| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675289 | A. Building<br>B. Wing | 12/10/2025 |

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| Avir at Azalea Heights | 3505 Old Jacksonville Rd<br>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.

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview and record review, the facility failed to ensure medications were prepared and administered in a manner that prevented medication errors for 1 of 2 MA medication carts (MA Cart #1) and 1 of 2 licensed nurse medication carts (LN Cart #1) observed for controlled medications storage.LVN B was observed on 12/10/2025 signing the controlled substance count sheets for the end of their shift at the beginning of their shift on LN Cart #1.MA A was observed on 12/10/2025 signing the controlled substance count sheets for the end of their shift at the beginning of their shift on MA Cart #1. These failures created the potential for medication diversion, administration of incorrect medication and compromised resident safety could place residents at risk of not receiving medications as ordered by the physician.Findings included:During an observation on 12/10/2025 at 3:22 PM, while doing observation of 2/4 med cart it was discovered that LVN A and MA B, were signing on and off at the same time of signing on at shift count, The controlled drugs on hand. During a record review on 12/10/2025 at 3:22 PM, the sign on/off sheet read, signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication count is in agreement with the quantity stated on the controlled.During an interview on 12/10/2025 at 3:25 PM, LVN A he said he always signed both coming/going slots on the Nurse on and Nurse off at the same time so he would not forget at the end of his shift, He said he knew he should not because he would be responsible if something happened to him during his shift. During an interview on 12/10/2025 at 3:30 PM, MA B she said she always signed both coming/going slots on the: Nurse on and Nurse off, at the same time so she would not forget at the end of her shift. She said she had gotten into trouble for forgetting to sign off so she did it at the same time. She knows she should not do it that way because if the count was wrong, she would be responsible if something happened to her during her shift.During an interview on 12/10/2025 at 3:35 PM, the ADON, Treatment Nurse, and DON all said each nurse and MA were to sign the Drug Administration Record Controlled Drug Count Record at the time coming on to their shift and at the time they were going off their shift. The DON said she had in serviced all nurses and MAs on the procedure and she was ultimately responsible for monitoring and making sure it was done correctly. Record review of a policy and procedure document titled Controlled Substances indicated the facility with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II -V of the comprehensive Drug Abuse Prevention and Control Act of 1976) revised November 2022.4. Nursing staff coming on duty and nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure assessments accurately reflected the resident's status of 1 of 5 residents (Resident #5) reviewed for accuracy of assessments. The facility failed to ensure 1 admission MDS assessment dated [DATE] and 2 quarterly MDS assessments dated 04/02/25 and 07/03/25 were accurately coded to reflect Resident #5's diagnoses of schizophrenia (a chronic brain disorder causing distorted reality), seizures, and TBI (an injury to the brain caused by an external force leading to functional, physical, cognitive, emotional, or behavioral problems). This failure could place residents at risk for not receiving needed care and services to maintain the highest level of well-being.Findings included: A review of a face sheet dated 12/10/2025 indicated Resident # 5 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included TBI, seizures, recurrent depressive disorder, and mood (affective) disorder (any of a group of conditions of mental and behavior disorders and include major depression disorder and bipolar disorder). A review of hospital records dated 03/07/2025 and sent to the facility on [DATE] reflected a list of Resident #5's medical diagnoses which included diagnoses of major depressive disorder, history of traumatic brain injury, and seizure disorder. A review of Resident #5's undated care plan indicated a focus/concern initiated on 03/11/2025 (day of admission) for antipsychotic medication related to Resident #5 having mood disturbances related to diagnoses of depression and schizophrenia. The same care plan also indicated a focus/concern initiated on 03/11/2025 for Resident #5 having difficulty expressing needs and the potential to misunderstand others due to cognitive communication deficits related to his history of traumatic brain injury. A review of an admission MDS dated [DATE] reflected Resident #5 had a BIMS score of 14 indicating his cognition was intact. The same MDS indicated Resident #5 was non-ambulatory, continent, and able to self-transfer. Further review of the admission MDS dated [DATE] reflected Section I: Active Diagnoses was not correctly coded to include Resident #5's medical diagnoses of TBI, seizures, and schizophrenia. A review of a quarterly MDS dated [DATE] reflected Section I: Active Diagnoses was not correctly coded to include Resident #5's medical diagnoses of TBI and schizophrenia. A review of a quarterly MDS 07/03/2025 reflected Section I: Active Diagnoses was not correctly coded to include Resident #5's medical diagnosis of TBI. During an interview with the MDS Coordinator on 12/10/2025 at 10:20 AM, she said the facility used the RAI Version 3.0 Manual as the policy for completing MDS assessments. She said it was her responsibility to correctly code the MDS. When asked about the coding of Resident #5's diagnoses on the MDS's, the MDS Coordinator said it was her mistake, and she was not sure how she missed coding them. During an interview with the DON on 10/12/2025 at 03:15 PM, she said she expected the MDS assessments to be coded correctly. She said it was a team effort to ensure the MDS's were coded correctly. A review of the October 2024 RAI 3.0 Manual: Section I: Active Diagnoses included the following: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided accurate Preadmission Screening and Resident Review (PASARR) Screenings for 1 of 5 residents (Resident #5) reviewed for PASARR. The facility failed to ensure Resident #5 had an accurate PASARR Level 1 Screening which indicated a diagnosis of mental illness and refer Resident #5 to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASARR Evaluation), individualized care, and specialized services to meet their needs.Findings included: A review of a face sheet dated 12/10/2025 indicated Resident #5 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included recurrent depressive disorder and mood (affective) disorder (any of a group of conditions of mental and behavior disorders such as major depression disorder and bipolar disorder). A review of an admission MDS dated [DATE] reflected Resident #5 had a BIMS score of 14 indicating his cognition was intact. Further review of the same MDS indicated Resident #5 was non-ambulatory, continent, and able to self-transfer. A record review of Resident #5's PASRR Level 1 Screening completed by the referring entity on 03/11/2025 indicated in section C0100 there was no evidence of this individual having mental illness. A review of hospital records dated 03/07/2025 and sent to the facility on [DATE], the day before Resident #5's discharge and admission to the facility, reflected a list of Resident #5's medical diagnoses which included a diagnosis of major depressive disorder. A record review of the care plan with a date initiated on 03/11/2025 indicated Resident #5 was at risk for complications of antipsychotic medication therapy related to Resident #5 having mood disturbances related to diagnoses of depression and schizophrenia. A record review of a MAR dated 03/11/2025 - 03/31/2025 indicated Resident #5 had orders for and received the psychotropic medications of sertraline and bupropion to treat a depressive disorder and quetiapine to treat an unspecified mood (affective) disorder. Record review of the Comprehensive (admission) MDS assessment dated [DATE] reflected in Section I: Active Diagnoses that Resident #5 had diagnoses of depression and mood disorder. During an interview on 12/10/2025 at 10:25 AM, the MDS Coordinator said she was responsible for ensuring the accuracy of the PASRR Level I screenings. She said she missed seeing that Resident #5's PASRR Level I was incorrect.She said Resident #5 did not receive a Level II PASRR screening due to the incorrect Level I PASRR. She said she coded the admission MDS assessment for depression and mood disorder but did not catch that the PASRR Level 1 screening was incorrect. She said the facility did not ensure an accurate Level I PASRR was completed which led to a Level II PASRR screening not being completed. During an interview with the SW on 12/10/2025 at 10:40 AM, she said she was responsible for notifying the LA of an incorrect PASRR. She said she was not aware that Resident #5's Level I PASRR was incorrect. During an interview on 12/10/2025 at 02:05 PM, the DON said the facility should have caught the error on Resident #5's PASRR Level I. She said it was important to have correct PASRR Level screenings to ensure residents were referred for PASRR Level II evaluations. The DON said incorrect PASRR screenings could result in a resident not receiving needed services. She said the facility used the RAI Version 3.0 Manual as the policy for completing PASRR tasks. A review of the October 2024 RAI 3.0 Manual: Chapter 3: Section A 1500 indicated the following: All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for a possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a baseline care plan within 48 hours of admission and provide the resident and or the resident representative with a summary of the baseline care plan for 1 of 5 residents reviewed for the base line care plans. (Resident # 93) The facility did not complete a baseline care plan within 48 hours of admission and provide a written summary of the baseline care plan to Resident # 93 or their responsible party. This failure could place newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission.Findings included:A review of Resident # 93's face sheet and physician's orders for December 8, 2025, indicated the resident was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses including displaced fracture of base of neck of right femur, seizures, hypertension, and Gasto-esophageal reflux disease. A review of the electronic record on 12/08/2025 for Resident #93 indicated no documentation of a baseline care plan or a written summary was performed and provided to the resident or her responsible party. During an observation and interview on 12/8/2025 at 9:30A.M., Resident # 93 was in his room. He was clean, well-groomed, and in bed with the bed in a low position, water and call light within reach. No signs of abuse, neglect, or environmental hazards were observed. The resident stated he was recently admitted for rehabilitation following a fall at home and hoped to return soon. During an interview on 12/08/2025 at 11:05 AM, ADON said the baseline care plan for Resident #93 was not in the clinical record and could not be located in the electronic clinical record. She said a baseline care plan for Resident #93, who was admitted on [DATE] and was due by 12/06/2025, should have been initiated by a RN or the DON with the interdisciplinary team adding to it. She explained that the baseline care plan is then reviewed with the resident and/or the responsible party, signed and filed in the electronic clinical record. During an interview on 12/10/2025 at 11:10 AM, the DON said the baseline care plan was not present in the clinical record for Resident #93. She said it was not done. She said the baseline care plan should have been initiated when Resident #93 admitted to the facility on [DATE] and completed on 12/06/2025. She said the RN in charge, usually the DON, should initiate the baseline care plan and the interdisciplinary team add to it and then it is presented to the resident and/or their responsible party and reviewed together. She said then the resident or the party responsible would sign they had received and reviewed the baseline care plan, and it would be indicated in the clinical record. Record review of the facility policy Care Plans - Baseline revised March 2022 indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission.4. The resident and/or representative are provided a written summary of the baseline care plan.5. Provision of the summary.is documented in the medical record. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 4 residents (Resident #45) reviewed for care plans. The facility failed to ensure Resident #45's care plan reflected her fingernail care needs and preference for eating her meals with her fingers and hands. This failure could place residents at risk of not receiving care and services to meet individualized medical and nursing needs. Findings included: A review of a face sheet dated 12/10/2025 indicated Resident #45 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included frontotemporal neurocognitive disorder (encompasses several types of dementia involving the progressive degeneration of the brain marked by communication loss, motor skill decline, and cognitive and physical impairment). A review of an annual MDS assessment dated [DATE] reflected Resident #45 had a BIMS score of 99 indicating she was not able to complete the interview. Further review of the same MDS indicated Resident #45 was non-ambulatory, incontinent, and dependent on staff for all activities of daily living. A review of the physician orders dated 12/10/2025 indicated Resident #45 had an order dated 10/18/2024 for a regular diet, regular consistency with no other specific instructions. A review of Resident #45's undated comprehensive care plan indicated an identified concern for self-care deficit that was initiated on 12/18/2024 and revised on 09/22/2025. The care plan did not address Resident #45's preference for finger foods, use of her fingers to eat and nail care needs. A review of Resident #45's nurse aides' task assignment sheet dated December 2025 did not indicate Resident #45 had any nail care needs. During an observation on 12/08/2025 at 11:05 AM, Resident #45 was observed sitting in a Geri-chair in the dining room following an activity. Resident #45 was observed to have a dried, brownish substance underneath her fingernails on both hands. An attempt to engage Resident #45 in conversation was unsuccessful. During an observation on 12/08/2025 at 12:25 PM, Resident #45 was observed sitting at a table in the dining room with an unidentified staff person sitting beside her. The staff person was observed to spoon feed Resident #45 bites of a vegetable salad while Resident #45 was observed to feed herself pieces of a hot dog and bun using her fingers. Resident #45's was noted to have a dried, brownish substance underneath her fingernails on both hands. During an observation on 12/08/2025 at 02:00 PM, Resident #45 was observed sitting in the dining room after lunch and was noted to have a dried, brownish substance underneath her fingernails on both hands. During an observation on 12/08/2025 at 04:30 PM, Resident #45 was observed sitting in the dining room at a table and a dried brownish substance was noted underneath her fingernails on both hands. During an observation on 12/09/2025 at 08:45 AM, Resident #45 was observed sitting in the dining room after breakfast and was noted to have a dried brownish substance underneath her fingernails on both hands. During an observation on 12/09/2025 at 12:30 PM, Resident #45 was observed sitting in the dining room at a table, using her fingers to feed herself a sandwich with CNA-F sitting beside her and spoon feeding her a vegetable. Resident was noted to have a dried, brownish substance underneath the fingernails on both hands. During an observation on 12/09/2025 at 02:10 PM, Resident #45 was observed sitting in the dining room with other residents, and was noted to have a dried, brownish substance underneath her fingernails on both hands. During an observation on 12/09/2025 at 04:45 PM, Resident #45 was observed sitting at a table in the dining room waiting for evening meal to be served. Her fingernails on both hands were noted to have a dried, brownish substance under them. During an observation on 12/10/2025 at 08:08 AM, Resident #45 was observed sitting upright in bed with the head of the bed elevated. Her fingernails on both hands were noted to be dirty with a dried, brown substance underneath her nails. During an interview and observation on 12/10/2025 at 08:11, the<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ADON opened Resident #45's hands and held them out for a closer observation of Resident #45's fingernails. All fingernails on both hands were observed to be dirty with a dried, brownish substance underneath them. The ADON said Resident #45's fingernails needed cleaning. During an interview and observation on 12/10/2025 at 09:30 AM, CNA-F was observed sitting beside Resident #45's bed and was cleaning Resident #45's fingernails. CNA-F said Resident #45 ate her meals using her fingers and hands. She said Resident #45 preferred having foods she could pick up with her fingers and eat. CNA-F said Resident #45 would allow staff to spoon feed her some things as long as Resident #45 could have something in her hands that she could feed herself. She said the dried, brownish substance was dried food. CNA-F said she should have cleaned Resident #45's fingernails after she helped her eat lunch on 12/09/2025. She said Resident #45 needed to have her fingernails and hands cleaned after every meal. CNA-F said if a resident required special instructions like nail care after meals, it should be on the nurse aides' task assignment sheet. During an interview on 12/10/2025 at 09:40 AM, CNA-G said she took care of Resident #45 on 12/08/2025. She said she did not notice Resident #45 needed nail care. An attempt to interview CNA-H, who was assigned to provide care to Resident #45 on 12/09/2025, by phone on 12/10/2025 at 10:02 AM was unsuccessful. During an interview with CNA-E on 12/10/2025 at 10:15 AM, she said she helped on the hall on 12/09/2025 where Resident #45 resided but could not recall providing any care to Resident #45. During an interview on 12/10/2025 at 02:10 PM, the DON said Resident #45's care plan and nurse aides' task assignment sheet should address Resident #45's preference for finger foods and her need for nail care after meals. She said the care plan team was responsible for ensuring the care plan addressed the specific needs of residents. She said eating with dirty fingernails could lead to illness. She said the nurses were responsible for ensuring residents received needed hygiene care. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered and dated as revised March 2018 and updated February 2025 included the following: 7. The comprehensive, person-centered care plan: .d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem areas and conditions. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for one of five residents (Resident # 45) reviewed for quality of life. The facility failed to ensure Resident #45 received nail care. This failure could place residents at risk for poor hygiene, dignity issues, and a decline in quality of life. Findings included: A review of a face sheet dated 12/10/2025 indicated Resident #45 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included frontotemporal neurocognitive disorder (a disorder that encompasses several types of dementia involving the progressive degeneration of the brain marked by communication loss, motor skill decline, and cognitive and physical impairment). A review of an annual MDS assessment dated [DATE] reflected Resident #45 had a BIMS score of 99 indicating she was not able to complete the interview. Further review of the same MDS indicated Resident #45 was dependent on staff for all activities of daily living (ADLs) which included showering and personal hygiene care. A review of a comprehensive care plan dated as initiated on 12/18/2024 indicated Resident #45 had a self-care deficit for activities of daily living. The care plan included interventions to address Resident #45's need for assistance with hygiene care. Record review of a nurse aides' task assignment sheet dated 12/2025 indicated the task of assisting Resident #45 with hand hygiene as needed was assigned to the certified nurse aides. Record review of the plan of care flowsheet schedule for 12/2025 indicated Resident #45 received hand hygiene care on 12/08/2025 at 04:04 AM, 01:59 PM, and 08:44 PM. The flow sheet indicated Resident #45 received hand hygiene on 12/09/2025 01:59 PM and 08:20 PM and again on 12/10/2025 at 04:10 AM. During an observation on 12/08/2025 at 11:05 AM, Resident #45 was observed sitting in a Geri-chair in the dining room following an activity. Resident #45 was observed to have a dried, brownish substance underneath her fingernails on both hands. An attempt to engage Resident #45 in conversation was unsuccessful. During an observation on 12/08/2025 at 12:25 PM, Resident #45 was observed sitting at a table in the dining room with an unidentified staff person sitting beside her. The staff person was observed to spoon feed Resident #45 bites of a vegetable salad while Resident #45 was observed to feed herself pieces of a hot dog and bun using her fingers. Resident #45's was noted to have a dried, brownish substance underneath her fingernails on both hands. During an observation on 12/08/2025 at 02:00 PM, Resident #45 was observed sitting in the dining room after lunch and was noted to have a dried, brownish substance underneath her fingernails on both hands. During an observation on 12/08/2025 at 04:30 PM, Resident #45 was observed sitting in the dining room at a table and a dried brownish substance was noted underneath her fingernails on both hands. During an observation on 12/09/2025 at 08:45 AM, Resident #45 was observed sitting in the dining room after breakfast and was noted to have a dried brownish substance underneath her fingernails on both hands. During an observation on 12/09/2025 at 12:30 PM, Resident #45 was observed sitting in the dining room at a table, using her fingers to feed herself a sandwich with CNA-F sitting beside her and spoon feeding her a vegetable. Resident was noted to have a dried, brownish substance underneath the fingernails on both hands. During an observation on 12/09/2025 at 02:10 PM, Resident #45 was observed sitting in the dining room with other residents, and was noted to have a dried, brownish substance underneath her fingernails on both hands. During an observation on 12/09/2025 at 04:45 PM, Resident #45 was observed sitting at a table in the dining room waiting for evening meal to be served. Her fingernails on both hands were noted to have a dried, brownish substance under them. During an observation on 12/10/2025 at 08:08 AM, Resident #45 was observed sitting upright in bed with the head of the bed elevated. Her fingernails on both hands were noted to be dirty with a dried, brown substance underneath her nails. During an interview and observation on 12/10/2025 at 08:11, the ADON opened Resident #45's hands and held them out for a closer observation of Resident #45's fingernails. All fingernails on both hands were observed to be<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dirty with a dried, brownish substance underneath them. The ADON said Resident #45's fingernails needed cleaning. During an interview and observation on 12/10/2025 at 09:30 AM, CNA-F was observed sitting beside Resident #45's bed and was cleaning Resident #45's fingernails. CNA-F said Resident #45 ate her meals using her fingers and hands. She said Resident #45 preferred having foods she could pick up with her fingers and eat. CNA-F said Resident #45 would allow staff to spoon feed her some things as long as Resident #45 could have something in her hands that she could feed herself. She said she thought the dried, brownish substance was dried food. CNA-F said she should have cleaned Resident #45's fingernails after she helped her eat lunch on 12/09/2025. She said Resident #45 needed to have her fingernails and hands cleaned after every meal. CNA-F said if a resident required special instructions like nail care after meals, it should be on the nurse aides' task assignment sheet. During an interview on 12/10/2025 at 09:40 AM, CNA-G said she took care of Resident #45 on 12/08/2025. She said she did not notice Resident #45 needed nail care. An attempt to interview CNA-H by phone on 12/10/2025 at 09:50 AM was unsuccessful. During an interview with CNA-E on 12/10/2025 at 10:15 AM, she said she helped on the hall on 12/09/2025 where Resident #45 resided but could not recall providing any care to Resident #45. During an interview on 12/10/2025 at 02:10 PM, the DON said Resident #45's care plan and nurse aides' task assignment sheet should address Resident #45's preference for finger foods and her need for nail care after meals. She said the care plan team was responsible for ensuring the care plan addressed the specific needs of residents. She said eating with dirty fingernails could lead to illness. She said the nurses were responsible for ensuring residents received needed hygiene care. A review of the facility's policy titled Activities of Daily Living(ADL), Supporting 2001, revised March 2018, and updated February 2025 included the following: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.including appropriate support and assistance with:a. hygiene . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675289 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at Azalea Heights | 3505 Old Jacksonville Rd<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and 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 residents (Resident #2) reviewed for Enhanced Barrier Precautions. CNA C failed to don PPE when she provided direct care for Resident #2 who required EBP.This failure could place residents under their care at risk for the transmission of communicable diseases and infections. Findings included:Record review of a face sheet dated 12/10/2025 indicated Resident #2 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses which included diabetes, difficulty swallowing, high blood pressure, atrial fibrillation (ineffective pumping of the upper heart chambers), chronic pain, radiculopathy of lumbar vertebrae (inflammation of a nerve root in the lower back), intervertebral disc degeneration (wear and tear of lower back that may lead to disc bulging, loss of disc space, compression and irritation of the adjacent nerve root), and osteoporosis (bone disease that develops when bone mineral density and bone mass decreases).Record review of the quarterly MDS dated [DATE] noted Resident #2 had a BIMS score of 15 which indicated she was not impaired cognitively. She required maximum assistance with most ADLs. She could feed herself. She was incontinent of bowel and bladder.Record review of Resident #2's care plan, last reviewed 10/29/2025, indicated she was at risk for infection or recurrent/chronic infection because she had a history of MDRO/ESBL/VRE of multi drug- resistant UTI requiring isolation and antibiotics. It also indicated she had a sheer wound on her right hip and was at risk for infection. EBP was not specifically indicated for her care issues.Record review of Resident #2's physician orders, active as of 12/10/2025, indicated to practice EBP as indicated, due to chronic wounds and history of MDRO every shift related to ESBL. The care plan indicated wound treatment to the right side of coccyx, sheer, clean with normal saline then apply Ansept gel and collagen powder and a drybordered gauze and to change it daily and PRN until healed. During an observation and interview on 12/08/2025 at 10:24 AM, CNA C was completing incontinent care and holding Resident #2 against her body. The CNA was wearing only gloves and no gown. She said the resident had a wound. At that time the resident said she had to urinate again so CNA affixed brief and told her to go ahead. She covered her and said she needed to go get more supplies to re-clean her and would be back. There was an EBP sign on the door and on the wall at bedside.During an observation on 12/08/2025 at 10:49 AM CNA C was observed returning to Resident #2's room to perform incontinent care. She entered the room and did not don a gown. She was wearing only gloves.During an observation on 12/08/2025 at 10:57 AM CNA C was providing incontinent care to Resident #2 and wearing only gloves. During an interview on 12/08/2025 at 11:11 AM CNA C said she was supposed to put on a gown to provide direct care to Resident #2 and she did not. She had no reason why she did not put on the gown.During an interview on 12/10/2025 at 11:00 AM the DON, said she was the infection preventionist and the one responsible for the infection control training. She said staff have been trained that the red heart placed on the door signifies a resident requiring EBP. A sign was also placed on the door and in the room indicating the resident required EBP. She said when direct care was to be used for a resident requiring EBP they had to put on a gown and gloves. She said residents requiring EBP have a device such as a catheter or feeding tube, a wound, or a history of multi-resistant organism infection.Record review of the facility's policy revised February 2025, and titled Enhanced Barrier Precautions indicated the following: .2a. Gloves and gown are applied prior to performing the high contact resident care activity.3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: .f. changing briefs or assisting with toileting.4. EBPs are indicated.for residents infected or colonized with a CDC targeted or epidemiologically important MDRO, including.g. ESBL-producing Enterobacterales; h. Vancomycin-resistant Enterococci. |

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| F 0628<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a required discharge summary for one of five residents reviewed for discharge (Resident #6). The facility failed to meet the requirement by not providing a completed discharge summary to the receiving healthcare facility for Resident #6. This failure could place residents at risk for not having continuity of care. Record review of Resident #6's undated face sheet indicated Resident #6 was admitted on [DATE] and discharged to another nursing home on [DATE]. Record review of Resident #6's medical record accessed on 12/10/2025 did not reveal a discharge summary. During an interview on 12/10/2025 at 1:30 PM, the ADON stated she did not know the facility's policy on discharge summaries. The ADON stated that she was told the SW and DON complete the discharge summary. The ADON stated with a completed discharge summary, the resident and receiving facility were aware of items including the correct medications and instructions for taking the medications and doctor's orders. During an interview on 12/10/2025 at 1:40 PM the SW revealed that she did not know the facility's policy on discharge summaries. She stated she had not been told if it was her responsibility. She stated she did not know who was responsible for completing the residents' discharge summaries. The SW stated that when a residents' discharge summary was not completed, it placed them at risk for missed appointments. During an interview and record review on 12/10/2025 at 1:50 PM, the DON provided an incomplete document entitled Discharge Summary - Planning/Instructions/Recapitulation. Record review of this document indicated it was incomplete in Resident #6's communication, physical functioning and structural problems, nutritional status, and discharge planning and missing Resident #6's customary routine, cognitive patterns, vision, mood and behavior patterns, psychosocial well-being, continence, dental status, and documentation of participation in assessment. The DON verbally confirmed that this was the document used as a discharge summary and recognized that it was not complete. During an interview on 12/10/2025 at 1:59 PM, the ADM stated nursing staff were responsible for discharge summaries. The ADM stated she was unaware of the facility's policy on discharge summaries. The ADM stated if they're supposed to have it, they're supposed to have it. Record review of the facility's policy dated October 2022 entitled Transfer or Discharge, Facility-Initiated indicated the following:<br>Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Information Conveyed to Receiving Provider g. All other information necessary to meet the resident's needs, including but not limited to. (6) a copy of the resident's discharge summary. |