STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675289	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Azalea Heights	3505 Old Jacksonville Rd Tyler, TX 75701

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1)The facility failed to prevent Resident #1 from sustaining a fall from the bed on 08/28/2025 which resulted in a fractured right femur. The noncompliance was identified as PNC (past noncompliance). The IJ began on 08/28/2025 and ended on 09/02/2025. The facility had corrected the noncompliance before the survey began.This failure could place residents at risk of potential accidents, injuries, harm, or death.Findings included:Record review of Resident #1's face sheet on 09/29/2025 indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including: anoxic brain damage (a medical emergency that occurs when the brain does not get enough oxygen, even when blood flow is adequate), convulsions, aphasia (disorder that affects how you communicate), nonpsychotic mental disorder (a mental health condition that does not involve psychosis and includes anxiety disorders, depression and personality disorders), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disease), and high blood pressure.Record review of a quarterly MDS dated [DATE] indicated Resident #1 had no speech, sometimes understood others and was sometimes understood, she had a BIMS score of 00 indicating severe cognitive impairment. She required total assistance with ADLs and could not feed herself. She was incontinent of bladder and bowel. She was dependent with mobility and walking unassisted. She had one fall with major injury since the prior MDS assessment. She received a mechanically altered diet. She had a surgical wound.Record review of care plans for Resident #1 indicated she had a care plan initiated on 10/18/2023 and revised on 05/02/2024 which indicated she was at risk for falls due to debility, weakness, and cognitive impairment. Goals included: The resident will be free from falls and/or will not experience significant injuries associated with falls through next review date. Care plan interventions included: bed at appropriate height when unattended and a bolster on mattress for safe boundaries to minimize risk for rolling out of bed.Review of Resident #1's Progress Notes in the electronic record indicated the following:Progress note dated 8/28/2025 at 2:55 PM indicated resident noted lying on her right side on the floor by her bed, laceration noted to face just under left eyebrow, purple bruise noted to right knee, decreased length and internal rotation noted to right lower extremity, resident shows signs and symptoms of pain when she attempts to move, all other extremities have normal ROM, EMS notified and in route, DON, Administrator, NP and family notified, attempted to make resident as comfortable as possible on floor without excessive movement, will continue to observe. Progress note dated 8/28/2025 at 3:08 PM indicated EMS in facility to transfer resident, resident in route to ER, attempted to call report in to hospital, nurse at ER stated she will receive report from EMS.Progress notes dated 8/31/2025 at 6:22 PM indicated Resident came from hospital after right hip surgery. resident currently stable, alert, and without acute distress. Dressing to surgical wound dry and intact. v/s BP 103/56, temp. 99.3 oxygen saturation 100% on room air heart rate 109. Will continue routine care and monitoring.During an observation on 09/29/2025 at 8:20 AM Resident #1 was at the nurses' station in her specialized wheelchair with the back tilted backwards. She was alert to her surroundings and looking about. She was clean and dressed appropriately for the day.During an observation on 09/29/2025 at 2:20 PM Resident #1 was in her bed. The head of the bed was elevated 45 degrees and she was lying on her left side. She opened her eyes when the room was entered but laid her head back down and closed her eyes. The bed was in the low position and bolsters were present on the bed on both sides of the resident. The bolsters were short in length and covered the middle length of the mattress.During an interview on 09/29/2025 at 2:25 PM CNA U was in Resident #1's room and said she had worked at the facility about a year. She said Resident #1 was to have bolsters on her bed when she was in the bed because she moved around a lot and could fall out of bed. During an interview on 09/29/2025 at 3:15 PM, ADON A said she was next door to Resident #1's room on the afternoon of 08/28/2025 and heard a loud bump or thud sound; She said LVN Q was making his start of shift rounds and called to her to come to Resident #1's room. She said the resident was on the floor. She said a wedge cushion was in front of the closet at the foot of the roommate's bed. She said the bed was also left in the higher position where it would normally be during a mechanical lift transfer. She said she did not see any bolsters or wedge cushions on the bed or around the resident. She said the resident required the bolsters because she wiggled and moved about in the bed and had very poor control over her body. During