STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455831	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Paris	610 Deshong Dr Paris, TX 75460

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #1 and Resident #20) of 14 residents reviewed for call lights. Staff failed to ensure Resident #1 and Resident #20's call bells were within reach. This failure could place residents at risk for decreased self-worth, quality of life, and dignity.Findings included:1. Review of Resident #1's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses in part including dementia, restlessness and agitation, unspecified lack of coordination, weakness, and a history of traumatic brain injury (brain injury caused by outside force). Review of Resident #1's Comprehensive Care Plan revised 11/28/25 reflected Resident #1 had a history of falling. An intervention with start date 3/04/24 stated, keep call light in reach at all times.Review of Resident #1's MDS assessment dated [DATE] reflected that the resident was severely cognitively impaired. Resident #1 required partial/moderate assistance with mobility and at least substantial assistance with self-care activities.2. Review of Resident #20's face sheet dated 12/02/25 reflected a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses in part of pneumonitis (inflammation of the lungs), weakness, and paraplegia (paralysis affecting the legs). Review of Resident #20's Comprehensive Care Plan revised 10/07/25 reflected Resident #20 had a history of falling. An intervention with start date 3/24/25 stated, keep call light in reach at all times. Review of Resident #20's MDS assessment dated [DATE] reflected that the resident was moderately cognitively impaired. Resident #20 was dependent on assistance with mobility and required at least partial/moderate assistance with self-care activities. In an observation and interview on 12/02/2025 at 9:04 a.m., Resident #1 was noted laying sideways in his bed and his call bell was observed curled up and hung on the wall past the foot of the bed and out of the reach of the resident. A fall mat was observed beside the bed. Resident #1 stated his brief was wet, and he needed assistance. Resident #1 did not answer when asked further questions about his call bell. Staff were informed of Resident #1's request, and CNA A came promptly to assist the resident. In an observation on 12/02/25 at10:56 a.m., Resident #20 was observed in bed. His call bell cord was wrapped around the siderail of the bed with the push-pad hanging down from the bed approximately 2 feet and out of reach of Resident #20. In a follow-up observation and interview on 12/03/25 at 11:57 a.m., Resident #20 was observed in bed, and his call bell remained out of reach in the same location as seen on 12/02/25 at 10:56 a.m Resident #20 stated that he wanted more water to drink but that his call bell was on the floor somewhere. He expressed frustration with being unable to call for assistance and stated, there is a law about that. He did not know how long his call bell had been out of reach. He stated his call bell was typically within reach. Resident #20 stated he could not walk or otherwise obtain assistance without using his push-pad call bell. In an observation on 12/02/25 at 12:02 p.m., CNA A walked into the room and Resident #20 told him he wanted his drink refilled. Resident #20's call bell was not within his reach. CNA A took the cup and left the room without changing the placement of the call bell. CNA A returned shortly with the drink and began preparing the resident for incontinence care and transfer.In an interview on 12/02/25 at 12:08 p.m., CNA A stated that he had observed Resident #1s (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received an accurate assessment, which was reflective of the resident's status for one (Residents #27) of four residents reviewed for accuracy of assessments. The facility failed to ensure Resident #27's (a discharged resident) most recent quarterly and discharge assessments accurately reflected his physical behaviors directed at others. This failure could place residents at risk of not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health.Findings included: Review of Resident #27's Face Sheet, dated 12/02/25, reflected a male, admitted on [DATE], and having diagnoses of congestive heart failure (a condition in which the heart cannot pump enough blood, causing fluid to build up in the body), stroke (a blood clot in the brain, causing brain damage), schizoaffective disorder (a condition with symptoms of hallucinations/delusions combined with mood problems), depression, dementia with agitation, and adjustment disorder (emotional and behavioral problems in response to stress) with anxiety and depression. A family member was listed as his responsible party. Review of Resident #27's quarterly MDS, dated [DATE], reflected the staff assessment of his mental status indicated he had a memory problem, and moderately impaired daily decision-making skills, no delirium, and no physical, verbal, or other behavioral symptoms, as well as no rejection of care in the seven-day look-back period. The document reflected Resident #27 required substantial/maximal assistance (helper does more than half the effort) for most of his ADLs. The document was electronically signed by the MDS Coordinator. Review of Resident #27's discharge MDS, dated [DATE], reflected he was discharged to an acute care hospital. The staff assessment of his mental status indicated he had a memory problem, and moderately impaired daily decision-making skills, no delirium, and no physical, verbal, or other behavioral symptoms, as well as no rejection of care in the seven-day look-back period. The document reflected Resident #27 required substantial/maximal assistance (helper does more than half the effort) for most of his ADLs. The document was electronically signed by the MDS Coordinator. Review of Resident #27's discharge MDS, dated [DATE], reflected he was discharged to an acute care hospital. The staff assessment of his mental status indicated he had a memory problem, and moderately impaired daily decision-making skills, no delirium, and no physical, verbal, or other behavioral symptoms, as well as no rejection of care in the seven-day look-back period. The document reflected Resident #27 was dependent on staff for toileting hygiene, putting on footwear, hygiene, refused lower body dressing, and was not bathed/showered due to his condition. The document was electronically signed by the MDS Coordinator. Review of Resident #27's care plans reflected the following:- A history of, and potential for showing signs of delusions/ hallucinations, and having conversation with someone who is not there. Dated 04/22/25, revised 09/02/25 by the MDS Coordinator- Memory recall problem due to stroke. Dated 01/22/24, revised 09/02/25 by the MDS Coordinator- Potential to exhibit physically and verbally abusive behavior, with examples of hitting, shoving, scratching, and making sexually inappropriate comments toward staff. A note that Resident #27 struck another resident was made on 09/02/24. Dated 08/14/23, and revised 09/02/25 by the MDS Coordinator.- Socially inappropriate and disruptive behavior, including speaking very loudly, frequent inappropriate comments in others, and can become aggressive at times. Dated 07/03/23, and revised 09/02/25 by the MDS Coordinator.- Refusing to take medications almost daily, and refusing labs. Dated 12/22/22, and revised on 09/02/25 by the MDS Coordinator. Review of Resident #27's progress notes reflected the following:- 08/09/2025 at 9:10 AM by LVN D Made x2 attempts to give medication and assess resident this AM. Residentattempted to punch nurse in the face when trying to check radial pulse. Resident was also verbally aggressive with nurse. (.)- 08/09/2025 at 1:10 PM by LVN D When nurse entered room to check on resident. Resident asked for ice water.When nurse attempted to hand resident ice water he clawed her arm. Spoke with (Resident #27's responsible (continued on next page)

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During a telephone interview on 12/04/25 at 2:33 PM with the MDS Coordinator she confirmed that she had believed that the rule about not documenting behaviors in the MDS was for both the section regarding refusal of care, and the section about behaviors affecting the resident or others. She said the accuracy of the MDS was important because it was a direct reflection of the care the resident received, and inaccuracies could potentially affect the accuracy of the care plans, as well. An interview on 12/04/25 at 2:38 PM with the Regional MDS Coordinator revealed she needed to check the RAI manual, but she thought that behaviors should be recorded in the MDS, and the section regarding refusals was the only part where they would not be recorded if they were already recorded. She said the section regarding behaviors affecting the resident or others were, in part, recorded by observation, so if a resident was observed having a behavior during the lookback period, it would be recorded in the MDS, regardless of whether it was an already-known behavior. After a few minutes she returned to confirm that it was only the rejection of care section that if it was care-planned it did not have to be coded in the MDS. She said the accurate assessments were important for patient care, reimbursement and care planning. Review of the facility Resident Assessments policy, revised in March of 2022, reflected: 8. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. Review of the current Centers for Medicare and Medicaid Services Long-Term Care Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, October 2025, reflected: Section E: Behavior: Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident themself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. This section focuses on the resident's actions, not the intent of their behavior. Because of their interactions with residents, staff may have become used to the behavior and may underreport or minimize the resident's behavior by presuming intent (e.g., Resident A doesn't really mean to hurt anyone. They're just frightened.). Resident intent should not be taken into account when coding for items in this section. (.) E0200: Behavioral Symptom-Presence & Frequency: Subsequent assessments and documentation can be compared to baseline to identify changes in the resident's behavior, including response to interventions.Steps for Assessment 1. Review the medical record for the 7-day look-back period. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. 3. Observe the resident in a variety of situations during the 7-day look-back period. Coding Instructions Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. Code 1, behavior of this type occurred 1-3 days: if the behavior (continued on next page)

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