

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/10/2025
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for RN coverage. The facility failed to provide RN coverage for 8 consecutive hours daily on 10/06/25, 10/10/25, 10/14/25, 10/16/25, 10/17/25, 10/17/25, 10/18/25, 10/19/25, 10/20/25, 10/24/25, 10/29/25, 10/30/25, 10/31/25, 11/04/25, 11/07/25, 11/10/25, 11/14/25, 11/19/25, 11/21/25, 11/26/25, 11/27/25, 11/28/25, 12/01/25, 12/02/25, 12/03/25, 12/04/25, and 12/05/25 (27 days from 10/06/25 through 12/09/25). This deficient practice had the potential to place residents at risk by leaving staff without supervisory coverage for RN specific nursing activities and for coordination of events such as emergency care and disasters. Findings included: During an interview on 12/08/2025 at 8:20 AM, the ADON said the facility has not had a DON since 10/05/25. She said they have weekend RN coverage but do not have 8 hours coverage during the week. She said the corporate nurse was the acting DON but was not in the building 8 hours a day during the week. During an interview on 12/08/2025 at 1:47 PM, The RNC/Acting DON said he was not here at all the week of 11/30/25 - 12/06/25. He said the week of thanksgiving he was in the facility 3 days for 8 hours. During an interview on 12/10/25 at 12:24PM, the MDS Coordinator said she was not aware of any other RN working in the facility than the corporate RNC and the weekend nurse. She said the weekend nurse does not work during the week. During an interview on 12/10/25 at 12:43PM, the ADON said the only two RN's that are currently working at the facility are the RNC/acting DON and the Weekend nurse. She said the weekend nurse does not work during the week. She said the previous DON quit on 10/05/25 via telephone. She said they have not had an RN in the facility every day since the DON left. She said The RNC/acting DON has been in the facility some days but not all. She said some assessments may not be able to be completed and they would be without RN supervision. During an interview on 12/10/25 at 12:51PM the Administrator said the old DON quit on 10/05/25 and they only have two RN's working in the facility. He said the weekend nurse does not work during the week. He said to his knowledge they had not met the RN hours requirement. He said the risk was no RN hours and some assessments may not be able to be completed. During an interview on 12/10/25 at 01:05PM, the RNC/Acting DON said him and the weekend nurse were the only RN's working at the facility. He said they have not been able to meet the 8 hour 5 day requirement for the RN hours. He said the risk was no RN supervision, he said it was possible some assessments may not be able to be completed due to no RN. Record review of a staffing schedule provided by the RNC/Acting DON on 12/09/25 at 2:54PM, reflected the RNC/Acting DON was present and working in the facility on the following days: *10/07/25, 10/08/25, 10/09/25, 10/13/25, 10/15/25, 10/21/25, 10/22/25, 10/23/25, 10/27/25, 10/28/25, 11/03/25, 11/05/25, 11/06/25, 11/11/25, 11/12/25, 11/13/25, 11/17/25, 11/18/25, 11/20/25, 11/24/25, 11/25/25, 12/08/25, and 12/09/25. Record review of RN E's employee timecard report for October and November 2025 reflected she worked the following days for at least 8 hours: *10/11/25, 10/12/25, 10/25/25, 10/26/25, 11/01/25, 11/02/25, 11/08/25, 11/09/25, 11/15/25, 11/16/25, 11/22/25, 11/23/25, 11/29/25, and 11/30/25. Record review of the facility's policy, Staffing, Sufficient and Competent Nursing, last revised August 2022, reflected: . Sufficient Staff.3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary clean, comfortable, and homelike environment for 3 of 21 residents reviewed for environment. (Resident #28, Resident #63 and Resident #66) 1.The facility failed on 12/08/2025 to ensure that Resident #28's bathroom was cleaned of water, an unidentified black track marks on the tile when the sink was leaking. 2.The facility failed to replace missing pieces from Resident #63 and Resident #66 window blinds. These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth. Findings included: Record review of Resident #28's face sheet, dated 12/10/25, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnosis included memory deficit following nontraumatic subcarotid hemorrhage, depression, vascular dementia (caused by impaired blood flow to the brain), anxiety disorder, epilepsy (a neurological disorder causing recurrent seizures), muscle wasting and atrophy, muscle weakness, dyspnea (shortness of breath), unsteadiness on feet, itther lack of coordination and fall on same level from slipping, tripping and stumbling without subsequent string against object, subsequent encounter.Record review of Resident #28's comprehensive MDS assessment, dated 10/29/25, reflected that she had a BIMS score of 4, which indicated severe cognitive impairment. She was also always continent of bladder and bowel. Record review of Resident #28's care plan, dated 10/24/25, reflected Resident #28 needed assistance with her ADL's. Record review of Resident #63's face sheet, date 12/10/25, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included attention and concentration deficit following cerebral infarction (brain tissue death), epilepsy (a neurological disorder causing recurrent seizures) and cerebral infarction (brain tissue death).Record review of Resident #63's comprehensive MDS assessment, dated 10/31/25, reflected that he had a BIMS score of 4, which indicated severe cognitive impairment. He was frequently continent with bladder and bowel. Record review of Resident #63's care plan, dated 10/24/2025, reflected Resident #63 has impaired temporal orientation (orientation to year, month and days related to diagnosis: dementia and memory deficit. Record review of Resident #66's face sheet, date 12/10/25, reflected he was a [AGE] year-old male, ordinaly admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included transient cerebral ischemic attack (a temporary blockage of blood flow to the brain), nontraumatic subdural hemorrhage (bleeding directly into the brain), dementia (a decline in mental ability severe enough to interfere with daily life), malaise (a general feeling of discomfort), headache and major depressive disorder (a serious mood disorder causing persistent sadness). Record review of Resident #66's quarterly MDS assessment, dated 06/13/25, reflected that he had a BIMS score of 3, which indicated severe cognitive impairment. He required assistance with toileting and supervision with showers. Record review of Resident #66's care plan, dated 09/05/2024, reflected Resident #66 has socially inappropriate disruptive behaviors at times. Assess resident for placement in a specially designed therapeutic unit. Convey an attitude of acceptance toward the resident, maintain a calm environment and approach the resident. During observation on 12/08/2025 at 9:10 A.M., Resident #28's bathroom floor was dirty with unidentified black track marks and water on the tile floor. Observations of the blinds in the resident rooms on the secured unit:12/08/2025 8:41 AM room [ROOM NUMBER]A- blinds missing pieces.12/08/2025 8:42 AM room [ROOM NUMBER]B- blinds missing pieces.12/08/2025 8:53 AM room [ROOM NUMBER]B- blinds missing pieces.12/08/2025 8:55 AM room [ROOM NUMBER]A-blinds missing pieces.12/08/2025 8:57 AM room [ROOM NUMBER]B-blinds missing pieces. 12/08/2025 9:00 AM room [ROOM NUMBER]A- blinds missing pieces.12/08/2025 9:03 AM room [ROOM NUMBER]B-blinds missing pieces.12/09/2025 10:37 AM room [ROOM NUMBER]-blinds missing pieces.12/09/2025 10:40 AM room [ROOM NUMBER]B-blinds missing pieces.12/09/2025 10:41 AM (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] A&B- blinds missing pieces.12/09/2025 10:42 AM room [ROOM NUMBER]B- blinds missing pieces.12/09/2025 10:43 AM room [ROOM NUMBER] A&B- blinds missing pieces.12/09/2025 10:37 AM room [ROOM NUMBER]A-blinds missing pieces.12/09/2025 10:59 AM room [ROOM NUMBER]-blinds missing pieces. During an interview on 12/09/25 at 10:45 A.M., Resident 28 said she told staff that the sink leaked in the bathroom and when she turned on the water it got on the floor. She said she did not know the lady's name she told. She said the facility finally cleaned the floor yesterday; she said it had been dirty since she had been there for several weeks. During an interview on 12/09/25 at 11:08 A.M., CNA F said she agreed that the floor in Resident #28's room was very dirty yesterday, and the floor had not been cleaned in several days. She said the dirty floor with the sink leaking and the water on the floor could be a safety issue. She said some of the residents had complained about the damaged blinds, because of the sunlight coming in during the day. She said she would go get maintenance immediately. During an interview on 12/09/2025 at 11:15 A.M., LVN G said she agreed she saw Resident #28's bathroom floor yesterday and it was dirty; she said it was an ongoing thing with her. She said she had not been notified of the Resident #28's sink leaking in her bathroom. She said the bathroom floor was a safety issue and fall risk from the sink leaking water. She said she could turn off the water in the bathroom until maintenance could look at the sink. She said she agreed that when the residents tried to sleep with the pieces missing from the blinds it was an issue, because some of the residents liked to sleep during the day and the sunlight came in through the damaged areas. During an interview on 12/09/25 at 11:19 A.M., Resident #63 he said sometimes the sunlight got in his eyes when he tried to sleep and it made it hard for him to sleep during the day. During an interview on 12/09/25 at 11:21 A.M., Resident #66 he said sometimes the sunlight bothered him when he tried to sleep, but the facility just needed to stay on top of it. During an interview on 12/10/25 at 10:44 A.M., Maintenance Supervisor H said he had not fixed the sink Resident #28's room, he said it was next on his list. He said LVN G wrote the issue on his list yesterday (12/09/2025). He said he was not aware of the sink leaking until LVN G and CNA F mentioned it to him yesterday. He said the water was shut off from the main valve until he could fix the sink. He said the risk of the sink leaking and the water on the floor in the bathroom was a slip hazard. He said he had not noticed the floor in Resident #28's room was dirty. He said the blinds back in the secured unit was an issue. He said he usually changed the blinds on the secured unit once a week. He said he thought the condition of the blinds on the secured unit would affect the residents' sleep and quality of sleep during the day. During an interview on 12/10/25 at 11:11 A.M., Housekeeping Aide J said he was not here Monday (12/08/25). He said he seen mud and dirt on Resident #28's bathroom floor. He said he was there on Tuesday (12/09/25), and he cleaned Resident #28's bathroom. He said when he cleaned her bathroom floor Tuesday (12/09/25) it was filthy with tracks of water and dirt. He said the floor was a risk; he said the floor was dirty, wet and was a risk for slips or falls. During an interview on 12/10/25 at 12:34 P.M., the ADON said she did not know Resident #28's floor was dirty, water was on her floor, and her sink was leaking. She said if the floor was wet that would be a fall risk. She said way the floor looked was unacceptable. She said she would not want her home to look like that. She said the residents fiddled with the blinds on the unit a lot, but the facility does need to be replacing them as we find an issue. She said it was the residents' right not to have the light in their room in their eyes to the best of our ability. During an interview on 12/10/25 at 12:45 P.M., Acting Director of Nursing he agreed the facility needed to fix the blinds for a better homelike environment in the residents' rooms on the secured unit. He said the dirty floor and leaking sink in Resident #28's room was a fall hazard for sure. He said he would expect staff to keep the residents' room clean and if there were any items identified staff would address them immediately. During an interview on 12/10/25 at 1:17 P.M., the Administrator said he would agree that the light coming in during the day, with the damaged blinds, was a homelike environment issue. He said he would notify the maintenance guy to replace the blinds. He said Resident #28's bathroom floor was unacceptable. He said he would not want his floors in his home to look like that. He said the (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water leaking from the sink was a fall hazard. Record review of a facility policy titled, Homelike Environment revised February 2021. Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 1 of 1 facility reviewed for nurse staffing posting. The facility failed to post the required current daily staffing information on 12/8/25 and 12/9/25. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included: During an observation on 12/8/25 at 3:39 PM, nurse staffing data was posted on a table, behind a Christmas tree, not easily visible, and was dated 10/3/25. During an observation and interview on 12/09/2025 at 10:40 AM, the ADON found nurse staffing posted by the front door on a table behind a Christmas tree. The staffing was dated 10/3/25. She said the staffing had not been posted or updated since that date. She said the DON was responsible for posting staffing, but she left on 10/5/25. She said since the DON was not here, she was not sure who was responsible, but she would find out. She said the risk of not posting nurse staffing was that no one would know how many staff were in the building or if they were adequately staffed. During an interview on 12/09/2025 at 10:57 AM, the ADON said no one was responsible for posting the staffing after the DON left on 10/5/25. She said someone should have been assigned but no one was. She said she just talked to the ADM and now she was assigned to post nurse staffing daily. She showed the surveyor the posted staffing sheet for today, (12/9/25.) During an interview on 12/9/25 at 2:14 PM, the BOM said she could not see the nurse staffing information because it was behind a Christmas tree on a table. She looked from different angles in the lobby and said she still could not see it. During an interview and observation on 12/9/25 at 2:16 PM, the ADON said she could not see the nurse staffing information on the table in the lobby because a Christmas tree was in front of it. The ADON moved the nurse staffing information in front of the Christmas tree. During an interview on 12/9/25 at 2:19 PM, the acting DON said the nurse staffing posting should be updated daily and should be visible, where everyone could see it. He said the risk of not posting nurse staffing information was that no one would be aware of how many staff were in the facility. During an interview on 12/10/2025 at 9:07 AM, the ADM said staffing should be updated daily and posted in an easily visible location. He said the risk of not having staffing posted was staff, visitors, and residents would not know how many staff were in the facility. During an interview on 12/10/25 at 1:15 PM, the ADM said the prior DON was responsible for the nurse staffing posting. He said since she left on 10/5/25 no one was responsible for making sure it was done. The ADM said yesterday (12/9/25) he and the ADON were responsible for posting the staffing daily. He said prior to yesterday, the last staffing post was 10/3/25. He said the daily nurse staffing posting should be updated daily and clearly visible/not blocked by anything, so everyone could see it. Record review of a Posting Direct Care Daily Staffing Numbers with a revised date of August 2022 indicated: Policy Statement Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RN's, LPN's, and LVN's) and the number of unlicensed nursing personnel (CNA's and NA's) directly responsible for resident care is posted [NAME] prominent location (accessible to residents and visitors) and in a clear and readable format. A. The name of the facility; B. The current date (the date for which the information is posted); C. The resident census at the beginning of the shift for which the information is posted; D. Twenty-four (24)-hour shift schedule operated by the facility; E. The shift for which the information is posted; F. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during the shift who are paid by the facility (including contract staff); G. The actual time worked during that shift for each category and type of nursing staff; and H. Total number of licensed and non-licensed nursing staff working for the posted shift. 3. Within two (2) hours of the beginning of each shift, the charge nurse or (continued on next page)		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, 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 3 of 14 residents (Resident #17, Resident #38 and Resident #60) reviewed for infection control practices. 1.The facility failed on12/09/25 to ensure that LVN A sanitized her hands while passing medications to Resident #38 and Resident #60. 2.The facility failed on 12/08/2025 to ensure that Resident #17's room was cleaned of feces, urine, and a unidentified black marks on the tile floor and bathroom. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1.Record review of Resident #38's face sheet, dated 12/10/25, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnosis included dementia (a decline in mental ability severe enough to interfere with daily life), candidiasis (a fungal infection), Alzheimer's (a progressive brain disorder) Other seasonal allergic rhinitis and shortness of breath. Record review of Resident #38's quarterly MDS assessment, dated 09/19/25, reflected that she had a BIMS score of 9, which indicated moderate cognitive impairment. She was also always continent of bladder and bowel. Shows that Resident #38 also triggered for dementia and loss of cognition. Record review of Resident #38's Order summary report, dated 12/10/25, reflected that she does not have an order for Geri-Tussin in oral liquid (Guaifenesin). Record review of Resident #38's care plan, dated 09/25/2025, reflected Resident #38 has a diagnosis of unspecified dementia (a decline in mental ability severe enough to interfere with daily life) with other disturbances. Interventions: administer prescribed medications per physician's orders. Record review of Resident #60's face sheet, dated 12/10/25, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnosis included dysphagia (difficulty swallowing food or liquids), Parkinson's disease (a progressive brain disorder causing movement issues), nonrheumatic aortic valve disorder (happens when the heart's main valve stiffens or doesn't close properly) and extended-spectrum beta-lactamases (bacterial enzymes that break down common antibiotics). Record review of Resident #60's quarterly MDS assessment, dated 07/24/25, reflected that she had a BIMS score of 15, which indicated she was cognitively intact. She was also always incontinent of bladder and bowel. Record review of Resident #60's Order summary report, dated 12/10/25, reflected Tylenol Tablet 325 mg (Acetaminophen). Give 2 tablets by mouth every 6 hours as needed for mild pain, start date 11/12/25. Record review of Resident #60's care plan, dated 10/30/25, reflected Resident #60 has complaints of chronic pain at times. Interventions include monitoring and recording any complaints of pain: location, duration, duration, quantity, quality, alleviating factors, aggravating factors. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of medications pass on 12/09/25 at 8:24 A.M., with LVN A. LVN A gave Resident #38 Geri-Tussin oral Liquid 30ml by mouth in a cup and gave and gave Resident #60 Tylenol tablet 325 mg (Acetaminophen) 2 tablets by mouth in a cup without sanitizing her hands. During an interview on 12/09/25 at 3:41 P.M., with LVN A said she was supposed to sanitize her hands between giving medications to residents. She said she was acknowledged that she did not sanitize her hands between giving Resident #38 and Resident #60's medications. She said she was in a rush this morning and she admitted it was wrong for her not to sanitize since the different upper respiratory infections were going around throughout the facility. She said s negative effect of improper hand hygiene was passing germs from one resident to another. She said the main concern was infection control. She said the facility had standing orders for the geri-tussin and she would make sure Resident #38 has an order for the medication. During an interview on 12/10/25 at 12:34 P.M., with ADON [NAME] said she except the staff to sanitize their hands between giving residents medications. She said improper hand hygiene puts the residents at risk for infection. She said a negative effect was infection control. She said the facility had standing orders for geri-tussin DM, but she needed to check to make sure LVN A had orders in for Resident #38. During an interview on 12/10/25 at 12:45 P.M., with Acting Director of Nursing he said expect for the nurses and staff to sanitize their hands between giving medications to residents. He said improper hand hygiene would place the resident at risk for an infection issue and cross contamination. He said he would ensure the order for the geri-tussin was placed under medications summary report. During an interview on 12/10/25 at 1:17 P.M., with the Administrator he said he expected the staff to sanitize their hands between giving residents medications. He said the risk of improper hand hygiene was an infection control issue. 2. Record review of Resident #17's face sheet, dated 12/10/25, reflected he was a [AGE] year-old male, initially admitted to the facility on [DATE], and most recently re-admitted on [DATE]. His diagnosis included Cerebral Infarction (happens when a blood clot blocks an artery supplying the brain, cutting off oxygen and nutrients, causing brain cells to die), Muscle Wasting and Atrophy (the decrease in muscle mass and strength, happening when protein breakdown exceeds synthesis, caused by inactivity (bed rest, immobilization), aging (sarcopenia), malnutrition, or diseases (cancer, heart failure, nerve damage), Chronic Pain (persistent pain lasting over three months, longer than normal healing, characterized by dull, throbbing, or burning sensations that affect daily life and can lead to depression, fatigue, and disability). Record review of Resident #17's quarterly MDS assessment, dated 08/25/25, reflected that she had a BIMS score of 10, which indicated moderate cognitive impairment. She was also frequently incontinent of bowel. Shows that Resident #17 also triggered for dementia and loss of cognition. Record review of Resident #17's care plan, dated 6/5/2024, reflected a focus of Resident #17 had experienced bladder incontinence at times. Additionally Resident #17 was limited in ability to bathe himself regarding his weakness and he would get tired easily. During an observation and attempted interview on 12/08/2025 at 9:09 a.m. it was observed that Resident # 17's room had black streaks of an unknown substance on the tile floor. The floor was sticky when walking on it. The room smelled of urine and feces. There was a yellow and brown liquid on the floor surrounding the toilet. Resident #17 was unable to answer questions when spoken to. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Mineola		STREET ADDRESS, CITY, STATE, ZIP CODE 320 Greenville Highway Mineola, TX 75773	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/08/2025 at 9:12 a.m. CNA C said the floor in Resident #17's room had been filthy, like the way it was for at least 5 days. He said he had not seen housekeeping in the B hall in several days. During an observation on 12/08/2025 at 11:30 a.m. it was observed that Resident #17's room had black streaks of an unknown substance on the tile floor. The floor was sticky when walking on it. The room smelled of urine and feces. There was a yellow and brown liquid on the floor surrounding the toilet. Resident #17's room is located on B hall. During an interview on 12/08/2025 11:35 a.m. with the Housekeeping Supervisor D she said that she has a housekeeper that works halls A and C. She said that she was working B hall, the hall Resident #17 resided on. She said she cannot do too much work because she was pregnant and could not do any labor. She said that Resident # 17 room was very dirty and needed to be cleaned every day. She said that Resident # 17 was using the bathroom on the floor and tracked it all over the room. She said that was the black areas which were on the floor. She said that she hired last Friday a new housekeeper to work the B hall but he called in today, said he had an emergency, and would not be at work. She said he worked last Saturday and Friday. She said she was responsible for B hall today. She said she doesn't know if her new hire housekeeper actually cleaned Resident #17's room last Saturday and Friday. She said the resident's rooms on B hall were not getting cleaned every day. She said when she could she would get in the room and clean it. During an interview on 12/8/2025 at 11:55 a.m. with CNA C he said to kitchen staff in the dining area that Resident #17 would be eating in his room. Surveyor who overheard this comment intervened and asked CNA C if Resident #17 would be eating in his room with urine, feces, and other black matter on the floor. CNA C said yes Resident #17 would be eating in his room in his room in the condition it was in. Surveyor asked CNA C if he was capable of mopping and cleaning Resident #17's room prior to him eating in his room. CNA C said that the cleaning supplies and mops were locked up and he didn't have access to them. Surveyor asked CNA C if he was capable of asking for someone for a mop and cleaning supplies since housekeeping was not cleaning Resident #17's room. CNA C left dining area. During an observation on 12/08/2025 at 12:11 p.m. it was observed that Resident #17 had the immediate area around his toilet mopped and the door was shut to the bathroom. The rest of Resident #17's room was not cleaned. Resident #17's room had black streaks of an unknown substance covering most of the resident's room. During an interview on 12/10/25 at 12:18 p.m. the ADON said that it was the responsibility of housekeeping to ensure that resident's floors are clean and not contaminated with urine and feces. She said that residents could be placed at risk of infection if floors were not clean and residents and staff are spreading urine and feces all over the facility. During an interview on 12/10/25 at 12:30 p.m. the Administrator said that housekeeping was responsible to ensure that floors are clean. He said that it was not acceptable to leave a resident's floor contaminated in urine and feces for long periods of time or to feed a resident in a room that was in that condition. He said that if housekeeping was not cleaning a resident's room a CNA or a nurse could clean a resident's room as well. During an interview on 12/10/25 at 1:02 p.m. with the Acting Director of Nurses he said that he expects that the facility be kept clean and that it was unacceptable for a resident's room to remain soiled with feces and urine for long periods of time. He said that residents could be placed at risk of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infections if they were exposed to urine and feces. Record review of a facility policy titled, Homelike Environment revised February 2021. Administration was asked for a infection control policy related to keeping the facility clean and was provided the following: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment. Record review of a facility policy titled, Hand washing/Hand Hygiene revised January 2025. Policy statement This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. 1. All personnel are trained and regularly in serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. 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. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, ect.) 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. Indications for Hand Hygiene 1. Hand hygiene is indicated: a. immediately before touching a resident; d. after touching a resident.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 of 6 residents (Resident #9) reviewed for PASRR. The facility failed to refer Resident #9 for PASRR level II assessment, to the state-designated authority, upon receipt of a psychosis (symptoms that happen when a person is disconnected from reality) diagnosis. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #9's face sheet, dated 12/09/25, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included unspecified psychosis. Dementia was not on his diagnosis list, and it was not designated as primary. The psychosis diagnosis was dated 11/06/24. Record review of Resident #9's quarterly MDS assessment, dated 11/21/25, reflected he had a BIMS score of 00, which indicated severe cognitive impairment. He was usually able to make himself understood and he was able to usually understand others. He had unclear speech. He received an antipsychotic and an antianxiety medication routinely. Record review of Resident #4's PASRR Level 1 Screening, dated 10/18/24, reflected that in Section C, Mental Illness was marked as no, which indicated Resident #9 did not have a mental illness. During an interview on 12/10/2025 at 12:24 PM, the MDS coordinator said she did not think Resident #9's PL1 should be positive because sometimes they do not have all of the diagnoses when they first receive the PL1 from the admitting facility. She said if the resident received the diagnosis of psychosis after he admitted, then she may have submitted a 1012 form and sent it to the Local authority. She said if she had submitted a positive PL1 form or a 1012 then the local authority would have come out and evaluated the resident. During an interview on 12/10/2025 at 12:43 PM, the ADON said she does not deal with PASRR. She said she does not review the PASRR forms. During an interview on 12/10/2025 at 12:51 PM, the Administrator said he was not aware Resident #9 had a diagnosis of psychosis. He said the PL1 form should have been marked as yes for mental illness or a 1012 form should have been completed. He said it was possible that the resident may have received PASRR services if evaluated by the Local authority. During an interview on 12/10/2025 at 1:05PM, the MDS Coordinator said a yes should have been marked on the PL1 form or a 1012 form should have been completed for Resident #9. She said she spoke with her corporate PASRR person, and they thought that a 1012 form or positive PL1 should have been completed. During an interview on 12/10/2025 at 1:15 PM, the RNC/Acting DON said his expectation would be for Resident #9 to have a positive PL1 form or a 1012 form. He said the risk was that Resident #9 may not be receiving services he could be getting. Record review of the facility's policy, PASRR, dated 07/29/25, reflected: .2. Screening Process:a). Level I Screening: This initial screening determines if the individual may have a mental illness or intellectual disability.5. Ongoing Review: Resident who are admitted under PASRR guidelines may undergo periodic reviews to ensure their needs are being met and that they continue to require nursing home care.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 1 resident (Resident #6) reviewed for respiratory care and services. The facility failed to clean the filter on an oxygen concentrator machine that was in use for Resident #6 on 12/08/25 and 12/09/25. This failure could place residents at risk for developing respiratory complications. Findings included: Record review of Resident #6's face sheet, dated 12/10/25, reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included pneumonia (an infection that inflames the air sacs in one or both lungs). Record review of Resident #6's quarterly MDS assessment, dated 08/22/25, reflected he had a BIMS score of 09, which indicated moderate cognitive impairment. Record review of Resident #6's Order Summary Report, dated 12/09/25, reflected the following orders: *Change oxygen filter for placement and cleanliness weekly on Sunday night and as needed. The start date was 12/09/25. *oxygen at 2 liters per minute via nasal cannula. The start date was 12/09/25. During an in observation on 12/08/2025 at 8:38 AM, Resident #6 was lying in bed in his room with oxygen in place via a nasal cannula. The oxygen concentrator filter was covered in a gray debris. During an observation on 12/09/2025 at 10:28 AM, Resident #6 was in his room lying in bed. He had oxygen in place via a nasal cannula. The oxygen concentrator filter was still covered in a gray debris. During an interview on 12/10/25 at 12:43PM the ADON said she washed Resident #6's concentrator filter on this day. She said every Sunday night and as needed, the filter should be cleaned by the nurse. She said the filter should be checked each shift by the nurse. She said the risk was infection control and the resident could get sick. During an interview on 12/10/25 at 12:51PM the Administrator said Resident #6's oxygen filter should have been cleaned. He said it was possible the resident could get sick. He said it could also affect airflow. During an interview on 12/10/25 at 01:15PM, the RNC/Acting DON said Resident #6's filter should be cleaned every Sunday night. He said the risk was that Resident #6 could have respiratory complications or illness. Record review of the facility's policy, Oxygen Administration, last revised October 2010, reflected that it did not mention the oxygen concentrator filter or its cleanliness.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 18 residents (Resident #31) reviewed for pharmacy services. The facility failed to ensure that 1 tablet of Resident #31's prescribed Hydrocodone (opiate pain medication) was properly accounted for and not missing on 12/10/25. This failure could place residents at risk for decreased quality of life, unrelieved pain, and dignity. Findings included: Record Review of Resident #31's undated face sheet indicated she was an [AGE] year-old female that admitted [DATE], with diagnoses that included: Cerebral infarction (a stroke, when a blood clot blocks an artery in the brain), chronic atrial fibrillation (the upper chambers of the heart beat chaotically and rapidly leading to an irregular and often fast heartbeat), Myelodysplastic Syndrome (a group of blood cancers where the bone marrow stem fail to produce enough healthy, mature blood cells leading to fatigue, anemia, infections, and bleeding), and pain. Record review of the quarterly MDS dated [DATE] indicated Resident #31 had a BIMS score of 15 indicating she was cognitively intact. The MDS indicated she had received PRN pain medications, had occasional pain, and received an opioid medication. Record review of the care plan dated 11/11/25 indicated Resident #31 had complaints of generalized pain and prescribed pain medications should be administered per her physician's orders. Record review of Resident #31's physician's orders dated 12/10/25 reflected the following: 12/8/25 Hydrocodone-Acetaminophen Oral tablet 5-325 mg, give 1 tablet by mouth every 4 hours as needed for pain. During an observation and interview of Nurse Cart A/B with LVN A on 12/10/25 at 9:28 AM this surveyor looked at the medication card for Resident #31's Hydrocodone-Acetaminophen Oral tablet 5-325 mg. There were 27 pills left in the punch card, however LVN A said the narcotic count sheet indicated there were 28 pills left in the punch card. LVN A said that was not correct. LVN A said she had not given Resident #31 any of those pills this morning or anytime today on her shift. During an interview on 12/10/25 at 9:33 AM, LVN A said she did not count the narcotics or reconcile the narcotics with LVN B when she took over the medication cart at approximately 6:30 AM this morning. She said she did not know why she did not reconcile/or count the narcotics. During an interview and record review on 12/10/25 at 9:34 AM, the ADON double checked the narcotic sheet for Resident #31's Hydrocodone-Acetaminophen Oral tablet 5-325 mg. The narcotic sheet indicated 28 pills should be in Resident #31's medication card. The ADON said there were only 27 pills left in the medication card for Resident #31. She said it appeared someone did not sign off the last pill given. The ADON said according to the narcotic sheet the last hydrocodone pill given to Resident #31 was on 12/9/25 at approximately 2:15 PM. The ADON said Resident #31 usually got 2-3 of those pills per day. The ADON and this surveyor looked at the MAR for Resident #31's hydrocodone and it indicated for the month of December she had not had any of the medication. The ADON said it appeared no medication was given in December 2025, and she did not know why the MAR would show that because she knew Resident #31 had several of those pills daily for pain. During an interview on 12/10/25 at 9:45 AM, This surveyor went into Resident #31's room. She was sitting in her recliner. Resident #31 denied any pain. She said LVN B had given her a pain pill last night. During a telephone interview on 12/10/25 at 9:52 AM, LVN B said she had given Resident #31 her Hydrocodone-Acetaminophen but forgot to document it. She said she had a new admit and was very busy. LVN B said she should have documented it but did not. During an interview on 12/10/25 at 10:16 AM LVN A said she came on shift this morning at 6:30 AM, but her shift was supposed to start at 6:00 AM. She said she was running late. She said LVN B did not ask her if she wanted to reconcile the medication and she did not ask LVN B. She said LVN B told her the narcotic count was correct. LVN A said the narcotic count was not correct. She said she and LVN B were supposed to count all narcotics before she took over the cart. She said she was taught to do that. She said she and LVN B (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not count the narcotics this morning because she was running late. She said the risk of not counting the cart was that she could be accused of taking/stealing medication, or lose her license. She said she did not take or steal that (hydrocodone) pill and she would not have taken any medication. She said Resident #31 takes pain medication at night. She said she was confident LVN B gave that pill to Resident #31 because she had a lot of pain and LVN B would have given it. She said when she and LVN B have reconciled a cart in the past, they had never had a problem with the count. LVN A said she had always counted her narcotics before taking over a medication cart or giving another staff a medication cart until today. She said she had not given Resident #31 any of her hydrocodone this morning since she arrived on shift. She said she could not document Resident #31's PRN hydrocodone in the MAR in PCC because PCC would not let her, it would not populate on the MAR. During an interview on 12/10/25 at 10:31 AM, the ADON said the PRN hydrocodone (MAR) for Resident #31 was put in PCC wrong. She said it was put in Medication Aide MAR instead of the Nurse MAR where it belonged. That was why the nurses could not document in PCC that they had given it because it would not populate. She said they were currently in the process of changing to PCC from another computer program and had moved over 1000 orders. She said it was a mistake and was put in the wrong place. The ADON said no one told her there was a problem documenting the PRN hydrocodone for Resident #31, so she did not know about it until today. During an interview on 12/10/25 at 10:40 AM, LVN A said she had tried to document on the MAR when she had given the hydrocodone to Resident #31 but PCC would not allow it to populate on the MAR. She said she should have told the ADON but she did not. She said she should have made a progress note when she had given the medication since she was not able to document it on the MAR. She said she always signed the narcotic sheet when she got out a medication. LVN A said she should have told the ADON it would not populate on the MAR in PCC, but she did not. She said she may have gotten busy and forgotten but should have addressed it immediately. She had some education on PCC but needed more. She said she got more education today after this surveyor finding the count was wrong on Resident #31's PRN hydrocodone. All her other PRN medications had been documented in PCC, but this one was on the wrong MAR. The ADON fixed it and showed her in PCC that it had been fixed and now she could document giving the PRN hydrocodone to Resident #31 on the MAR. During an interview on 12/10/25 at 11:09 AM, LVN B said she gave Resident #31 her PRN hydrocodone 5/325 mg about 5:50 AM, last night right before shift change. LVN B said she walked by Resident #31's room and Resident #31 said her right shoulder was hurting 7 out of 10, (the pain scale is 0 - 10, with 0 being no pain and 10 being the worse pain imaginable), so she gave her a PRN hydrocodone. She said she took full responsibility for not documenting that and she should have documented it. She said she was very busy for her shift but that was no excuse for not documenting what she should have. She said she could not document giving the PRN medication on the MAR in PCC because it would not populate. She said Resident #31's hydrocodone was the only medication that she gave that would not populate on the MAR in PCC. She said she did not tell anyone that she could not document it in PCC, but she should have because she could have been accused of a diversion and did not want to ever overmedicate a resident. LVN B said normally she would document giving the medication on the narcotic sheet and in PCC, but she could not document it in PCC because PCC did not allow her to. She said she and LVN A did not reconcile/count the medication/narcotics when she gave the medication cart to LVN A this morning. She said LVN A was running late, there was a lot going on and they just did not do it. She said there was no excuse, and she apologized. She said this was the first and only time they had not reconciled the medications, and it was a stupid mistake. She said did not take, swallow, or steal that pill. She had given it to Resident #31. During an interview and record review on 12/10/25 at 11:18 AM, the ADON said she could not print out the incorrect MAR from earlier this morning that indicated no PRN hydrocodone had been given to Resident #31 in December 2025 because she already changed it to make it correct, but showed this surveyor an Order Audit Report that indicated she made the change and fixed the problem getting Resident #31's PRN hydrocodone on the correct MAR with a date of (continued on next page)		

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(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 - Few	12/10/25 at 10:29 AM. During an interview on 12/10/25 at 12:29 AM, the ADON said it was the expectation that the nurses reconcile the narcotic medication count at the beginning and end of each shift change. The reason was to prevent medication errors. She said LVN A and LVN B were in the wrong because they did not do that. She said both had been given a disciplinary write up for not following policy. She believes Resident #31 received her pain pill because Resident #31 told her she did. She said Resident #31 told her this morning about 10:00 AM that she had no pain and that LVN B had given her a pain pill. No one told her there was an issue with documenting Resident #31's PRN hydrocodone in PCC. She found out today. The ADON said when she checked to see what the problem was, she realized that particular medication (Hydrocodone) was a PRN medication on the wrong MAR sheet and was not showing up on the Nurse MAR sheet so they could not check off/document that they given it. She said she fixed it this morning at 10:29 AM and educated the nurses on PCC documentation. The risk of not documenting that medication was given on the narcotic sheet or in PCC was the resident could fail to have pain control, there could be a drug diversion, or the resident could get an extra pain pill. During an interview on 12/10/25 at 12:42 PM, the acting DON said nurses should always reconcile their medication carts at shift change and all narcotics should be counted. He said all medications given should be documented so staff know what has been given to the resident. He said the risk of not reconciling/counting narcotics on a medication cart could be a drug diversion, a missed or double dose of medication to a resident, and/or not knowing when a resident got their medication. During an interview on 12/10/25 at 12:45 PM, the ADM said LVN B should have documented the PRN hydrocodone immediately on the narcotic sheet when she gave it to Resident #31. He said if LVN A and LVN B had reconciled the cart like they were supposed to they would have realized LVN B did not document she gave Resident #31 the medication. He said when the nurses realized they could not document the medication in the MAR in PCC they should have reported it so that it could have been fixed. He said the risk of not documenting medications given to a resident was that they could get more than they should. Record review of a Controlled Substances policy with a revised date of November 2022 indicated: .Dispensing and Reconciling Controlled Substances1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2.The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following:a.Records of personnel access and usage;b.Medication administration records;c.Declining inventory records; andd.Destruction, waste and return to pharmacy records.3.Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count.4.The nurse coming on duty and the nurse going off duty make the count together and document and dreport any discrepancies to the director of nursing services. Missing observation in the DPS.		

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 12/10/2025
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure all drugs were stored in a locked compartment and only accessible by authorized personnel for 1 of 13 (Resident #2) residents reviewed for medication storage and 1 of 4 medication carts (#1, #2, #3, #4). The facility failed to securely store medications, albuterol inhaler, for Resident #2. The facility failed to securely store medications, nystatin topical powder, in the locked drawers of the medication cart. This failure could place residents at risk for adverse reactions. Findings included: Record review of a face sheet dated 1/23/25 indicated Resident #2 was [AGE] years old and was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including displaced intertrochanteric fracture (serious break in the upper thigh bone (femur) near the hip joint, where the broken pieces have shifted out of alignment), ocular pain (discomfort on or around the eye, ranging from stinging/burning), muscle wasting and atrophy (decrease in muscle mass and strength, happening when protein breakdown exceeds synthesis, caused by inactivity (bed rest, immobilization), aging (sarcopenia), malnutrition, or diseases (cancer, heart failure, nerve damage). Record review of the MDS dated [DATE] indicated Resident #2 had a BIMS score of 14 which indicates normal cognitive function. MDS showed that Resident #2 required partial or moderate assistance with ADLs. Record review of a care plan revised on 10/10/25 indicated Resident #2 required assistance with his ADLs. Care plan did not indicate that Resident #2 used an albuterol inhaler. Record review of a physician's order dated 10/8/2025 for Resident #2 showed an order for albuterol sulfate and staff were to administer the medication by, aerosol inhaler; 90 microgram/actuation; amount: 2 puffs; inhalation. During an observation and interview on 12/8/2025 at 8:43 a.m. Resident #2 had an albuterol inhaler on his bedside table. Resident #2 said that he uses this inhaler every day. He said he leaves it on his bedside table and does not put it away in a drawer. During an observation on 12/8/2025 at 8:52 a.m. it was observed on top of B hall medication cart in plain view on B hall, a bottle of nystatin topical powder. Medication was not locked inside the medication cart drawer and was available for anyone to reach and take. During an interview on 12/10/25 at 9:00 a.m. ADON, she stated there are no residents in the facility that can self-administer medications which included albuterol inhalers. During an interview on 12/10/2025 at 9:25 a.m. LVN A said that residents should not have albuterol inhalers in their room without nurse supervision. She said that an albuterol inhaler should be kept in the nurse's medication cart. She said that nystatin topical solution should not have been stored on top of the medication cart as well. She said it should have been stored inside the locked drawers on the medication cart. She said that residents could possibly misuse both an albuterol inhaler and nystatin topical powder. She said that a resident could be harmed if they misused medication. During an interview on 12/10/25 at 12:18 PM, the ADON said that both albuterol inhalers and nystatin powder should have been stored in the locked medication cart. She said that it was the responsibility of nurses to ensure that the medications of residents are stored inside the medication cart and secured. She said that residents could be placed at risk of harm if they misused medication. During an interview on 12/10/25 at 12:30 PM, the Administrator said that medications should have been stored inside their locked drawers on the medication cart. He said that residents could harm themselves if they had access to medications. He said that nystatin topical powder and albuterol inhalers should be locked in their respective medication carts. During an interview on 12/10/25 at 1:02 p.m. with the Acting Director of Nurses he said that he expects that all medications are secured in the appropriate medication cart and locked. He said that residents could be placed at risk of harm if they misused medications or got ahold of medication that was not theirs. Record review of a facility policy titled, Medication Labeling and Storage revised in February 2023 reflected, The facility stores all medications and biologicals in (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Mineola		STREET ADDRESS, CITY, STATE, ZIP CODE 320 Greenville Highway Mineola, TX 75773	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.		