

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675949	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/06/2026
NAME OF PROVIDER OR SUPPLIER Avir at Cowhorn Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 5524 Cowhorn Creek Texarkana, TX 75503	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and supervision, in that: Resident #1 was transferred without a gait belt and staff failed to utilize safe body mechanics during the transfer on 6/22/26. This failure placed the residents at risk for loss of balance, fall, and injury. The findings included: Record review of Resident #1's face sheet, dated 07/06/2026, revealed Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of cerebral vascular accident (a type of stroke that occurs when a blocked or narrowed blood vessel disrupts blood flow to the brain), hemiplegia (one-sided paralysis or weakness of the face, arm or leg), and dementia (pattern of mental decline caused by different diseases or conditions. Most commonly, dementia occurs when brain nerve cells (neurons) die, and connections between neurons are interrupted). Record review of Resident #1's quarterly MDS assessment dated [DATE], indicated Resident #1 required maximal/substantial (helper does more than 1/2 the work) for transfer to and from chair to bed. Record review of Resident #1's physical therapy treatment encounter notes dated 06/19/2026 revealed Resident #1 required maximal assist with verbal and tactile cueing for safety from bed to wheelchair. Record review of Resident #1's care plan, dated 06/25/2026, revealed a care plan for : ADL performance deficit: Resident #1 required substantial/maximal assistance for ADLs such as transfer and bed mobility. Record review of a video dated 06/22/2026 at 9:54 a.m., showed Resident #1 being transferred from her wheelchair to her bed by CNA A. Resident #1 was in her wheelchair sitting perpendicular to her bed. CNA A pulled Resident #1 up by looping her forearms under Resident #1's armpits and spun her around 180 degrees. No gait belt was used. Resident #1 did not participate in the transfer and 100% of the work was done by CNA A. During an interview on 07/06/2026 at 1:15 p.m., the Director of Rehab viewed the video and stated the transfer of Resident #1 by CNA A on 06/22/2026 at 9:54 a.m., was very unsafe. She stated all transfers were to be done with a gait belt. She stated Resident #1 should have been aligned parallel to her bed for a 90-degree pivot transfer. She stated swinging Resident #1 from 180 degrees could have injured Resident #1 and CNA A or Resident #1 could have fallen related to the improper transfer. The Director of Rehab stated Resident #1 had been a maximum assist pivot transfer for several months. She stated Resident #1 had been on therapy services for over 60 days working on transfer training. During an interview on 07/06/2026 at 1:44 p.m., CNA A stated she remembered the transfer with Resident #1 on 06/22/2026 because she almost dropped Resident #1. She stated Resident #1 would generally assist the smallest amount, but she felt Resident #1's knees buckle during the transfer causing her to almost drop Resident #1. She stated she should have used a gait belt and chicken winging (putting your arms under the residents' arms and lifting the resident) the resident during (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer was not a proper transfer technique. She stated a few days after the transfer an in-service was done about proper transfer techniques and using a gait belt during transfer. During an interview on 07/06/2026 at 3:00 p.m., the DON stated it was the facility's policy to use gait belts with transfers. She stated the CNAs had access to the residents' profile that showed how much assistance each resident needed for safe care. She stated Resident #1 was maximum assistance and required only 1 staff member for safe transfer with a gait belt. She stated she did transfer training in-servicing on 06/23/2025-06/25/2026 for CNAs. She stated she estimated she in-serviced about 1/2 the staff so far and was continuing with the training until she had everyone trained. She stated all staff were educated about safe transfer on hire and annually unless circumstances arose when an in-service or training needed to be done in-between. During an interview on 07/06/2026 at 3:30 p.m., the Administrator stated it was the facility's policy to follow the safest technique for transfers for all residents. The Administrator stated Resident #1's care plan stated 1 person for transfers, but CNA A should have used proper technique and a gait belt. The Administrator stated training had been done with most of the staff on proper transferring. She stated improper transfers could lead to falls or injuries for both the residents and staff. Review of an undated facility policy titled "Safe Lifting and Movement of Residents" revealed "Manual lifting of residents shall be eliminated when feasible. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belt, lateral boards) and mechanical lifting techniques. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which: a. involves employees in identifying problem areas and implementing workplace safety and injury-prevention strategies."		