STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Avir at Mineola		STREET ADDRESS, CITY, STATE, ZIP CODE 320 Greenville Highway Mineola, TX 75773	

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 observation, interview, and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical and mental status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 4 (Resident #1) residents reviewed for notification of change. The facility failed to ensure Resident #1's physician was notified when she had a fall which resulted in an abrasion to her face on 03/18/2026. This failure could place residents at risk for experiencing unnecessary pain, not receiving necessary treatments and medications, and a decreased quality of life.Findings included: Record review of Resident #1's face sheet, dated 03/26/2026, indicated a [AGE] year-old female, admitted [DATE], with diagnoses including Alzheimer's disease (a progressive irreversible neurodegenerative disease resulting in a memory decline), dysphagia (difficulty swallowing), lack of coordination, and cognitive communication deficit. Record review of Resident 1's Quarterly MDS assessment, dated 12/09/2025, indicated she was understood by others and was able to understand others. The MDS assessment indicated Resident #1 had a BIMS score of 08, which indicated moderate cognitive impairment. The MDS assessment indicated Resident #1 required assistance with showering/bathing, toileting hygiene, and required supervision or touching assistance for personal hygiene. The MDS assessment indicated Resident #1 had falls. Record review of Resident #1's care plan, with a target date of 03/09/2026, indicated she had a history of falling and potential for future falls related to Alzheimer's disease, unsteady gait, wandering and psychotropic medications. Interventions included giving resident verbal reminders not to ambulate/transfer without assistance, to keep bed in lowest position with brakes locked, keep call light in reach at all times, and keep personal items and frequently used items within reach. Record review of Resident #1's Order Summary Report, dated 03/26/2026, indicated May admit to the secured unit due to exiting seeking behavior dated 12/09/2025. Record review of the Fall (unwitnessed) Incident Report, dated 03/18/2026, indicated LVN A notified Resident #1's physician of the fall on 3/18/2026 at 5:50 p.m. Record review of Resident #1's Progress Note, dated 03/18/2026 at 7:52 p.m., signed by LVN A, indicated, called to the secure unit with resident noted on floor lying on right side in hallway. Per CNA resident was lying on left side when noticed she had fallen. Moving all extremities same as prior to fall. Very light bruise noted to left side of forehead 2.5 cm x 2 cm. Neuros initiated per protocol. Son made aware. Denies pain. Record review of Resident #1's hospital discharge, dated 03/19/2026 at 8:40 a.m., indicated, Patient is well appearing. She is pleasantly demented denied any complaint other than pain to the superficial area of the head with bruising and hematoma. CT scan was performed today which was without signs of skull fracture or intracranial hemorrhage (brain bleed). Overall, it was reasonable to discharge patient to the nursing facility with close follow-up. There were no new orders indicated per the hospital discharge. During an interview and observation on 03/26/2026 at 06:40 a.m., Resident #1 was observed lying bed with a hematoma approximately the size of an egg to the left side of her forehead with blueish discoloration from the eye down to her cheek bone area. Resident #1 was not a good historian related to the Alzheimer's disease process. Resident #1 said (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	she was not sure what happened, but it happened real good. Resident #1 said she had some pain at some point, but she could not recall when. Resident #1 pointed out to the hallway as she was talking about the incident. Resident #1's bed was observed in the lowest position with the call light in reach. Resident #1's room was observed free of clutter. During an interview on 03/26/2026 at 10:40 a.m., LVN A said she documented that she contacted Resident #1's physician when the fall occurred, but she did not notify the physician. LVN A said she documented it and forgot to call the physician during all the excitement between Resident #1 and a different resident that was having issues at the same time. LVN A said it was very important to notify the physician when a fall, incident, or change in condition occurred to ensure the resident received the proper care they required such as new orders for treatments to identify any fractures or bleeds. LVN A stated she had initiated the neuro checks at the time of Resident #1's fall with unremarkable vital signs and neurologic results. LVN A stated Resident #1 had not complained of pain. LVN A stated she notified the ADON, DON and Resident #1's family member at the time of the incident. During an interview on 03/31/2026 at 02:15 p.m., LVN B said Resident #1 had increased facial pain and bruising, so she notified Resident #1's physician. LVN B said when she contacted Resident #1's physician he stated he was not aware Resident #1 fell the previous day (03/18/2026). LVN B said she was given the order to send Resident #1 out to the hospital immediately. LVN B said the physician should have been notified when the fall occurred to prevent complications that could occur related to fractures or a brain bleed. During an interview on 03/31/2026 at 04:30 p.m., the Physician said he was notified of Resident #1's fall the day after she fell (03/19/2026). The Physician said when he was notified, he sent Resident #1 out to the hospital immediately because she had increased facial pain and bruising. The Physician said if he would have been notified the day Resident #1 fell, he would have sent her to the ER immediately because she hit her head. The Physician said when a resident fell and hit their head, he wanted to rule out anything major, like a brain bleed or swelling, immediately. During an interview on 03/31/2026 at 03:35 p.m., the DON said she was aware of Resident #1's fall on 03/18/2026. The DON said she was not aware that LVN A did not notify the physician. The DON said it was very important to always notify the physician regarding falls or changes in condition to receive new orders for treatments and to ensure the resident did not have any fractures or bleeding. During an interview on 03/31/2026 at 04:35 p.m., the ADON said was aware of Resident #1's fall on 03/18/2026. The ADON said she was not aware until the following day on 03/19/2026 when the resident was sent out to the hospital with increased pain and bruising that the physician had not been notified at the time the fall occurred. The ADON said the physician should have been notified at the time the incident occurred in case the physician gave new orders or treatments, and to ensure the resident had not experienced a fracture or a bleed that had not been identified. During an interview on 04/01/2026, the Administrator said he expected the physician to be made aware of any changes in condition regarding the residents when they occurred. The Administrator said he expected the DON and ADON to provide oversight to the clinical staff to ensure the physician was being notified. The Administrator said it was important for the physician to be notified to ensure continuity of care for the residents, and so injuries were identified and proper treatments were completed. Record review of the facility's policy titled, Change in Resident's Condition or Status, revised April of 2025, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 1. 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; .