

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  Avir at Azalea Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide personal privacy when providing care for 1 of 7 (Resident #1) residents reviewed for privacy. The facility did not ensure CNA A and CNA B pulled the privacy curtain while providing incontinent care on Resident #1 on 4/29/26. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: 1. Record review of the face sheet dated 4/29/26 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Guillain-Barre Syndrome (a rare autoimmune disorder where the immune system attacks the peripheral nerves (nerves located away from the center of the body), causing rapid-onset weakness, tingling, and potential paralysis), anxiety, major depressive disorder, muscle weakness, and need for assistance with personal care. Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 15 and was cognitively intact. The MDS indicated Resident #1 was dependent on staff for toileting. Record review of the care plan revised 1/3/26 indicated Resident #1 had a self-care deficit related to impaired physical mobility with interventions including incontinent care with one-person staff assist. During an observation on 4/29/26 at 1:16 p.m. CNA A performed incontinent care with assistance from CNA B on Resident #1. Resident #1's roommate was observed lying in bed with eyes closed. CNA A and CNA B did not pull the privacy curtain prior to starting or during incontinent care. During an interview on 4/29/26 at 1:24 p.m. CNA B said when performing incontinent care the privacy curtain should be pulled. CNA B said Resident #1 had not been provided with privacy during incontinent care. CNA B said she forgot to ensure the privacy curtain was pulled. CNA B said the importance of providing privacy during incontinent care was so no one could watch and so the resident was covered. During an interview on 4/29/26 at 1:26 pm CNA A said when performing incontinent care, the door should be shut, or the privacy curtain should be pulled. CNA A said she thought the privacy curtain had been shut during Resident #1's incontinent care. CNA A said the importance of providing privacy during incontinent care was resident rights. During an interview on 4/30/26 at 11:41 a.m. the DON said she expected staff to provide privacy to a resident when performing personal care. The DON said she expected staff to provide privacy by closing the door, pulling the privacy curtain, and closing the blinds. The DON said the importance of providing privacy during care was for the residents' dignity. During an interview on 4/30/26 at 12:00 p.m. the Administrator said she expected staff to provide privacy to the residents anytime they were providing a resident with personal care. The Administrator said she expected staff to provide privacy by closing the door, pulling the privacy curtain, and closing the blinds. The Administrator said the importance of providing privacy to the residents during care was so the residents did not feel their privacy was being invaded. Record review of the facility's Perineal (diamond-shaped region located between the thighs) Care revised 2/2018 indicated, The purpose of this procedure is to provide comfort and cleanliness to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Steps in Procedure.f. Provide privacy as appropriate, such as closing doors/curtain, drape resident. Record review of the facility's Resident Rights policy revised 2/2021 indicated, Employees (continued on next page)</p>		

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:  675289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  Avir at Azalea Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>shall treat all resident with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence.t. privacy and confidentiality.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  Avir at Azalea Heights		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 staff (CNA A) viewed for infection control. The facility failed to ensure CNA A performed hand hygiene between glove changes while providing incontinent care to Resident #1 on 4/29/26. This failure could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings Include: During an observation on 4/29/26 at 1:16 p.m. CNA A performed incontinent care with assistance from CNA B on Resident #1. CNA A and CNA B obtained hand sanitizer from dispenser on the wall outside Resident #1's room. CNA A and CNA B knocked on the door prior to entering and closed door behind them. CNA A and CNA B used the hand sanitizer in their hand to perform hand hygiene and put on a clean pair of gloves. CNA A moved Resident #1's bed out from against the wall, removed her gloves, and did not perform hand hygiene. CNA A put on clean gloves, opened front of Resident #1's brief, used disposable wipes to wipe Resident #1's pelvic and vaginal area, removed her gloves, and did not perform hand hygiene. CNA B assisted Resident #1 in rolling onto her side. CNA A put on clean gloves, used disposable wipes to wipe Resident #1's bottom, removed the dirty brief, removed gloves, and did not perform hand hygiene. CNA A obtained a clean brief, put on clean gloves, and removed chuck pad (highly absorbent, disposable or washable underpads designed to protect beds, furniture, and wheelchairs from fluid leaks) from underneath Resident #1. CNA A removed gloves, did not perform hand hygiene, and obtained clean chuck pad. CNA A put on clean gloves, placed clean chuck pad underneath and put clean brief on Resident #1. CNA A gathered up trash, removed, gloves, exited room, performed hand hygiene, and disposed of trash. During an interview on 4/29/26 at 1:26 p.m. CNA A said hand hygiene should be performed prior and after providing care to a resident. CNA A said hand hygiene should be performed between glove changes. CNA A said she did not perform hand hygiene between glove changes because the hand sanitizer dispensers were located outside the resident rooms in the hallway. CNA A said the facility did have small bottles of hand sanitizer floating around somewhere but she was not sure where. CNA A said the importance of proper hand hygiene was to prevent the spread of germs and cross contamination. During an interview on 4/30/26 at 11:41 a.m. the DON said she expected staff to perform hand hygiene before entering a room, before putting on gloves, after taking off gloves, during care, and when exiting a room. The DON said the importance of hand hygiene was infection control. During an interview on 4/30/26 at 12:00 p.m. the Administrator said she expected hand hygiene to be performed before and after providing care, eating, and using the restroom, before putting on gloves, and after removing gloves. The Administrator said the importance of proper hand hygiene was to prevent the spread of germs. Record review of the facility's Handwashing/Hand Hygiene policy updated 1/2025 indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol-based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility. Hand hygiene is indicated: a. immediately before touching a resident. c. after contact with blood, body fluids, or contaminated surfaces. d. after touching a resident. e. after touching the resident's environment. g. immediately after glove removal. immediately after glove removal.</p>		