STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675408	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Overton	1110 Hwy 135 S Overton, TX 75684

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative where there was a significant change in the resident's physical, mental, or psychosocial status and when there was a need to alter treatment significantly for 1 of 2 residents (Resident #1) reviewed for falls. The facility failed to notify Resident #1's responsible party when he fell on 6/22/26 resulting in a laceration to the bridge of his nose.The facility failed to notify Resident #1's attending physician and responsible party when he fell on 6/27/26. These failures could place residents at risk for delayed treatment, not receiving necessary treatments and medications, and a decreased quality of life.Findings included:Record review of a facility face sheet dated 3/11/26 for Resident #1 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of Senile degeneration of brain (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia).Record review of a comprehensive MDS dated [DATE] for Resident #1 indicated a BIMS score of 99, which indicated he was unable to complete the interview. He had severely impaired cognition. He had a history of falls prior to admission and had experienced falls while in facility. Record review of a comprehensive care plan dated 6/22/25 for Resident #1 indicated he was at risk for falls.Record review of incident report dated 6/22/25 at 5:16 am indicated that Resident #1 had sustained a witnessed fall on 6/22/25. Notifications section of incident report reads: .Resident Representative Notified: No. and incident report was signed by LVN A.Record review of an incident report dated 6/27/25 at 1:51 am indicated that Resident #1 had sustained an un-witnessed fall on 6/27/25. Notifications section of incident report read: .Attending faxed: No.; .Physician Notified: No.; and .Resident Representative Notified: No. and incident report was signed by LVN A.Record review of a nursing progress note dated 6/22/25 at 5:18 am for Resident #1 read: .Resident ran into door facing, fell to floor, laceration noted to bridge of nose 1x05 cm. Area cleaned, tao applied. and was signed by LVN A. No documentation of notification or an attempted notification to responsible party was indicated for fall sustained on 6/22/25 at 5:18 am.Record review of a nursing progress note dated 6/27/25 at 1:52 am and signed by LVN A for Resident #1 indicated no documentation of notification to responsible party or physician. There was no documentation for physician or responsible party notifications or attempted notifications for fall sustained on 6/27/25 at 1:52 am.During a telephone interview on 3/10/26 at 9:49 am with Resident #1's Responsible Party said he had fallen that first night and cut his nose. She said facility staff did not call and notify her nor the hospice agency. She said she did not find out about the fall until she came back to the facility on 6/23/25 and saw his nose. She said she believed he also had other falls at the facility that she was not notified of.A telephone interview was attempted with LVN A on 3/11/26 at 7:40 am, there was no answer, phone call went straight to voicemail. A message was left requesting a return phone call. No return call was received before exiting facility on 3/11/26 at 11:30 am.During an interview on 3/11/26 at 9:38 am LVN B said if she completed an incident report for a resident fall, she would indicate whether or not family and physician notifications were made on the (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report. She said if the report indicated notifications were not made, that meant the physician or responsible party were not notified. She said if she was not able to reach them, she would at least document the attempt and document later in a progress note when notifications were made. She said residents' families may not know what was going on with the residents if appropriate notifications were not made, or residents could be at risk of infections if treatments were needed and no orders were obtained. During an interview on 3/11/26 at 10:00 am DON said family and physicians should be notified of any resident falls and they may not know what was going on with the residents if proper notifications were not made. She said the nurse completing the incident report was responsible for making the notifications. She said if a resident needed treatment or evaluation and the physician was not notified; they could be at risk of infections. She said this incident occurred before she started employment as the DON at the facility so she could not comment on what happened. She said that going forward, they would do audits to ensure notifications were being handled appropriately. During an interview on 3/11/26 at 10:18 am administrator said she expected her staff to make notifications to MD, family, and administrator, after a resident fall. She said she and the DON reviewed incident reports and signed off on them and would continue to do so, ensuring appropriate notifications were made going forward. She said this incident occurred before she was employed at the facility. She said if notifications were not made appropriately, residents could develop an infection or anxiety. Record review of a facility policy titled Change in a Resident's Condition or Status dated April 2025 read: .The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident. and .a nurse will notify the resident's representative when: a. the resident is involved in an accident or incident that results in an injury including injuries of an unknown source.Record review of information given to resident's upon admission titled Your Rights and Protections as a Nursing Home Resident undated, read: .You have the right to: .Have your representative notified: The nursing home must notify your doctor and, if known, your legal representative or an interested family member when the following occurs: .You're involved in an accident and are injured and/or need to see a doctor.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered careof the residents that meet professional standards of quality care for 1 of 6 residents (Resident #1) reviewed for baseline care plans.The facility failed to ensure Resident #1's baseline care plan was completed within 48 hours of admission on [DATE]. This failure could affect residents by not addressing their physical, mental, and psychosocial needs for each resident to attain or maintain their highest practicable physical, mental, and psychosocial outcome.Findings included:Record review of a facility face sheet dated 3/11/26 for Resident #1 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of Senile degeneration of brain (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior, and is the most common cause of dementia).Record review of a comprehensive MDS dated [DATE] for Resident #1 indicated a BIMS score of 99, which indicated he was unable to complete the interview. He had severely impaired cognition. He had a history of falls prior to admission and had experienced falls while in facility.Record review of an electronic medical record for Resident #1 on 3/11/26 indicated there was no baseline care plan completed.Record review of a comprehensive care plan initiated on 6/22/25 for Resident #1 indicated it only addressed falls and behavioral symptoms.During an interview on 3/11/26 at 9:45 am the MDS nurse said baseline care plans should be initiated within 24 to 48 hours. She said if a comprehensive care plan was initiated in place of the baseline, it should include ADLs, transfers, social needs, orders, etc. She said staff may not know how to care for the residents if the baseline care plan was not initiated. During an interview on 3/11/26 at 10:00 am the DON said baseline care plans should be initiated within 48 hours or as soon as possible after admission. She said if a resident was admitted on the weekend, the RN supervisor was responsible for initiating it. She said during the week, responsibility would fall on her or any other RN that was in the facility. She said that going forward, they would do audits to ensure care plans were being initiated appropriately. She said this incident occurred before she was employed at the facility and she could not comment on why it was not completed. She said staff could not properly care for the residents without an appropriate care plan in place. During an interview on 3/11/26 at 10:18 am the administrator said she expected her staff to initiate care plans appropriately. She said she and the DON would be reviewing admissions to ensure care plans were done appropriately going forward. She said staff may not be able to meet the needs of the residents if care plans were not put into place because staff would not be aware of their needs. Record review of a facility policy titled Care Plans - Baseline dated 2001 read: .A baseline care plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. and .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy Orders; e. Social Services; and f. PASARR recommendation, if applicable.