STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455678	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Longview	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to be treated with respect and dignity for 1 of 4 residents reviewed for resident rights. (Resident #4)The facility failed to ensure Resident #4 was treated with dignity and respect when LPN M used explicit language while exiting room.This failure could place residents at risk for feeling disrespected, a decreased sense of self-worth, and depression. Findings included:Record review of Resident #4's face sheet, dated 3/24/2026, indicated Resident #4 was a [AGE] year-old female readmitted on [DATE]. Resident #4 had diagnoses including urinary tract infection (an infection in any part of the urinary system), Parkinsonism (a group of movement related symptoms caused by neurological disorders), polyneuropathy (a nerve disease caused by damage to many nerves), muscle wasting and atrophy (a thinning of muscle mass due to disuse or nerve problems) and type II diabetes (a condition in which the body has trouble controlling blood sugar).Record review of Resident #4's quarterly MDS, dated [DATE], indicated she was usually able to make self-understood and usually understood others. Resident #4 had a BIMS score of 10 indicating she had moderate cognitive impairment. Resident #4 required moderate assistance with toileting, lower body dressing, and bathing. The quarterly MDS indicated Resident #4 did not have pain.Record review of Resident #4's care plan, dated 1/27/2026, indicated Resident #4 had potential for pain related to polyneuropathy. Interventions included:Administer analgesia (an agent producing diminished sensation to pain without loss of consciousness) as per orders.Administer medications not classified as pain medication, Pregabalin (a medication used to treat epilepsy, anxiety and nerve pain) and observe for effectiveness/side effects.Monitor/document for probable cause of each pain episode. Remove/limit cause where possible.Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria (a condition characterized by feelings of deep unhappiness, discontentment, and disconnect from one's identity or reality); nausea, vomiting, dizziness, and falls. Report occurrences to the physician.Monitor/record/report to nurse resident complaints of pain or requests for pain treatment.Notify physicians if interventions were unsuccessful or if current complaints were a significant change from resident's experience of pain.Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal, or resistance to care.Evidence discovered during review on 3/23/2026 at 2:34p.m., an electronic monitoring video, undated, revealed LPN M walking to Resident #4's bedside with a small cup in her hand. LPN N attempted to hand Resident #4 medication cup and turned away exiting the room. The nurse turned and stated, I don't have to take this (explicit language) and exited the room. Resident #4 placed her hands on top of her head.During an interview and interview on 3/23/2026 at 2:23 p.m., Resident #4 was observed clean and well-groomed. Resident #4 said some of the staff treated her with dignity and respect. She said staff screamed at her and told her to Knock it off and were rude to her. Resident #4 said she had depression and took medication for her depression. Resident #4 said she reported a staff member who treated her poorly. Resident #4 could not identify the other nurse other than she worked on a different hall. Resident #4 said there were only a few (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses that made her feel that she was worth something.During a phone interview on 3/24/2026 at 3:25p.m., the RP said she had a video from Resident #4's electronic monitoring device on 12/12/2025 at 10:00 PM and had reported the incident to the nurse and the previous ADM. The RP said the incident was abuse in a sense because Resident #4 needed care. Resident #4's RP said it was more mental abuse.During a telephone interview on 3/24/2026 at 4:12 PM, LPN M said she worked at the facility for a couple of months. She said she had cared for Resident #4. LPN M said Resident #4 was complaining of nausea and felt she was going to get sick on 12/12/2025. LPN M said while she was walking out of the room, she said, I am sick of this (Explicit language). LPN M said she referred to that statement to CNA E. LPN M said she would not discuss lead up to the statement she made and said it was related to a previous conversation. LPN M said she could not recall if she administered Resident #4's medication. LPN M said, I told you what I know.During an interview on 3/26/2026 at 2:20 p.m., CNA E said she had not heard anyone talking rudely to residents. CNA E said LPN M was across the hall from Resident #4's room. CNA E said LPN M attempted to give Resident #4 her medications. CNA E said LPN M walked out of Resident #4's room and said she did not know what was wrong with Resident #4 because she would not take her medications. CNA E said there was no conversation outside the door before LPN M went in or when she came out of her room. CNA E said LPN M wore a hearing piece in her ear and could have been on the phone. CNA E said she never heard her talk rudely to anyone. CNA E said she would report to the ADM if she heard something. The ADM was the abuse coordinator. She said it could impact a resident if they overhead something said and thought the staff was talking to them. She said all staff were responsible for making sure residents were treated with dignity and respect.During an interview on 3/26/2026 at 3:25 PM, LPN L said she had not observed any staff talking disrespectfully to residents. She said she would report to the ADM. LPN L said she was in-serviced on abuse, neglect and exploitation, dignity and respect. LPN L did not indicate when the last in-service was completed. LPN L said if a resident overhead a conversation, the resident could misinterpret a statement made and make them feel they were not liked and feel low about themselves. She said it could make a resident feel depressed. LPN L said the ADM was responsible for ensuring residents were treated with dignity and respect and it was everyone's job to treat residents with dignity and respect.During an interview on 3/26/2026 at 4:08 PM, the ADON said the incident occurred prior to her employment with the facility. The ADON said she was new to her role as ADON and heard about the incident with Resident #4. She said there was a video that was brought into question and the facility had to report it. She said LPN M was terminated. The ADON said she was not aware of any staff yelling at Resident #4. The ADON said everyone was responsible for ensuring residents felt said and treated with dignity and respect. She said a resident could negatively impact the way the resident feels about themselves and could impact care.During an interview on 3/26/2026 at 4:50 PM, the ADM said the statement by LPN M could be taken wrong and could be abuse. She said she expected the staff to talk to residents in a manner that showed dignity and respect. The ADM said she expected the staff to report any disrespect immediately. The ADM said it could affect a resident emotionally in a negative way. The previous ADM was out and unavailable for questions.Record Review of LPN M file indicated she was hired on 8/14/2025 and was terminated on 12/17/2025. The employee record indicated she was terminated for Resident Interaction and signed by the previous ADM on 12/22/2026. There was not a grievance/complaint log related to the incident identified or other identified grievances regarding the LPN M. Record Review of grievance/complaints for December 2025 did not indicate concerns for LPN M. There was no grievance identified for this incident on 12/12/2025. The previous interim ADM was unavailable for interview. The intake report indicated the facility investigation was unconfirmed. Record review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, indicated, Policy.Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint.Policy (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interpretation and implementation.1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to a. facility staff, other residents.2. Develop and implement policies and protocols to prevent and identify a. abuse or mistreatment of residents, b. neglect of residents, c. theft, exploitation or misappropriation of resident property. 3. Ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates. 5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. Psychosocial outcomes.1. Some situations of abuse do not result in observable physical injury, or the psychosocial effects of abuse may not be immediately apparent.Abuse may result in psychological, behavioral, or psychosocial outcomes including, but not limited to the following.a. Fear of a person or place, of being left alone, of being in the dark.b. Extreme changes in behavior.c. running away, withdrawal, isolating self, feeling guilt and shame, depression, crying.Record review of the facility policy titled, Resident Rights, revised February 2021, indicated, .Employees shall treat all residents with kindness, respect, and dignity.Policy Interpretation and Implementation.1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the right to: a. a dignified existence.b. be treated with respect, kindness, and dignity.c. free from abuse, neglect, misappropriation of property and exploitation.u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal.v. have the facility respond to his or her grievances.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident had the right to be free from misappropriation of property, and exploitation for 4 of 4 residents (Resident #1, Resident #2, Resident #3, Resident #4) reviewed for misappropriation of property. 1.The facility failed to prevent the misappropriation of Resident #1's Hydrocodone (Norco). 2. The facility failed to prevent the misappropriation of Resident #2's Acetaminophen-Codeine 300-30 mg two tablets every six hours for pain. 3. The facility failed to prevent the misappropriation of Resident #3's Hydrocodone 10-325 mg (Quantity 20 tablets) delivered on [DATE]. 4. The facility failed to prevent the misappropriation of Resident #4's Pregabalin 200 mg (Quantity 50 tablets) delivered on [DATE]. These failures placed residents at risk for misappropriation of physician ordered medications which could result in residents not having medications/treatments available and a decline in health. Findings included:1.Record review of Resident #1's face sheet, dated [DATE], indicated Resident #1 was a [AGE] year-old female readmitted on [DATE]. Resident #1 had diagnoses including acute osteomyelitis of left ankle and foot (a serious bone infection that can arise from wounds, diabetes, or other health conditions, leading to pain, swelling, and potential complications if left untreated), Type II Diabetes with diabetic chronic kidney disease (a condition in which the body has trouble controlling blood sugar and over time damaging the tiny blood vessels in the kidneys), protein-calorie malnutrition (a form of undernutrition caused by insufficient intake of protein and calories, leading to muscle and fat loss and impaired bodily functions) and acute pain from trauma (intense pain caused by injury to tissues).Record review of Resident #1's quarterly MDS, dated [DATE], indicated she was usually able to make self-understood and understood others. Resident #1 had a BIMS score of 15 indicating she was cognitively intact. Resident #1 required moderate assistance with most activities including toilet transfer, and tub/shower transfer. Resident #1's MDS did not indicate she had pain during the look back period of 5 days prior to assessment. The Quarterly MDS indicated Resident #1 was prescribed an opioid (a class of natural synthetic, or semi-synthetic drugs that relieved pain by binding to receptors in the brain) medication used to treat pain) medication.Record review of Resident #1's care plan, dated [DATE], indicated Resident #1 was on pain medication therapy Hydrocodone-Acetaminophen 10-325 mg every 6 hours (a medication used to treat pain) and Methocarbamol 750 mg (a muscle relaxant used to relieve pain and discomfort from acute musculoskeletal conditions) every 8 hours as needed with interventions to administer analgesic medications as ordered by physician and monitor side effects every shift. Additional interventions included monitor/document/report as needed adverse reactions to analgesic therapy such as altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritic (severe itchy skin), respiratory distress/decreased respirations, sedation, and urinary retention.Record review of Resident #1's Medication Administration Record, dated [DATE]-[DATE], indicated she was prescribed Hydrocodone-Acetaminophen 10-325 mg 1 tablet by mouth every 6 hours as needed for pain.During an interview on [DATE] at 2:57 p.m., Resident #1 said she did not have pain every day. She said she had pain every other day. She said she had received her medications immediately when she asked for it.During an interview on [DATE] at 10:37 a.m., LPN A said LPN B was running around and seemed off. LPN A said LPN B was falling asleep during narcotic counts. LPN A said Resident #1 had 18 Norco tablets counted from the previous night and only 17 tablets in her bottle the next morning when she came in to work. LPN A said Resident #1 told her that she had not received her medication that night ([DATE]) and the medication did not show it was administered in the computer. LPN A said LPN B signed off on the narcotic count sheet that she administered the Norco at 9:00 p.m. LPN A said LPN B had been at the facility earlier in the day at about noon. She said she thought the nurse was just tired. LPN A said she did not notify the ADM. She said she reported to the weekend supervisor.During an interview on [DATE] at 10:55 a.m., Resident #1 said there was one (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	night a couple of weeks ago where she fell asleep and no one woke her up to administer her medications. She said it was the same night she did not receive her pain medication. She said she could not recall who the nurse was that night. Resident #1 denied any issues receiving her medications and said she asked for her pain medications when she needed.2. Record review of Resident #2's face sheet, dated [DATE], indicated Resident #2 was a [AGE] year-old male admitted on [DATE]. Resident #2 had diagnoses including cerebral infarction (occurs when a blood clot forms in an artery in the brain disrupting blood flow and leading to brain death), hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood, particularly low-density lipoprotein), spinal stenosis, lumbar region (a condition characterized by the narrowing of the spinal canal, which can put pressure on the spinal cord and nerves), nontraumatic subarachnoid hemorrhage (a medical emergency characterized by bleeding in the space between the brain and the tissues that cover it, often leading to severe headaches and require immediate treatment) and type II diabetes (a condition in which the body has trouble controlling blood sugar).Record review of Resident #2's admission MDS, dated [DATE], indicated he was usually able to make self-understood and usually understood others. Resident #2 had a BIMS score of 10 indicating he had moderate cognitive impairment. Resident #2 was dependent on staff for toileting and bathing, personal hygiene, and lower body dressing. The MDS indicated Resident #2 received scheduled pain medication and as needed pain medication.Record review of Resident #2's care plan, dated [DATE], indicated Resident #2 took Gabapentin, Acetaminophen-codeine and Lyrica for pain related to diabetic neuropathy. Interventions included:The resident's pain would be alleviated/relieved by gabapentin and acetaminophen-codeine.Administer analgesic gabapentin and acetaminophen/codeine as per orders. Give half hour before treatment and care.Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.Evaluate the effectiveness of pain interventions. Review for compliance, alleviating symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.Record review of Resident #2's Medication Administration Record, dated [DATE]-[DATE], indicated he was prescribed Gabapentin 600 mg one tablet four times a day related to pain due to trauma and acetaminophen-codeine 300-30 mg one tablet every six hours as needed for pain.During an interview on [DATE] at 10:34 a.m., Resident #2 said sometimes his pain medication was effective. Resident #2 refused to answer any additional questions.During an interview on [DATE] at 10:37 a.m., LPN A said Resident #2 was prescribed Tylenol #3 1 tablet every 6 hours as needed for pain. LPN A said she reached out to the Physician and requested Resident #2's Tylenol #3 to be changed to 2 tablets every 6 hours for pain and Lyrica changed from 1 tablet daily to twice daily on [DATE]. She said there were three new medication cards delivered for Resident #2's Tylenol and Lyrica. She said when she returned the next morning ([DATE]), Resident #2 had one card with four tablets of Tylenol #3 missing. LPN A said LPN B had two tablets left in a cup on the medication cart. She said she picked up the medication cup, held them, and told LPN B that she would administer the medication. LPN A said she was able to identify the tablets from the imprint on the tablets. LPN A said LPN B was falling asleep while counting and seemed odd. LPN A said she was drug tested due to misappropriation and informed the facility that she was prescribed Tylenol #3 and said she knew she would come back positive. She said when she took her pain medication, she called off the next day so she would not be providing care while taking the medication. LPN A said she did not contact the Administrator because the weekend supervisor arrived to the facility. LPN A said LPN B seemed off at the beginning of her shift and she thought she was tired. LPN A said Resident #2 was screaming in pain and she administered his Tylenol #3 that morning. LPN A said she felt LPN B placed the residents in danger. LPN A did not state how she felt the nurse endangered residents. During an interview on [DATE] at 11:15 a.m., CNA C said LPN B moved fast. CNA C said LPN B could not get her motor skills going and she felt that she endangered the residents. She said LPN B often left things a mess in resident rooms and stated she was wound up. CNA C said multiple residents asked for pain medication and LPN B would not answer the call lights for pain medications. CNA C said LPN B would (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tell the residents she would get there when she could get there. CNA C said she had reported the nurse to LPN D. CNA C said she had been in-serviced on Abuse and Neglect and would report to the nurse, DON and ADM.During an interview on [DATE] at 11:48 a.m., the ADON said she had only been in her role for three months. She said the facility changed the way they counted the medication cart for narcotics. She said she was pulling expired and discontinued medications. She said the staff was in-serviced on medication handling, pharmacy, and misappropriation of medications.During an interview on [DATE] at 11:51 AM, the DON said she heard there was commotion on the unit. She said she received a call from CNA E. The DON said CNA E attempted to reach her on [DATE] at 8:00 a.m. The DON said the shift changed at 6:00 AM and that was the first call she received. The DON said she called and spoke with LPN B and LPN A. The DON said they explained the discrepancy with the narcotics and were still attempting to figure it out. The DON said she was not sure why it took them so long to call her. The DON said she lived one hour away from the facility, and it took her a while to get there. She said she did not come to the facility because there were two Supervisors on the floor at the time. She said RN F was oriented on the floor with RN G. The DON said CNA C reported the impaired nurse the day after it happened (unknown date). She said CNA C was upset and reported LPN B wasted a tube feeding in a resident bed, was tripping over herself, and felt there was something wrong with LPN B. The DON said it may have been a couple of days later, but she had instructed her that information needed to be reported immediately, and she said CNA C agreed to report immediately moving forward. The DON said she called the police department to make a report. She said the facility initiated a card audit and drug testing. The DON said she was told the drug screen (a technical analysis of biological sample typically urine used to detect the presence or absence of a specific illegal drug)for LPN B came back with a temperature issue. The DON did not come to the facility that day. The DON said she expected the nurses to contact her immediately of any medication discrepancies and to report any impaired employees immediately to her. She said an impaired nurse could cause a loss of trust, dignity, medication errors, treatment errors including a decline in a resident. She said the staff were in-serviced on abuse and neglect.During an attempted interview on [DATE] at 1:40 PM, LPN B was contacted and unable to leave a message due to voicemail was full.During an attempted interview on [DATE] at 2:52 PM, CNA E was contacted and a voice message was left and not returned by the end of this investigation.During an interview on [DATE] at 2:58 PM, RN F said she worked on the day of the drug diversion([DATE]). She said the only thing she did was perform the urine drug screen. She said the medication had already been counted. RN F said she and the Director of Human Resources stood at the door while LPN B provided the urine sample. RN F said the urine tested positive, but the temperature was not correct. RN F said she was not familiar with the test, and the Director of Human Resources did the test. RN F said she did not believe all the specimen was her urine and so the facility retested. RN F said LPN B handed them back an empty cup and told them she could not go again.During an interview on [DATE] at 3:05 PM, the Director of Human Resources said she drug tested the nurse on the drug diversion. She said RN F was with her and she had the specimen cup to provide. She said she made LPN B aware she had to take a drug screen. The Director of Human Resources said they took LPN B to an empty hall to provide privacy to obtain the sample. She said the first sample did not provide the proper temperature and stated it was positive for amphetamine. The Director of Human Resources said she asked LPN B if there was anything she was taking that could reflect on a drug screen and LPN B denied taking anything. The Director of Human Resources said if staff were prescribed a medication, they would tell her and show proof of the prescription. The Director of Human Resources said the Administration was the one who made the police report. The Human Resource Coordinator said LPN B was no longer employed and did not return after the incident.During an interview on [DATE] at 1:04 PM, the DON said the facility did a narcotic count for every hall using an audit tool. She said the facility did not have an actual form. The DON said for the March diversion,([DATE]-[DATE]) she identified residents who did not receive their scheduled medications. (Not signed off on the MAR). She said the staff (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intervened and interviewed residents, but they said they received their medications. The DON said the facility did another audit and contacted the pharmacy about medications not being delivered. She said nursing staff used the electronic medication dispensing system because the medications were not being delivered timely. The DON said the medications not delivered timely placed the residents at risk for receiving late administered medications. She said the nurses must pull the medications from the electronic medication dispensing system. The DON said the nurse had to stop and get the medications from the electronic medication dispensing system and the facility was working to address the situation. The DON said LPN B told her she did administer the medication but did not sign them out. The DON said she did an in-service with the staff on reporting impaired staff or nurses, Abuse, Neglect and Exploitation, and types of abuse. The DON said she had not reported the nurse to the licensing board and was consulting with corporate pending the State investigation. The DON said she expected the nurses to report any suspicion of an impaired staff member. The DON said she did not know if she was impaired but was different and extremely defensive. The DON said it was hard to tell over the phone.During an interview on [DATE] at 10:46 AM, LPN L said she had worked with LPN B. She said LPN B got overwhelmed and got behind. LPN L said LPN B would not change out the feeding tube bags for residents timely during her shift and she reported LPN B to the supervisor. LPN L said she would report any suspicion of an impaired staff member to the ADM and DON. She said she had spoken to the nurse before and told the DON of her concerns regarding residents with feeding tubes about a month ago.During an interview on [DATE] at 4:28 PM, the DON said she expected the staff to report any impaired staff member or concerns to her. She said she expected the nurses to report in real time any medication discrepancies during shift change. She said the receiving nurse was responsible for reporting the discrepancies and should not accept the keys or receive the medication cart until the counts were correct. She said a medication diversion could cause a resident not to receive their medication timely. The DON said a nurse may be impaired while attempting to care for a resident.During an interview on [DATE] at 4:53 PM, the ADM said she expected the staff to report any staff member who appeared impaired. She said she expected the nurses not to receive a medication cart if medications were not reconciled. The ADM said the DON and the charge nurse were responsible for ensuring the medications were secured. She said it could negatively impact the health and wellbeing of the residents.3. Record review of Resident #3's face sheet, dated [DATE], indicated Resident #3 was a [AGE] year-old female readmitted on [DATE]. Resident #3 had diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarette smoke and air pollution), urinary tract infection (an infection in any part of the urinary system), overactive bladder (sudden urges to urinate that may be hard to control), type II diabetes (a condition in which the body has trouble controlling blood sugar), and polyneuropathy (a nerve disease caused by damage to many nerves).Record review of Resident #3's quarterly MDS, dated [DATE], indicated she was able to make self-understood and understood others. Resident #3 had a BIMS score of 15 indicating she was cognitively intact. Resident #3 was dependent on toileting and bathing, personal hygiene, and dressing lower body. The quarterly MDS also indicated Resident #3 was on scheduled pain medication.Record review of Resident #3's care plan, undated, indicated Resident #3 was on pain medication therapy related to chronic pain. Interventions included:Administer analgesic medications as ordered by physicians. Monitor/document side effects and effectiveness every shift.Ask physician to review medication if side effects persist.For respiratory depression: Monitor respiratory rate, depth, and effort after administration of pain medications.Monitor for increased risk for falls.Monitor/document/report as needed adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritus, respiratory distress/decreased respirations, sedation, urinary retention.Record review of Resident #3's Medication Administration Record, dated [DATE]-[DATE], indicated she was prescribed Hydrocodone-Acetaminophen 10-325 mg 1 tablet by mouth one tablet four times daily for pain (continued on next page)

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	455678	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Longview	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management.Record review on [DATE] of the facility's Provider Investigation Report , requested to be scanned prior to departure on [DATE] to surveyor. Second request was made on [DATE] due to not receiving the information as requested.During an interview on [DATE] at 2:39 PM, Resident #3 said a couple of times the facility told her they had not received her pain medications but did not indicate a specific date or time the medications were not received. She reported that her pain medications were effective in managing her pain.4. Record review of Resident #4's face sheet, dated [DATE], indicated Resident #4 was a [AGE] year-old female readmitted on [DATE]. Resident #4 had diagnoses including urinary tract infection (an infection in any part of the urinary system), Parkinsonism (a group of movement related symptoms caused by neurological disorders), polyneuropathy (a nerve disease caused by damage to many nerves), muscle wasting and atrophy (a thinning of muscle mass due to disuse or nerve problems) and type II diabetes (a condition in which the body has trouble controlling blood sugar).Record review of Resident #4's quarterly MDS, dated [DATE], indicated she was usually able to make self-understood and usually understood others. Resident #4 had a BIMS score of 10 indicating he had moderate cognitive impairment. Resident #4 required moderate assistance with toileting, lower body dressing, and bathing. The quarterly MDS indicated Resident #4 did not have pain.Record review of Resident #4's care plan, dated [DATE], indicated Resident #4 had potential for pain related to polyneuropathy. Interventions included:Administer analgesia as per orders.Administer medication not classified as pain medication, Pregabalin and observe for effectiveness/side effects.Monitor/document for probable cause of each pain episode. Remove/limit cause where possible.Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea, vomiting, dizziness, and falls. Report occurrences to the physician.Monitor/record/report to nurse resident complaints of pain or requests for pain treatment.Notify physicians if interventions are unsuccessful or if current complaints are a significant change from resident's experience of pain.Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal, or resistance to care.During an interview on [DATE] at 2:23 PM, Resident #4 said she took pain medication and reported the pain medication was effective. She said there was a delay in medications received at times but did not recall a date or time. Resident #4 said she had to ask for pain medications because they were not scheduled.During an interview on [DATE] at 1:04 PM, the DON said the facility took statements from the staff but could not locate them and the previous Administrator was out. The DON said the facility changed pharmacies and she was not sure if the medications were received. She said the pharmacy did not use a packing slip and were digital. She reported the pharmacy would drop off medication in a package and she had completed an audit identifying some of the medications were not in the package delivered. The DON said the facility implemented a new process to identify each medication that was received. She said the staff must log on to the portal and print out the packing slip and if the medication was not in the package, the staff must call the pharmacy before the delivery driver leaves. The DON said prior to January, the nurse would just sign for the bag of medications received. The DON said she was not sure if the medication for Resident # 3 or Resident #4 was delivered to the facility.During an interview on [DATE] at 2:01 PM, LPN H said she worked the 6:00 PM- 6:00 AM shift and she was not sure when the medication for Resident #3 and Resident #4 went missing. She said the ADON notified her there was medication missing and she was told everyone had to do a drug test. She said the facility did not do drug test until two weeks after the medication was missing. LPN H said she was not in-serviced on drug diversion or abuse, neglect, and exploitation. She said she had not worked at the facility since February 2026. LPN H said she was given a packet on documentation that was asked to sign a signature page. LPN H said she was not even sure the medication was in the building. She said the North wing nurse would come to the unit and just set the medication at the nurse station and not hand it to the nurse. LPN H said the Hospice companies would have medications mailed to the facility. She said one day, there was a box with Tramadol, Xanax in a box for a Hospice (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. She said the medication was in the box for weeks. She said she put the medications on the cart when she found them. LPN H said she was messaged by the DON on [DATE] that she had 24 hours to take a drug test but said the medication went missing a couple of weeks before.During an interview on [DATE] at 2:12 PM, CMA J said she was in-serviced on proper handling of narcotics and there was a new sheet to sign in and out medications. CMA J said she had been in-serviced on abuse and neglect, signs of abuse and would report to the nurse over her and the DON.During an interview on [DATE] at 10:04 AM, RN K said the pharmacy normally dropped off at the North Hall, but it depended on the delivery driver. She said she would log in to the portal and print out the packing slip and check off all the medication that was in the package. RN K said if narcotics came in, she would get 2 narcotic sheets, and 2 nurses signed off on the delivery with the narcotic count sheet that was received. She said she started in [DATE] and was trained on the receipt of medications. RN K said if she did not receive a medication for a resident, she would check the Pyxis machine to determine if it was available. She said she would notify the MD to determine if the medication could be held until delivered if the medication was not available on the Pyxis. She said she would follow the orders the Physician provided and document on the MAR that the medication was being held and provide the reason. She said she would communicate on the 24-hour report to the oncoming staff. RN K said the delivery depended on then the nurse put in the order. She said if an order were placed after 5 o'clock p.m., the medication would not arrive until the next day.During an interview on [DATE] at 10:46 AM, LPN L said medications were delivered at night and she worked the day shift. She said if medications were received during the day shift, there was a process that the nurses had to log on to a portal and print the packing slip. She said the slips let them know what was in the package being delivered and they check the medication off by the quantity, the number of cards and they can sign after checking it all off. She said she made a copy of the sheet so there were two copies. LPN L said she had not received any packages that were off counts. She said the staff reviewed the process in meetings.During an interview on [DATE] at 3:16 PM, LPN L said she was aware of the medication missing in January (2026)She said she was not drug tested. She said she worked the North Hall. LPN L said if she ever had an off count, she would look to see where she was off and look to see if there was a miscount. She said she counted at the end of shift and before handing off the keys. She said she had worked with other nurses whose counts were off. She said she would go back and see when the medication was administered. She said sometimes they would check off the medication that were administered on the computer and later sign off on the narcotic sheet. She said the CMA, LPN, and RN were responsible for ensuring counts were correct. LPN L said they must print out the packing slip and stated it indicated how many cards, count and what was delivered. She said there was a cheat sheet form to follow, and the facility educated the staff. She said it could negatively impact residents because they may not get their pain medications causing blood pressure elevation and mood changes.During an interview on [DATE] 4:02 PM, the ADON said there was not a protocol in December (2025), and the new Pharmacy did not have packing slips. She said at that point, the facility had to intervene after identifying an issue. She said the staff started printing the packing slip and placed it in a book. She said the nurses and CMA had been in-serviced on how to log in, medication management, storage, and drugs. The ADON said she was not sure if the facility received the medications that were missing in January. She said at that time, they were paperless and there was not a resolution with the pharmacy to fix it. She said they had issues finding the packing slip and it was a batch signature. The ADON said she and the DON were responsible for ensuring the medications were received. The ADON said by not having the medication if ordered and not available could cause an issue or harm to a resident.During an interview on [DATE] at 4:28 PM, the DON said she expected the staff to follow the new protocol for counting the cards and signing with two nurses each shift or with medication cart change. She said she expected the nurses to report to her immediately if there were any discrepancies with medications. The DON said the charge nurse was responsible for ensuring the medications were stored and accounted for on their shift. She said she (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was responsible for medication storage and all accounted for medications. She said a resident could become stronger or weaker depending on the resident response to their medications.During an interview on [DATE] at 4:53 PM, the ADM said she expected the medication, narcotics to be reconciled and properly accounted for and stored. The ADM said the DON was responsible for making sure the medications were properly stored and accounted for. She said it could negatively impact a resident's wellbeing.Record review of the facility's Provider Investigation Report, dated [DATE], indicated the facility assessed sampled residents for pain, staff was in-serviced on abuse, neglect and exploitation, audited the last 30 days of narcotic medication deliveries to the facility, completed MAR to cart audits (a critical safety check comparing physical medication supplies in medication cart against active authorized orders listed on the MAR)for all units, and initiated and in-serviced card/bottle count and log (a critical safety and compliance process used to ensure that the physical inventory of medication matches the records on MAR)for each cart to be completed with each narcotic count on [DATE]. Record review indicated the facility initiated, and continued, monitoring tools three times a week for four weeks for the following: a. Medication room, b. Medication process being followed correctly, c. Narcotic count, card/bottle count audits, d. Resident Safe survey interviews. Record review of the facility's policy, dated 12/2025, titled, Drug discrepancies/Diversion of Medications, indicated, Policy.all discrepancies, suspected loss, and/or diversion of medications, irrespective of drug type or class, are immediately investigated and a report filed. Procedures.Immediately upon discovery or suspicion of a discrepancy, suspected loss of diversion, the ADM, DON and consultant pharmacist are notified and investigation conducted.I. Discrepancy on a drug count.The DON investigates the discrepancy and researches al the records related to medication administration and the supply.Medication reconciliation is made from the last known date and time of reconciliation.A thorough search is conducted in all drug storage areas, the resident room, and any locations where medications may have been used or placed during medication administration.If the discrepancy cannot be reconciled after a thorough investigation has be completed the remaining supply is documented with the current date and the accountability process restarted.The medication in question should be checked several times.Appropriate agencies required by state regulation will be notified. II Loss of supply of medication.The DON investigates the suspected loss and research all the records related to medication receipt, its use since receipt, and all persons involved with medication administration and supply of medication and identifies the last known point in time that medication was available. The pharmacy should be notified, and the pharmacy should verify the medication was dispensed.4. If the loss invoices a controlled substance, all the controlled drug accountability procedures and documents should be reviewed and audited. If the audit reveals a particular individual or individuals who might be suspected of involvement of loss, appropriate disciplinary actions are taken and deferred to human resource policy.