

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455678	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Longview		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Hollybrook Dr Longview, TX 75605	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1's Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram (is medication used to control or relieve pain) was available for administration on 01/19/26. This failure could place residents at risk for pain. Findings include: Record review of Resident #1's face sheet, dated 1/19/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Nondisplaced Intertrochanteric Fracture of Left Femur (a stable hip fracture where the bone is broken but remains in proper alignment), Bipolar Disorder (a chronic mental health condition characterized by intense mood swings, ranging from extreme highs to lows), and Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life, going beyond normal, temporary anxiety). Record review of Resident #1's admission minimum data set assessment, dated 1/22/26, revealed Resident #1 had a brief interview for mental status score of 11, which indicated moderate impaired cognition. Resident #1 was administered pain medication as needed. Record review of Resident #1's care plan, with a problem area, initiated on 1/19/26, revealed Resident #1, had an actual fall with no injury Poor Balance, Poor communication/comprehension, Unsteady gait. Record review of Resident #1's order, dated 1/19/2026, for Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram. Order read, Give one tablet by mouth as needed for moderate to severe pain. Record review of Resident #1's medication administration record, dated for the month of January 2026, revealed Resident #1 was not administered Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram. Resident #1 received Acetaminophen-Codeine Oral Tablet 300-30 Milligram (is medication used to control or relieve pain) on January 21st, 2026, at 1800 hours (6:00 p.m.), January 22nd 2026 at 0000 (12:00 a.m.), January 22nd 2026 at 0600 Hours (6:00 a.m.), January 22nd 2026 at 1200 hours (12:00 p.m.), January 22nd 2026 at hours 1800 hours (6:00 p.m.), January 23rd 2026 at 0000 (12:00 a.m.), January 23rd 2026 at 0600 Hours (6:00 a.m.), January 23rd 2026 at 1200 hours (12:00 p.m.), January 23rd 2026 at hours 1800 hours (6:00 p.m.), January 24th 2026 at 0000 (12:00 a.m.), January 23th 2026 at 0600 Hours (6:00 a.m.) Resident #1's medication administration record medication of Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram showed that no medication was administered at any point in the resident's stay at the facility. During an interview on 2/17/26 at 10:33 a.m. with the facility Nurse Practitioner, she said she prescribed Acetaminophen-Codeine Oral Tablet 300-30 Milligram on 1/21/26 for Resident #1 and Resident #1 was being given over the counter pain medication when she first admitted to the facility because her medications did not come with her from the hospital. She said she was unsure why the pharmacy was not able to fill Resident #1's prescribed medicines when she admitted. Resident #1 was not in much pain when she admitted. She was not grimacing and never acted</p> <p>(continued on next page)</p>		

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:	Facility ID: 455678
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>like she was in pain while she was a Resident at the facility for the short period she was in the building. She said she was up a lot of the days she was there and doing great, related to her pain. She said she would never let someone sit and hurt ever. She said that Resident #1 did not receive the Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram that was prescribed to her. She said the night Resident #1 admitted she did not admit with any medications. She said she tried to pull her Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram from the Pyxis system but was denied as the prescription was not signed by the physician. Resident #1 instead received Acetaminophen-Codeine Oral Tablet 300-30 Milligram as she was unable to fill a prescription of Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram. During an interview on 2/17/26 at 1:15 p.m., ADON A said she wasn't sure why the Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram was not filled by the pharmacy, but she suspected there was an error since they switched to a new pharmacy. She stated it was possible there was an issue with the physician's office and the pharmacy having the wrong number when they sent the script over. During an interview on 2/17/26 at 1:45 p.m. with LVN B, she said the night Resident #1 admitted she did not admit with any medications. She said she tried to pull her Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram from the Pyxis (automated medication dispensing cabinets and management systems), but the medication was denied because the script was not signed by the facility medical director. She said she notified the family regarding the lack of medication and asked if they wanted to send Resident #1 out to the emergency room for pain management, but the family declined. She said the facility Nurse Practitioner was on call and she sent her a message regarding the medication issue on 1/19/26, but she never got back with her until early the next morning. We treated Resident #1 with over-the-counter pain medications instead. She said Resident #1 did not appear to be in any pain. She said they took her vitals and her vitals remained in normal range. During an interview on 2/17/26 at 2:40 p.m. with the Administrator, he said he expected his facility nurses to get pain medication as quickly as possible to residents who admitted with pain or an order for pain medication. He stated LVN B should have called the Director of Nurses or himself so the Medical Director could be notified and get a good script called in. He said residents could be placed at risk for pain if they went without their prescribed medications. During an interview on 2/17/26 at 3:27 p.m. with the Nurse Practitioner, she said she was not on call at the time she allegedly got a message about the Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram, nor did she remember getting a message. She said she did not know why the pharmacy could not fill the Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram. She said she did not know if the Medical Director did not sign the prescription. She said she found out on January 21, 2026 the Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligram had not made it to the facility, so she called in an order for Acetaminophen-Codeine Oral Tablet 300-30 Milligram. She said she was unsure why it took from that morning until 10:00 p.m. that night for the medication to be administered to Resident #1. She stated Resident #1 was not in pain during her admission to the facility. During an interview on 2/17/26 at 3:47 p.m. with Resident #1 and the Family Member, in a telephone call, the Family Member said Resident #1 was in some pain while at the facility, but she wasn't grimacing or in screaming pain. He said he did not believe her to be in severe or excruciating pain. Resident #1 said she was in some pain while in the facility but had a little relief from the medication she was given. She said she did not remember which medication gave her pain relief. Resident #1 and the Family Member said they could no longer speak as they needed to see an Orthopedic Doctor. During an interview on 2/18/26 at 9:00 a.m., the Director of Nurses said when the facility had a new admission their aim was to get their pain medication the day they admitted. She said nursing management was responsible to ensure medications ordered by a physician made it to the facility and</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>were available to the resident. She said they were required to administer and procure the medications ordered by the resident's physician. She said a resident could be placed at risk of uncontrolled pain if they did not have the residents prescribed pain medications available. Record review of the facility's policy, revised April of 2019, titled Administering Medications. Policy revealed, Medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame.</p>		