

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Avir at Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Commons Drive Athens, TX 75751	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services, including the accurate acquiring, administering and receipt of all drugs and biologicals, to meet the needs of 1 of 6 (Resident #2) residents reviewed for pharmacy services. The facility failed to ensure Resident #2 was administered Enoxaparin Sodium (used to prevent and treat blood clots) Injection 40mg/0.4ml on per physician order due to the medication being unavailable. The facility failed to ensure Resident #2 was administered Lisinopril-hydrochlorothiazide (used to treat high blood pressure) 20-25mg as prescribed due to the medication being unavailable. These failures could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings include: 1. Record review of the face sheet dated 7/10/2026 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone that happens in the area directly surrounding an artificial joint replacement), constipation, gastro-esophageal reflux disease without esophagitis (acid reflux), type 2 diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal blood sugar levels), morbid obesity (a severe form of obesity where excess body fat threatens a person's health and daily life) due to excess calories, essential hypertension (high blood pressure), polyosteoarthritis (osteoarthritis in many joints at the same time). Record review of the MDS dated [DATE] indicated Resident #2's 5-day Medicare MDS Assessment reflected she has a BIMS score of 15, indicating she was cognitively intact. Record review of Resident #2 care plan dated 5/29/2026 indicated she has hypertension and is at risk for fluctuations in blood pressure. Interventions include check blood pressure prior to the administration of antihypertensive medications, monitor for and record any noted medication side effects, obtain and monitor lab work and diagnostic studies as ordered. Record review of Resident #2's physician orders dated 7/10/2026 indicated Resident #2's had an order for Enoxaparin Sodium Injection Syringe 40mg/0.4ml given intramuscularly every 12 hours starting on 5/22/26 with no stop date. The physician orders indicated Resident #2 had an order for Lisinopril/Hydrochlorothiazide 20-25mg given 1 tablet by mouth in the morning for HTN starting 5/23/2026. Record review of June 2026 MAR indicated Resident #2 was not administered the following medications as per physician orders: Enoxaparin Sodium 40mg/0.4ml injection: - 6/26/2026 the AM dose; -6/3/2026, 6/14/2026, 6/17/2026, 6/18/2026, 6/23/2026, 6/25/2026, and 6/28/2026 the PM dose; and -6/9/2026, 6/11/2026, 6/13/2026, 6/15/2026, 6/16/2026, and 6/24/2026 the AM and PM dose. Lisinopril-hydrochlorothiazide Oral tablet 20-25mg: -6/22/2026, 6/23/26, 6/24/26, 6/25/26 and 6/26/2026 the AM dose. Based on a record review of the progress notes dated 6/1/2026 to 6/30/2026, indicated that the medications Enoxaparin Sodium Injection 40mg/0.4ml and (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lisinopril-hydrochlorothiazide were documented as unavailable on dates not given. Based on a record review on 7/10/2026 of blood pressures documented on the MAR from 6/22/2026 to 6/26/2026, Resident #2 had no elevated blood pressures. During an interview conducted on 7/10/2026 at 11:00 AM, Resident #2 stated that she was at the facility for rehabilitation following surgery on her leg. She stated that there had been days when she missed her enoxaparin sodium injection 40mg/0.4ml and lisinopril-hydrochlorothiazide 20-25mg, and stated that the staff told her the medication was not available. She stated that she did not feel her health had been affected, but she remained concerned. During an interview conducted on 7/10/26 at 11:07 AM, the DON stated that Resident #2 should have received her enoxaparin sodium injection 40mg/0.4ml and lisinopril-hydrochlorothiazide 20-25mg as ordered. The DON stated that there should have been documentation regarding notifying the physician or calling the pharmacy if those actions had been taken regarding Resident #2's medication. The DON stated that the facility had experienced issues with getting medications from the pharmacy following the change of ownership on 6/1/26. The DON stated that she expected the nursing staff to notify the physician of a resident missing medications or of medications not being available from the pharmacy[PH4.1]. During an interview conducted on 7/11/2026 at 11:22 AM, the NP stated that she was aware that the facility was having some issues with the changeover of the new company and switching pharmacies. She stated she is in the building 5 days a week and was never notified that Resident #2 had missed her Lisinopril-hydrochlorothiazide oral tab 20-25mg from 6/22/2026 to 6/26/2026. She would expect the staff to notify her if resident is missing any medications. She stated she feels there was no harm if her blood pressure was controlled and she would prefer; she miss the doses due to her not wanting her blood pressure to bottom out. She feels confident that facility would have notified her if resident's blood pressure were not being controlled. She stated as far as the Enoxaparin Sodium she would not [PH5.1]be comfortable managing that medication and would expect the facility to contact the physician regarding the Enoxaparin Sodium. During an interview conducted on 7/11/2026 at 11:52 AM, the Physician stated that he was aware the facility was having some overall issues with getting medication from the new pharmacy due to the changeover. He stated that he was familiar with Resident #2 and confirmed that he was not notified when she did not receive 21 doses of Enoxaparin Sodium Injection 40mg/0.4ml between 6/3/2026 and 6/28/2026. Physician stated that the medication was given prophylactically and not as an active treatment. Physician stated he was unsure why Resident #2 had been discharged from the hospital with no stop date. He also stated that normally the order would be one injection once daily instead of twice daily; therefore, even though she missed 21 doses, she still received over half of what a normal prescription would be and exhibited no clinical issues or concerns. The Physician stated that he believed Resident #2 received no harm due to the facility not following the order. During an interview conducted on 7/13/2026 at 11:15 AM, RN A stated that if medication was unavailable for administration, she would go to the Pyxis machine to retrieve it, and if it was not there, she would notify the DON. She noted that the risks or outcomes would depend on the specific medication that was missed, but stated that at that time, she was unaware of any issues resulting from the missed medications. During an interview conducted on 7/13/2026 at 11:30 AM, the DON stated that the risk for residents if they did not receive medications as ordered could prevent the medication from providing its intended therapeutic effect, leading to an adverse reaction[PH6.1]. During an interview conducted on 7/13/2026 at 11:57 AM, the Administrator stated that she expected staff to give medications as ordered and noted that not following physician orders for medications could cause adverse effects for the residents. She stated that she was aware that there had been issues with getting medications from the pharmacy timely. She stated that the facility had created training (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regarding the chain of custody of medications, along with notifying the pharmacy when medications needed refills. Record review of the facility's Medication Shortages/Unavailable Medications policy not dated indicated, When medications are not received or are unavailable for the customers, the licensed nurse will urgently initiate action in cooperation with the attending physician and the pharmacy provider. if a medication shortage is noted at the time of medication administration, the licensed nurse or certified medication assistant must immediately initiate action to obtain the medication and not wait until the med pass is completed.		

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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 interviews and record reviews, the facility failed to consult the resident's physician and notify when there was a need to alter treatment significantly for 1 of 6 residents (Resident #2) reviewed for notification of changes. The facility failed to contact the prescribing physician for Resident #2's Enoxaparin Sodium (used to prevent and treat blood clots) Injection Syringe 40mg/0.4ml to obtain a stop date or confirm or clarify administration duration. The facility failed to notify the MD Resident #2 missed a total of 21 doses of Enoxaparin Sodium Injection 40mg/0.4ml due to the medication being unavailable. The facility failed to notify the MD Resident #2 missed a total of 5 doses of Lisinopril-hydrochlorothiazide (used to treat high blood pressure) 20-25mg due to the medication being unavailable. These failures could place residents at risk for not receiving the therapeutic effect of prescribed medications or a decline in health. Findings include: 1. Record review of the face sheet dated 7/10/2026 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone that happens in the area directly surrounding an artificial joint replacement), constipation, gastro-esophageal reflux disease without esophagitis (acid reflux), type 2 diabetes (a chronic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal blood sugar levels), morbid obesity (a severe form of obesity where excess body fat threatens a person's health and daily life) due to excess calories, essential hypertension (high blood pressure), polyosteoarthritis (osteoarthritis in many joints at the same time). Record review of the MDS dated [DATE] indicated Resident #2's 5-day Medicare MDS Assessment reflected she had a BIMS score of 15, indicating she was cognitively intact. Record review of Resident #2's hospital discharge orders dated 05/22/2026, indicated Resident #2 had an order for Enoxaparin Sodium Injection Syringe 40mg/0.4ml starting on 5/22/26 with no stop date. Record review of Resident #2's care plan dated 5/29/2026 indicated she had hypertension and is at risk for fluctuations in blood pressure. Interventions include checking blood pressure prior to the administration of antihypertensive medications, monitor for and record any noted medication side effects, obtain and monitor lab work and diagnostic studies as ordered. Record review of Resident #2's physician orders dated 7/10/2026 indicated Resident #2 had an order for Enoxaparin Sodium Injection Syringe 40mg/0.4ml given intramuscularly every 12 hours starting on 5/22/26 with no stop date. The physician orders indicated Resident #2 had an order for Lisinopril/Hydrochlorothiazide 20-25mg give 1 tablet by mouth in the morning for HTN starting 5/23/2026. Record review of the Resident #2's June 2026 MAR indicated Resident #2 was not administered the following medications as per physician orders: Enoxaparin Sodium 40mg/0.4ml injection: - 6/26/2026 AM dose; -6/3/2026, 6/14/2026, 6/17/2026, 6/18/2026, 6/23/2026, 6/25/2026, and 6/28/2026 PM dose; and -6/9/2026, 6/11/2026, 6/13/2026, 6/15/2026, 6/16/2026, and 6/24/2026 AM and PM dose. Lisinopril-hydrochlorothiazide Oral tablet 20-25mg: -6/22/2026, 6/23/26, 6/24/26, 6/25/26 and 6/26/2026 AM dose. Record review of Resident #2's electronic medical records, accessed on 07/10/2026, did not indicate contact with the prescribing physician regarding the Enoxaparin Sodium Injection to obtain a stop date or confirm or clarify administration duration. Record review of the progress notes conducted dated 6/1/2026 to 6/30/2026 indicated that Resident #2's medications were documented as unavailable. The progress notes did not indicate the facility had notified the doctor or NP that the medications Enoxaparin Sodium Injection 40mg/0.4ml and Lisinopril-hydrochlorothiazide were unavailable or not given. During an interview (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted on 7/10/26 at 11:07 a.m., the DON stated that Resident #2 should have received her enoxaparin sodium injection 40mg/0.4ml and lisinopril-hydrochlorothiazide 20-25mg as ordered. The DON stated that there should have been documentation regarding notifying the physician or NP if medication was unavailable[PH1.1][SS1.2]. During an interview conducted on 7/11/2026 11:22 a.m., the NP stated that she was aware that the facility was having some issues with the changeover of the new company and switching pharmacies. She stated she is in the building 5 days a week and was never notified that Resident #2 had missed her Lisinopril-hydrochlorothiazide oral tab 20-25mg from 6/22/2026 to 6/26/2026. She would expect the staff to notify her if resident is missing any medications. She stated she feels there was no harm if her blood pressure was controlled and she would prefer; she miss the doses due to her not wanting her blood pressure to bottom out. She feels confident that facility would have notified her if the resident's blood pressure were not being controlled. She stated as far as the Enoxaparin Sodium she would not be comfortable managing that medication and would expect the facility to contact the physician regarding the Enoxaparin Sodium. During an interview conducted on 7/11/2026 at 11:52 AM, the Physician stated he was aware the facility was having some overall issues with getting medication from the new pharmacy due to the changeover. He stated that he was familiar with Resident #2 and confirmed[PH2.1] that he was not notified when she did not receive 21 doses of Enoxaparin Sodium Injection 40mg/0.4ml between 6/3/2026 and 6/28/2026. The Physician expressed that the medication was given prophylactically and not as an active treatment. The Physician stated he was unsure why Resident #2 had been discharged from the hospital with no stop date. He also stated that normally the order would be one injection once daily instead of twice daily; therefore, even though she missed 21 doses, she still received over half of what a normal prescription would be and exhibited no clinical issues or concerns. The Physician said that he believed Resident #2 received no harm due to the facility not following the order. During an interview conducted on 7/13/2026 at 11:15 AM, RN A stated that if medication was unavailable for administration, she would go to the Pyxis (an automated dispensing cabinet [PH3.1][SS3.2]used in hospitals to securely store, track, and dispense medications and medical supplies) machine to retrieve it, and if it was not there, she would notify the DON. She stated that she should have contacted the NP. RN A stated she did not notify the physician of Resident #2 not receiving her medications or her medications being unavailable. RN A stated the risks of a resident not receiving their prescribed medication would depend on what the medication was that was not administered. During an interview conducted on 7/13/2026 at 11:30 AM, the DON stated that the risk for residents if the doctor was not notified could include adverse reactions. The DON noted that if notification had been completed, the physician would have been able to evaluate the resident and decide if another medication could be substituted or discontinued of medication. The DON stated that the physician would not be aware of following up on the condition of the resident after not receiving the medication if he was not informed. The DON stated that staff should document all communication with the physician. During an interview conducted on 7/13/2026 at 11:57 AM, the Administrator stated that she expected staff to give medications as ordered and noted that not following physician orders for medications could cause adverse effects for the residents. She stated that she expected that at any time medications were not available, staff were to notify the physician or NP, along with nursing management. She stated that nursing management could then coordinate with the NP or physician to come up with an alternative solution. Record review of the facility's Change in a Resident's Condition or Status policy last revised 4/2025 indicated, Our facility promptly notifies the resident, his or her attending physician, healthcare provider, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attending physician, healthcare provider, or physician on call when there had been a(an):.b. discovery of injuries of unknown origin.d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly.Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status.		