication carts (LVN Cart #1 and RN Cart #2), and one of two mediation storage rooms reviewed for pharmacy services. LVN D failed to use the proper technique for administration of eye drops for Resident #1 on 3/4/2026. LVN B failed to use the proper technique for administration of eye drops for Resident #81 on 3/5/2026. RN A signed the controlled substance count sheets for the end of their shift at the beginning of their shift on RN Cart #2 on 3/5/2026. LVN B signed the controlled substance count sheets for the end of their shift at the beginning of their shift on LVN Cart #1 on 03/5/2026. The facility failed to ensure expired medications were removed from the medication storage room. These failures had the potential to place residents at risk for not receiving the intended therapeutic effect of prescribed medications, ineffective treatment, administration of medications that are no longer safe or effective, and inaccurate medication control practices, which could lead to potential resident harm.1. Observation on 3/4/2026 at 9:10 a.m., revealed during a medication pass observation, the surveyor observed LVN D administer eye drops to Resident #1. LVN D assembled the required equipment and followed general aseptic technique for medication administration. However, LVN D failed to use the proper technique for administration of eye drops. Specifically, LVN D did not gently pull the resident's lower eyelid down to create a conjunctival pocket (a small pocket) and did not instruct the resident to look upward during installation of the eye drops. Observation on 3/5/2026 at 10:00 a.m., revealed during a medication pass observation, the surveyor observed LVN B administer eye drops to Resident # 81. LVN B assembled the necessary equipment and supplies and followed general aseptic guidelines for medication administration. However, LVN B did not gently pull the resident's lower eyelid down to create a conjunctival sac (a small pocket) and instead instilled the eye drops directly onto the eyeball. During an interview on 3/5/2026 at 11:30 a.m., LVN B stated she had been trained in the proper administration and care of eye drops. LVN B stated the correct technique included maintaining aseptic technique and gently lowering the lower eyelid to create a conjunctival sac to ensure the eye drop is properly instilled. During an interview on 3/5/2025 at 11:40 a.m., the Director of Nursing (DON) stated that nursing staff were trained on the proper administration of eye drops, including the guidelines and procedural steps. After reviewing the facility policy and professional standards of practice, the DON acknowledged that steps #7 and # 8 of the procedure were not followed during the observed medication administrations. The DON stated that all nursing staff would be re-in-serviced on the proper technique for the administration of eye drops. Review of the facility policy on Instillation of Eye Drops (Dated 2001 Med Pass) revealed: Steps in the Procedure: # 7 Gently pull the lower eyelid down. Instruct the resident to look up. # 8 Drop the medication into the mid lower eyelid fornix (Conjunctival fornix is the loose, folded, pocket-like tissue joining the inner eyelid to the eyeball surface) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 3/5/2026 at 12:05 p.m., of the main medication storage room revealed three bottles of medication that were expired and had not been removed from active medication storage. The medications revealed: Magnesium oxide 400mg Expired 1/2026, Naprosyn 224mg Expired 1/2026, and CoQ10 100mg Expired 2/2026. During an interview on 3/5/2026 at 12:07 p.m., LVN B and LVN E confirmed that medications observed in the medication storge room were labeled with expiration dates 1/2026 and 2/2026. LVN E stated she primarily worked on weekends. Both nurses stated the main medication storage room was checked for expired medications; however, neither nurse was able to confirm how often the medication storage room was routinely checked to ensure expired medications are removed. Durning an interview on 3/5/2026 at 1:30 p.m., the DON stated that expired medications should be removed from the medication storage area and disposed of according to facility policy and guidelines and should not remain in active medication storage room. The DON stated the medication storage room was normally checked monthly for expired medications. The DON further stated nursing staff would be reminded to continue performing monthly checks of medication storage areas to ensure expired medications are identified and removed. Review of the policy for Medication Labeling and Storage dated Med-Line, revised February 2001 indicated: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. During an observation on 3/5/2026 at 11:30 AM, while doing observation of 2/2 med cart it was discovered that RN A and LVN B were signing on and off at the same time of signing on at shift count, the drug-controlled drugs on hand. During a record review on 3/5/2026 at 11:30 AM the sign on/off sheet read, signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication count is in agreement with the quantity stated on the controlled. 3. During an interview on 3/5/2026 at 11:45 AM with RN A, she said she was aware she could not to sign the day/off until she actually was going off shift. During an interview on 3/5/2026 at 11:45 AM with LVN B said she was aware that nurses should not sign the narcotic count sheet for the off-going shift until they were leaving their shift. Interview on 03/05/2026 12:00 PM with the DON and let he see the 8-hour shift-to shift Narcotic Count Sheet and she agreed that the nurses were not to sign the sheet only at the beginning and end of their shift Record review of a policy and procedure document titled Controlled Substances indicated the facility with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II -V of the comprehensive Drug Abuse Prevention and Control Act of 1976) revised November 2022. 4. Nursing staff coming on duty and nurse going off duty make the count together and document and report any discrepancies to the director of nursing services

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to coordinate the assessment of 1 of 6 residents (Resident #6) reviewed for the pre-admission screening and resident review (PASRR) program and PASRR assessments and evaluations. The facility failed to ensure Resident #6 had an accurate Level 1 PASRR screening that reflected an active mental illness diagnosis. This failure could place residents with mental illness diagnoses at risk of not being evaluated for and potentially not receiving PASRR services for care and treatment. Findings included: Record review of a face sheet dated 03/04/2026 indicated Resident #6 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included major depressive disorder (a serious mood disorder characterized by persistent sadness, loss of interest, and fatigue lasting at least 2 weeks, severely impacting daily life). Further review of the same face sheet indicated a diagnosis of schizoaffective disorder [a chronic mental health condition combining psychotic symptoms (hallucinations, delusions) with mood disorder symptoms (mania or depression) was added to Resident #6's list of diagnoses on 09/21/2023. Record review of an admission MDS: Section I dated 03/18/2023 indicated Resident #6 had a diagnosis of depression. Record review of a quarterly MDS: Section I dated 05/16/2024 indicated Resident #6 had a diagnosis of depression and schizophrenia. Record review of the physician's orders dated 03/04/2026 indicated Resident #6 had diagnoses of major depressive disorder and schizoaffective disorder. Record review of Resident #6's undated care plan indicated interventions to address concerns for major depressive disorder and the potential risk of hallucinations, delusions, and behaviors related to the diagnosis of schizoaffective disorder. Record review of the admission MDS: Section I dated 03/18/2023 indicated Resident #6 had a diagnosis of major depressive disorder. Record review of Resident #6's Level 1 PASRR screening dated 03/14/2023 indicated she did not have a mental illness diagnosis. Record review of Resident #6's Level 1 PASRR screening dated 04/01/2024 indicated she did not have a mental illness diagnosis. During an interview with the MDS Coordinator on 03/05/2026 at 11:10 AM, she said both of Resident #6's Level 1 PASRR screenings were incorrect. She said the LA should have been notified of the incorrect Level 1 PASRR and a new Level 1 PASRR should have been submitted. The MDS Coordinator said a corrected Level 1 PASRR would have led to a PASRR evaluation that would have determined if Resident #6 qualified for PASRR care and services. The MDS Coordinator said she was not the person responsible for the PASRR process during the time Resident #6's Level 1 PASRRs were completed and did not know why steps were not taken to correct them. During an interview with the DON on 03/05/2026 at 11:20 AM, she said the MDS Coordinator was responsible for the PASRR process. The DON said the accuracy of Level 1 PASRR screenings was important to ensure residents who were eligible for PASRR services received those services. During an interview with the MDS Coordinator on 03/05/2026 at 02:05 PM, she said the RAI manual was the source used for managing the PASRR process.