

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/16/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 6 (Resident #73) residents reviewed for quality of care. The facility failed to ensure Resident #73's skin was maintained during a respite care stay from 07/03/26 until 07/06/26. This failure could place residents at an increased risk for a decreased quality of care, neglect, and avoidable wound treatment. The finding included: Record review of the face sheet, dated 07/14/26, reflected Resident #73 was an [AGE] year-old female who admitted to the facility on [DATE] and discharged home on [DATE]. She had diagnoses that included hemiplegia, affecting right dominant side (paralysis of right side caused from a stroke) and vascular dementia without behaviors (type of dementia caused by reduced or blocked blood flow to the brain, leading to cognitive impairment that affects memory, thinking, and daily functioning). Record review of the baseline care plan, dated 07/03/26, reflected Resident #73 communicated easily with staff and was able to understand the staff. Her initial discharge goal was to receive respite care (a brief stay (no more than 5 days) for caregiver relief). The baseline care plan reflected Resident #73 usually required partial/moderate assistance with toileting hygiene and toilet transfer. She was frequently incontinent of bowel. She had no documented skin integrity issues. Record review of the admission note, dated 07/03/26, reflected Resident #73 had no skin issues. Record review of the Braden skin evaluation, dated 07/03/26, reflected Resident #73 was at risk for skin breakdown. Record review of the Discharge summary, dated [DATE], reflected Resident #73 had discharged from the facility with her family member. There were no skin issues identified. Record review of a photograph, dated 07/06/26 at 6:29 p.m., reflected Resident #73's buttocks had white scar tissues that had several areas of missing skin. The open areas were superficial with no measurable depth noted. The areas appeared bright red and wet. The areas were not directly over a bony prominence. During an interview on 07/14/26 at 9:54 a.m., Resident #73's family member stated she admitted on [DATE] for a respite care stay and left on 07/06/26. On 07/06/26, Resident #73's family member stated she called the facility around 4 p.m. to let them know she would be coming to pick up Resident #73 and requested that she was assisted on getting ready to leave. She said when she arrived at the facility at approximately 5:30 p.m., Resident #73 had dried bowel movement all the way up her back and around her perineal area. The family member stated Resident #73 had a clean incontinent pad that was placed on top of the dirty bottom sheet. She stated the bottom sheet had dried bowel movement. The family member stated Resident #73 had developed open areas on her bottom that were noticed when Resident #73 was being cleaned on 07/06/26. The family member stated that when Resident #73 was admitted to the facility, she did not have any skin issues. She stated CNA M provided care to Resident #73 on the day she admitted and could have verified she had no skin issues. The family member stated Resident #73 was taken to a wound care doctor and was still receiving treatment. The wound (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care doctor's notes were requested. During an interview on 07/14/26 at 1:40 p.m., CNA M stated when Resident #73 admitted to the facility on [DATE] her skin was immaculate. She stated Resident #73's skin was smooth and oiled down. CNA M stated she provided incontinent care and she had no open areas on her bottom. CNA M said she saw old scar tissue that appeared white, but nothing that was open. She stated the CNAs were responsible for completing rounds every two hours and when someone was incontinent. She stated she worked on 07/03/26 and on 07/04/26 and did not notice any skin issues on Resident #73. During an interview on 07/14/26 at 2:43 p.m., LVN F said on 07/06/26 at about 4 p.m., she asked CNA Q, who was sitting in the lobby area, to ensure Resident #73 was assisted with getting ready to leave the facility. She stated she instructed CNA Q to make sure she was clean and that her family member was going to take her home. LVN F stated her family member arrived at the facility around 5:30 p.m., and she was disgraced by what she observed. LVN F stated Resident #73 had bowel movement half-way up her back. She stated some of the stool was dried and some of it was loose, like she had multiple bowel movements. LVN F stated she asked the family member to step out of the room, so she could assist Resident #73 with incontinent care. She stated Resident #73 had several small, open, blistered areas on her bottom. LVN F stated it looked like the soiled brief had been sitting around that area causing moisture against the skin. LVN F stated it appeared the moisture could have caused some skin damage. During an interview on 07/15/26 at 2:13 p.m., LVN R stated on 07/03/26 she had been called in by the facility and arrived around 12:15 p.m. She stated she received report from the Wound Care Nurse that Resident #73 had just admitted. LVN R stated she performed Resident #73's skin assessment. She stated Resident #73 had no skin issues on admission. She stated Resident #73's skin was clean, oiled down, and she had no dry skin. LVN R denied working any more while Resident #73 was at the facility. During an attempted telephone interview, on 07/16/26 at 8:24 a.m., CNA Q did not answer the telephone. Unable to leave a voice message and there was no return telephone call upon exit of the facility. During an interview on 07/16/26 at 12:21 p.m., the DON stated Resident #73 had been admitted on [DATE] and discharged from the facility on 07/06/26. The DON stated she was unaware of any problems with Resident #73's stay until 07/07/26. She said on 07/07/26 during staffing meeting, she was informed by Resident #73's family member that Resident #73 was not checked on or changed during her stay. She was told that no one provided care whatsoever. She stated she was told that Resident #73 developed bed sores. The DON said she requested pictures from Resident #73's family member but had not received them. She stated once the family member voiced her concerns the Administrator took over the investigation. The DON stated she did not speak with the nurse who discharged Resident #73 but stated CNA Q had been terminated for failing to show up for her scheduled shift, unrelated. The DON stated she was unaware or unable to verify Resident #73 had any skin issues upon discharge. The DON stated she expected the discharge nurse to perform a skin assessment and report any skin issues identified. She stated skin issues should have been documented in a progress note or change of condition form. She stated the appropriate notifications should have been completed. She stated it was important to prevent the development of skin issues or breakdown for the resident's overall health. During an interview on 07/16/26 at 1:05 p.m., the Administrator stated Resident #73's family member had voiced complaints that Resident #73 had not been changed at any point during her stay. The Administrator stated that was untrue, because during the family members complaints, she stated when my mother was being changed. The Administrator stated she spoke with CNA M who stated she changed Resident #73. She was unable to contact CNA Q and she was terminated. She stated the family member had mentioned something about her skin, but she was unable to verify Resident #73 had developed any skin concerns while at the facility. She stated she spoke with LVN F who (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharged Resident #73 and she did not mention any skin concerns. The Administrator stated she expected the nurses to perform a skin assessment upon discharge and document their findings. She stated if new skin issues were identified, she expected the nurses to notify the physician and the family. She stated it was important to ensure residents did not develop skin breakdown for their overall health and quality of care. Record review of Resident #73's discharge from wound care clinical services note dated 07/16/26, reflected there was no open wound present. The notes indicated keep turning her every hour and keep clean of fecal matter to prevent pressure sores and continue to use the zinc to prevent moisture build up.[sic] There was no wound details and the weeks in treatment indicated 0. Record review of the Change in a Resident's Condition or Status policy, dated April 2025, reflected Our facility promptly notifies the resident, his or her attending physician, and the resident repetitive of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a(an): accident or incident involving the resident.significant change in the resident's physical/emotional/mental condition.need to alter the resident's medical treatment significant. Specific instruction to notify the physician of changes in the resident's condition.prior to notifying the physician. the nurse will make detailed observations and gather relevant and pertinent information.		