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	05/07/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing for 1 of 3 residents reviewed for pressure injuries (Resident #1). The facility did not ensure Resident #1 received his ordered wound care on the following dates and shifts; 4/24/26 on the pm shift; 5/1/26 on the pm shift; 5/2/26 on the am shift; and 5/3/26 on the pm shift after returning from the hospital for surgical debridement of his Stage IV pressure injury to the right hip. This failure could place Resident's with pressure injuries at risk for infection and wound deterioration.Findings included: Record review of Resident #1's face sheet indicated he was [AGE] years old re-admitted to the facility on [DATE]. The face sheet revealed Resident #1 was originally admitted to the facility on [DATE] on with diagnoses including chronic osteomyelitis with draining sinus (a persistent, long-term infection and inflammation of the bone, often leading to bone destruction, often requiring surgery and prolonged antibiotics- draining sinus is severe complication of chronic bone infection, where a persistent channel forms from infected bone through soft tissue to the skin, releasing pus) of the right femur (thigh bone), chronic osteomyelitis of the left femur, incomplete quadriplegia (spinal cord injury above the thoracic spine who retains partial motor function or sensation below the injury site), and a stage IV pressure injury of the right hip. Record review of the admission MDS assessment dated [DATE] revealed Resident #1 had clear speech, made himself understood and understood others. The MDS indicated Resident #1 was cognitively intact with a BIMS score of 13. The MDS indicated Resident #1 had no behavior of rejecting care. The MDS indicated Resident #1 was dependent on staff for toileting, showering, dressing the lower body, putting on and removing footwear. The MDS indicated Resident #1 required partial/ moderate assistance with personal hygiene. The MDS indicated Resident #1 indicated Resident #1 required substantial/maximal assistance with dressing the upper body, but required setup/clean-up assistance only with eating and oral hygiene. The MDS indicated Resident #1 had an indwelling catheter and ostomy (including ileostomy, colostomy). The MDS identified Resident #1 had 1 unhealed stage III pressure injury present on admission and 1 unhealed Stage IV pressure injury present on admission. The MDS indicated Resident #1 had pressure reducing device for his bed, pressure injury/ulcer care and the application of ointments/medications for pressure injury treatment. Record review of the care plan revised on 3/23/26, detailed that Resident #1 had a stage IV pressure injury to the right hip. Care plan interventions included administer treatments as ordered and monitor for effectiveness. The care plan also detailed Resident #1 had a stage III pressure injury to the coccyx (commonly known as the tailbone). Record review of the physician order with a start date of 4/21/26 and discontinue date of 4/29/26 indicated Resident #1 was to receive wound to the right hip pressure ulcer as follows: Dakins (1/4 strength) external solution 0.125% (Sodium Hypochlorite) Apply to right hip topically two times a day for wound healing right hip pressure ulcer (stage4); cleanse with wound cleanser, pack with dakins moistened, fluffed gauze, apply skin prep to surrounding skin, cover with superabsorbent dressing. Record review of the active physician order with a start date of 4/29/26 indicated Resident #1 was to receive wound care to the right hip pressure ulcer as follows: Cleanse with wound cleanser, pack with vashe moistened, (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluffed gauze, apply skin prep to surrounding skin, cover with superabsorbent dressing every shift for wound healing. Record review of the wound care progress note dated 3/10/26 documented Resident #1 Stage III pressure injury to the tail bone measured 0.5 cm in length by 1 cm in width by 0.2 cm in depth. The wound care progress note documented the Stage IV pressure injury to the right hip as measuring 4.5 cm in length by 2.5 cm in width and 0.2 cm in depth. This note was completed by Wound Care provider NP E. Record review of the wound care progress note dated 3/18/26 indicated the Stage III pressure injury to the tailbone had resolved. The note stated Coccyx PU: Resolved. Resident wound has resolved. Resolved wounds do not achieve their original tensile strength. It is possible for wounds to recur despite proper care and interventions. This note was completed by Wound Care provider NP E. Record review of the nursing progress note dated 4/7/26 documented Resident #1's Stage IV pressure injury 4.5 cm in length, 2.5 cm in width, and 2.4 cm in depth. Record review of the nursing progress note dated 4/13/26 documented NP E and NP F were notified Resident #1's Stage IV pressure injury had appearance changes and were in agreement to send Resident #1 to the hospital for further evaluation. Record review of the nursing note progress noted dated 4/20/26 at 9:09 p.m. indicated Resident #1 had returned from the hospital stating Resident arrived via (ambulance) transportation. Record review of the wound assessment report dated 4/21/26 detailed Resident #1's stage IV pressure injury to the right hip measured 5 cm in length by 9 cm in width and 3 cm in depth. The assessment was completed by NP E. During an interview on 5/5/26 at 11:00 a.m., Resident #1 said he received a surgical debridement of his wound at the hospital. He said he had history of pressure wounds and osteomyelitis in both his right and left legs. Resident #1 said he even had to have some bone removed from the right hip in the past. Resident #1 said since he returned from the hospital (on 4/20/26), he had not received wound care twice a day like he was supposed to. He said he could not say exactly how many days he had not received twice a day wound care, but stated it was more than three times. Record review of the Resident #1's April 2026 MAR/TAR reflected he missed wound care on the pm shift of 4/24/26. Record review of the Residents #1's May 2026 MAR/TAR reflected he was not provided wound care on the following dates and shifts;*5/1/26 on the pm shift;*5/2/26 on the am shift; and*5/3/26 on the pm shift. Record review of Resident #1's nursing progress notes dated April - May 2026 indicated Resident #1 was provided care by the following nurses on the following shifts; *4/24/26 on the pm shift - LVN A*5/1/26 on the pm shift- LVN G*5/2/26 on the am shift - LVN H*5/3/26 on the pm shift- LVN I. During an observation on 5/6/25 at 11:30 a.m., RN B performed wound care to Resident #1's Stage IV pressure injury to the right hip. The wound bed was bright red and had scant amount of light yellow slough (soft, moist, stringy, or viscous necrotic tissue, typically pale yellow, tan, or white, that forms on a wound bed as a byproduct of the inflammation phase), no foul odor was noted. The wound measured 6.2 cm in length 8.5 centimeters in width with a depth of 0.5 cm. During an interview on 5/6/26 at 3:00 pm, NP E said Resident #1's pressure wound was unavoidable. NP E said Resident #1 had a long history of osteomyelitis and history of bone removal. NP E said he admitted with the Stage IV wound and also had a Stage III to the sacrum on admission that had been resolved at that time. NP E said it was likely Resident #1 would have incomplete healing and recurrence of wounds. NP E said it was important for nurses to provide ordered wound care for maximum benefit. During an interview on 5/6/26 at 3:47 pm, NP F said Resident #1's pressure wound was unavoidable. NP F said it was unlikely that Resident #1's pressure injury would not heal for any significant length of time, and the possibility of new wounds was likely due to his complex medical diagnoses including chronic osteomyelitis. Record review of the progress note dated 5/1/26 at 5:53 pm documented Resident #1 had just returned from outpatient wound care. During an interview on 5/7/26 at 11:03 am, LVN H said she was a contracted staffing agency nurse that regularly worked at the facility. LVN H said she did remember Resident #1 asking her to look at his wound and change the dressing. LVN H said she asked another nurse to come with her to do the dressing change. LVN H said the nurse was busy and never assisted her and she forgot to return and look at the dressing herself, but said Resident #1 never got back on his call light about it. LVN H said (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not recall having wound care scheduled on her shift. During an interview on 5/7/26 at 4:00 p.m. at 3:50 p.m ., the DON said she expected nurses to perform wound care as ordered. The DON said the ADON J was the wound care nurse and quit without notice on 5/5/26. The DON said, until that [NAME], ADON J was providing wound care Monday through Friday during business hours. The DON said any ordered care on the weekends or night shift was to be performed by the charge nurses. The DON said the facility was working to reduce the use of staffing agency nurses. The DON said the facility was actively hiring and offering incentive bonuses. A follow up interview was attempted on 5/7/26 at 12:00 p.m. with LVN A over the phone but was not completed due to no answer. Record review of the facility's policy and procedures titled, Wound Care, revised October 2010, stated, the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician's order for this procedure. Documentation, The following information should be recorded in the resident's medical record: (1)The date the wound care was given. (2) The initials of the individual performing the wound care. (3) Any change in the resident's condition. (3) Any problems or complaints made by the resident related to the procedure. (4) If the resident refused the treatment and the reason(s) why. (5) The signature and title of the person recording the data.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and observations, the facility did not administer parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 2 residents reviewed for parenteral fluids (Resident #1). The facility failed to ensure Resident #1's PICC (peripherally inserted central catheter, is a long, thin, flexible tube inserted through a vein in the upper arm and guided into a large vein near the heart or just inside the heart) line dressing was changed at least every seven days. This failure could place residents receiving fluids or medications through a PICC line at risk of systemic infection. Findings included;Record review of Resident #1's face sheet indicated he was [AGE] years old re-admitted to the facility on [DATE] (originally admitted to the facility on [DATE]) with diagnoses including chronic osteomyelitis (a persistent, long-term infection and inflammation of the bone, often leading to bone destruction, often requiring surgery and prolonged antibiotics) of the right femur (thigh bone) and chronic osteomyelitis of the left femur. Record review of the care plan revised on 4/30/26 revealed the care plan did not address Resident #1's PICC line access. Record review of the hospital outpatient antibiotic infusion routine orders dated 4/20/26 indicated Resident #1 was to be administered Intravenous (within a vein- refers to the administration of fluids, medications, or nutrients directly into a patient's bloodstream through a needle or tube) piperacillin tazobactam (an antibiotic medication) 4.5 grams every 8 hours through 6/9/2026. The order indicated Resident #1 had a PICC line stating .PICC/midline Care weekly and prn (as needed). Record review of Resident #1's physician order summary report dated 5/5/26 revealed no orders for PICC line dressing changes. Record review of the Resident#1's MAR/TAR for April 2026 revealed no indication there had been any PICC line dressing changes performed. Record review of the Resident#1's MAR/TAR for May 2026 did not indicate there had been any PICC line dressing changes performed from 5/1/26 to 5/6/26. During an observation and interview on 5/5/26 at 11:00 a.m., Resident #1 laid in his bed. Resident #1 had a clear dressing to the anterior portion of the right upper arm dated 4/20/26. Resident #1 said he had the dressing since he went to the hospital. During an observation and interview on 5/5/26 at 1:13 pm, Resident #1 laid in his bed. Resident #1 had a clear dressing to the anterior portion of the right upper arm dated 4/20/26. A line insertion was visible under the clear dressing. Resident #1 said the dressing was placed during his most recent hospital stay. Resident #1 stated the dressing had not been changed since being re-admitted to the facility. During an observation and interview on 5/5/26 at 1:13 pm, Resident #1 laid in his bed. Resident #1 had a clear dressing to the anterior portion of the right upper arm dated 4/20/26. A line insertion was visible under the clear dressing. Resident #1 said the dressing was placed during his most recent hospital stay. Resident #1 stated the dressing had not been changed since being re-admitted to the facility. During an interview on 5/5/26 at 1:17 p.m., LVN A said she was caring for Resident #1. LVN A said she was staffing agency nurse and worked regularly at the facility. LVN A said she did not know if Resident #1's intravenous line was a standard peripheral IV or a PICC line (a standard IV is inserted into a shallow vein and has a short catheter, in contrast a PICC line is peripherally inserted midline catheter, the catheter is much longer and goes all the way up to a vein near the heart or just inside the heart). LVN A said she would have to look at his chart to check. During an observation on 5/6/26 at 9:15 a.m., Resident #1 laid in his bed. Resident #1 had a clear dressing to the anterior portion of the right upper arm dated 4/20/26. Resident #1 said he had the dressing since he went to the hospital. During an observation on 5/6/26 at 1:00 p.m., Resident #1 laid in his bed. Resident #1 had a clear dressing to the anterior portion of the right upper arm dated 4/20/26. Resident #1 said he had the dressing since he went to the hospital. During an interview on 5/6/26 at 1:15 p.m., RN B said PICC line dressing changes should have a sterile dressing change every 7 days as needed. RN B said if an as needed change needed to be performed, that dressing would be dated and the next dressing change (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be performed 7 days from that date. RN B said it was important for PICC line dressing changes to be performed every seven days to reduce the risk of infection. RN B said PICC line infections could be very serious because they were central line catheters. RN B said she was not caring for Resident #1 today but had taken care of him since his return from the hospital on 4/20/26. RN B said she had not performed a PICC line dressing change on Resident #1. RN B said it must have not been time for the dressing change when she cared for him. RN B said the PICC line dressing changes would show up on the nursing MAR or TAR for the Resident when it was time for it to be done. During an interview on 5/6/26 at 1:28 pm, LVN C said she had not taken care of Resident #1 since he had been back from the hospital. LVN C said she thought PICC line dressing changes needed to be done every 24 hours but was not sure. LVN C said she had not taken care of a resident with a PICC line since she started working at the facility at the end of January. During an interview on 5/6/26 at 1:40 p.m., LVN D said she was contracted agency nurse and had worked at the facility in the past. LVN D said she was taking care of Resident #1 today, and it was her first shift at the facility in six months. LVN D said PICC line dressing changes needed to be done every 3 days. LVN D said she was not sure if Resident #1 had a PICC line and would have to look in his chart. During an interview on 5/6/26 at 4:00 p.m. the DON said PICC line dressings were to be changed every 7 days. The DON said there was an order set associated with PICC line dressings that the admitting nurse should have entered when Resident #1 was admitted from the hospital with a PICC line. Record review of the facility's policy and procedure dated 11/1/25, titled Medication Administration -Intravenous Therapy, stated .Purpose-to ensure safe, effective, and standardized intravenous (IV) therapy and medication administration via Peripheral IVs, Midline Catheters, and PICC Lines in accordance with facility standards and regulatory requirements. The policy and procedure did not address the frequency or procedure for PICC line dressing changes. During an interview on 5/7/26 at 2:30 p.m., the Administrator said the facility had no additional policy and procedure pertinent to PICC lines. The CDCs Intravascular Catheter-related Infection (BSI) Prevention Guidelines accessed at, https://www.cdc.gov/infection-control/hcp/intravascular-catheter-related-infections/summary-recommendations , stated. Replace dressings used on short-term CVC (central vascular catheters[includes PICC lines]) sites at least every 7 days for transparent dressings, . replace dressings used on short-term CVC sites every 2 days for gauze dressings.