

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

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Form Approved OMB
No. 0938-0391

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 07/29/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on and record review, the facility failed to develop and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 1 of 7 residents (Resident #1) reviewed for care plans.1. The facility failed to implement Resident #1's care plan by not performing a mechanical lift.2. The facility failed to implement Resident #1's care plan when CNA A attempted to transfer Resident #1 by himself on [DATE] by lifting her under her arms. These failures could place residents in the facility at an increased risk of injury, a decline in physical or functional well-being, and not receiving necessary care or services to meet their needs. Findings included: Record review of Resident #1's face sheet dated [DATE] indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including hemiplegia {unable to move one side of body} and hemiparesis {partial weakness of one side of body} following a cerebral infarction {stroke-death of brain tissue caused by blocked blood vessels that cuts off oxygen and blood} affecting the left non-dominant side, chronic obstructive pulmonary disease {long-term lung condition that limits airflow and makes it hard to breathe}, heart failure, peripheral vascular disease {slow blood circulation disorder caused by narrowing, blocking, or spasms of blood vessels outside the heart and brain}, fracture of upper end of left humerus {upper arm bone}, displaced simple supracondylar fracture of left humerus {lower end of upper arm bone}, history of fracture of lower end of left humerus in 2021, other specified disorders of bone density and structure, osteoarthritis {joint disease, characterized by the breakdown of the protective cartilage, pain during movement, and joint stiffness}, pain, lack of coordination, weakness and abnormality of gait and mobility. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was usually understood and usually understood others. The MDS indicated she had a BIMS score of 13, which indicated she was cognitively intact. The MDS indicated Resident #1 had functional limitation of motion to upper and lower extremities on one side of her body. The MDS indicated Resident #1 used a wheelchair for mobility. The MDS indicated Resident #1 dependent on staff for most ADLs including tub/shower transfer, chair/bed to chair transfers, and rolling side to side. Record review of Resident #1's care plan dated initially [DATE] and revised on [DATE] indicated she had limited physical mobility related to left sided hemiplegia with left hand contracture, age related debility, and generalized weakness with interventions including she required total assist of two staff and mechanical lift for transfers and in the event of equipment unavailability, utilize 2-3 person total assist for transfers to ensure resident and staff safety. The care plan indicated Resident #1 was at risk for injury related to diagnosis of osteoporosis (medical condition that makes bones weak, thin, fragile, greatly increasing the risk of sudden breaks) and osteopenia (condition of lower-than-normal bone mineral density that serves as a warning sign for osteoporosis) with an initiated date of [DATE]. Record review of video footage dated [DATE] beginning at 2:50 PM, started (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675949	Facility ID: 675949 If continuation sheet Page 1 of 11

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be important to follow the care plan because that was how you take care of the patient. The DON said there were a lot of risks to the resident if the care plan was not being followed, depending on what was not followed. The DON said all the nursing staff, ADONs, and MDS nurses were responsible for ensuring the care plan was followed. The DON said the Kardex (the care plan for the CNAs) and the ADL flowsheet was like a roadmap of how to care for the resident. The DON said the resident could be transferred manually if there was an issue with the mechanical lift, only as a backup. The DON said she would expect the manual lift to be done safely and with the proper equipment. During an interview on [DATE] at 2:51 PM, the ADM said the purpose of the care plan was to be person centered for staff to know how to care for the resident in the best way possible. The ADM said she would expect the care plan to be followed. The ADM said if there was a reason the mechanical lift was not feasible, then she would expect the staff to do a manual lift in the safest way possible. The ADM said she would expect the facility's policies to be followed. Record review of the facility's policy dated revised [DATE] and titled Care Plans, Comprehensive Person-Centered, indicated . A comprehensive, person-centered care plan that includes measurable objectives and timetables to the meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident . the care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment . each resident's comprehensive person-centered care plan was consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to . g. receive the services and/or items included in the plan of care . the comprehensive person-centered care plan . described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making .		

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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 observation, interview and record review, the facility failed to ensure the resident's environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 residents (Resident #1) reviewed for accidents and supervision. 1. The facility failed to ensure CNA A did not attempt a one-person resident transfer from the shower chair to Resident #1's wheelchair and then from her wheelchair to her bed on [DATE] by lifting her under her arms.2. The facility failed to ensure CNA A and CNA B performed a safe transfer from Resident #1's wheelchair to her bed on [DATE] by lifting her under her arms without the use of a gait belt or other assistive devices.3. The facility failed to ensure ADON E documented the staff's report of almost dropping Resident #1 or when Resident #1's family member showed her the video of the [DATE] transfer that showed CNA A almost drop Resident #1 trying to transfer her by himself and then the unsafe transfer performed by CNA A and CNA B. These failures could place residents at risk of injury. Findings included: Record review of Resident #1's face sheet dated [DATE] indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including hemiplegia {unable to move one side of body} and hemiparesis {partial weakness of one side of body} following a cerebral infarction {stroke-death of brain tissue caused by blocked blood vessels that cuts off oxygen and blood} affecting the left non-dominant side, chronic obstructive pulmonary disease {long-term lung condition that limits airflow and makes it hard to breathe}, heart failure, peripheral vascular disease {slow blood circulation disorder caused by narrowing, blocking, or spasms of blood vessels outside the heart and brain}, fracture of upper end of left humerus {upper arm bone}, displaced simple supracondylar fracture of left humerus {lower end of upper arm bone}, history of fracture of lower end of left humerus in 2021, other specified disorders of bone density and structure, osteoarthritis {joint disease, characterized by the breakdown of the protective cartilage, pain during movement, and joint stiffness}, pain, lack of coordination, weakness and abnormality of gait and mobility. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was usually understood and usually understood others. The MDS indicated she had a BIMS of 13, which indicated she was cognitively intact. The MDS indicated Resident #1 had functional limitation of motion to upper and lower extremities on one side of her body. The MDS indicated Resident #1 used a wheelchair for mobility. The MDS indicated Resident #1 dependent on staff for most ADLs including tub/shower transfer, chair/bed to chair transfers, and rolling side to side. Record review of Resident #1's care plan dated initially [DATE] and revised on [DATE] indicated she had limited physical mobility related to left sided hemiplegia with left hand contracture, age related debility, and generalized weakness with interventions including she required total assist of two staff and mechanical lift for transfers and in the event of equipment unavailability, utilize 2-3 person total assist for transfers to ensure resident and staff safety. The care plan indicated Resident #1 was at risk for injury related to diagnosis of osteoporosis (medical condition that makes bones weak, thin, fragile, greatly increasing the risk of sudden breaks) and osteopenia (condition of lower-than-normal bone mineral density that serves as a warning sign for osteoporosis) with an initiated date of [DATE]. Record review of progress notes dated [DATE] did not indicate ADON E had assessed Resident #1 after being notified by staff that they almost dropped her during a transfer. Record review of progress notes dated [DATE] indicated ADON E had done a skin assessment on Resident #1 and it (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not reveal any new skin issues. Record review of video footage dated [DATE] beginning at 2:50 PM, started with Resident #1 sitting up in a wheelchair near her bed in her room. There were three staff members in the room. CNA C was standing on the opposite side of the bed. CNA B locked the wheelchair and then stood behind the wheel chair holding it. CNA A then walked in front of Resident #1 and put his arms under both of Resident #1's arms with his hands placed just behind her shoulders and lifted Resident #1 from her wheelchair and started to turn her toward her bed. Resident #1's arms then went straight up, and she began to slip through CNA A's hands. CNA A then tried to turn Resident #1 back toward the wheelchair and her lower part of her back could be seen at the level of the wheelchair seat. CNA B then reached over the back of the wheelchair and grabbed Resident #1 under her arms and said Come on {CNA C's name}. CNA C came around the end of the bed, and CNA A, CNA B, and CNA C were able to pull Resident #1 back up into the wheelchair. Staff were heard saying We got you, unable to determine which staff said it. Resident #1 was wearing only a hospital type gown with the back of the gown open and there was no gait belt or any other assistive device being used. CNA C then stepped in front of Resident #1 and put both of her arms under both of Resident #1's arms and CNA A put his right arm under Resident #1's right arm. CNA C and CNA A then lifted Resident #1 and turning/dragging her to her left as CNA B pushed Resident #1's bottom toward the bed with one hand and they were able to get her top half of Resident #1's body onto the bed and then lifted her legs onto the bed. Resident #1 said put me on the bed and CNA B and CNA C both said you are on the bed. CNA B asked Resident #1 if she was okay. Resident #1 said I'm fine, sit me up. CNA B said they could not sit her up until they put her brief on. CNA B and CNA C then rolled Resident #1 from side to side and placed her brief on her and pulled her up in bed. CNA B then rubbed lotion on Resident #1's legs. Resident #1 said get me some pills and CNA C said, that's the nurse's job, do you want me to tell her? Resident #1 said yes, I'm hurting. CNA B and CNA C were discussing the shower chair and CNA B said, that shower chair did it, they need to get a better shower chair, and then it sounded like they were discussing the mechanical lift but was only able to make out all that was said, except someone going to get stuck midair. The three staff members covered Resident #1 with a sheet and blanket and continued their discussion but was unable to understand what was being said over the sound of the television. CNA B asked Resident #1 if she was good and Resident #1 said cover me up and CNA B said, I got you. The video ended at 2:55 PM. During an interview on [DATE] at 12:03 PM, Resident #1's family member said he had video footage of a male staff member (CNA A) trying to transfer Resident #1 by himself on [DATE] without a mechanical lift or gait belt and he almost dropped her when she slid down and additional staff came in and helped get her back up in the wheelchair. During an interview on [DATE] at 2:35 PM, LVN F said she had worked at the facility since 12/2025. LVN F said staff had reported that the mechanical lift was not working at times. LVN F said normally it was the battery and they had several batteries to change it out. LVN F said staff would just have to go get another battery and replace it. LVN F said she worked on [DATE] and staff did not report having to manually transfer Resident #1. LVN F said Resident #1 was a mechanical lift and it would depend if the three staff members were strong enough to lift her to safely transfer her safely manually. LVN F said there was no way to safely transfer Resident #1 other than using a mechanical lift. LVN F said staff could possibly use the mechanical lift pad with four people, 1 on each corner if they had to. LVN F said there was one mechanical lift, and she thought they used the one lift for both ends of the building. LVN F said they could drop Resident #1 and could cause injury to the resident if they performed an unsafe transfer. During an interview on [DATE] at 2:53 PM CNA C said she had worked at the facility for about four months. CNA C said she did assist transfer Resident #1 without a mechanical lift because the aide that had her that day said that the mechanical lift would not work (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Cowhorn Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 5524 Cowhorn Creek Texarkana, TX 75503	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and they had changed the battery and it still did not work. CNA C said they came and got her to assist to transfer Resident #1 from the wheelchair to her bed. CNA C said it was CNA B and CNA A who were in Resident #1's room to manually transfer her. CNA C said the transfer went good, because they had three people in there. CNA C said there was not a time that they almost dropped her. CNA C said the only thing Resident #1 said before the transfer was to get her out of the wheelchair because her bottom hurt. CNA C said they did tell the nurse about the lift not working and was told to change the battery and it still was not working, so she guessed that was when they came and got her to assist with the transfer. CNA C said they needed to use the mechanical lift or at least 3-4 people to lift Resident #1 safely. CNA C said they probably should have used a gait belt. CNA C said Resident #1 could have fell and been injured. During an interview on [DATE] at 3:13 PM, CNA B said she had worked at the facility since [DATE]. CNA B said CNA A and herself gave Resident #1 a shower on [DATE] and there was no issue in the shower itself. CNA B said there was an issue with the mechanical lift and the battery died. CNA B said she left the shower room and went to the nurses' station and told the nurse the battery was dead and the older white lady went into the room and brought her a battery. CNA B said she put the battery on the mechanical lift and it was dead, so she then went and told the older white lady that battery did not work either. CNA B said she tried a total of three batteries, the one on the mechanical lift and 2 others, and did not know they had six batteries. CNA B said there was a charger behind the nurses' station, but she did not know there were more batteries because she had just started [DATE]. CNA B said there were two batteries on chargers and one on the lift and they were all dead. CNA B said she put the battery on the charger so it would charge. CNA B said she went and told CNA A and asked him what they were supposed to do then if the lift was not charged. CNA B said she did not know if CNA A asked the nurse what to do, but she knew she did not tell anyone about manually lifting Resident #1. When CNA B was informed of viewing the video footage of the transfer from the wheelchair to the bed for Resident #1 on [DATE], she said CNA A and CNA C transferred Resident #1 from the wheelchair to the bed and she held the wheelchair from behind. CNA B said the first time CNA A tried to transfer Resident #1 by himself and he almost dropped her. CNA B said she was still learning at that time and was not comfortable doing the transfer. CNA B said they should not have lifted her from under her arms and they should have used a gait belt. CNA B said they did not wait for the mechanical lift battery to charge because Resident #1 was crying out in pain due to her bottom was hurting. CNA B said at that moment they did what they thought was right. CNA B said Resident #1 could have fell and could have been injured during the transfer. CNA B said after the transfer, she told ADON E that it was not a smooth transfer and told her CNA A almost dropped Resident #1 when he attempted to transfer her by himself and they eased her back to the wheelchair and then two people transferred her back to bed from the wheelchair. CNA B said after Resident #1's shower and they could not get a working battery for the mechanical lift; she did not feel comfortable transferring Resident #1 from the shower chair to the wheelchair and CNA A transferred Resident #1 by himself and thought he bear hugged her. CNA B said that transfer went much smoother than the one in her room. During an observation and interview on [DATE] at 3:40 PM, Resident #1's family member was at Resident #1's bedside. Resident #1 was lying in bed asleep and she appeared clean and well kept. Resident #1's family member said he was told the mechanical lift was not working on [DATE] and he did not know how staff transferred her from the shower chair to the wheelchair to take her back to her room. Resident #1's family member said he came to the facility on [DATE] and showed ADON E the [DATE] video footage of the male staff member (CNA A) almost dropping Resident #1 in her room when trying to transfer her by himself. Resident #1's family member said ADON E called him back that afternoon at 4:27 PM and said she had (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	talked to the staff and said the lift was broken because the battery did not charge, and they denied they dropped Resident #1. Resident #1's family member said ADON E said the staff should have at least used a gait belt because they could have re-injured her arm by lifting her under her arms. During an interview on [DATE] at 4:57 PM, CNA A said he had worked at the facility for two to three months PRN. CNA A said he could not really remember much about Resident #1's transfer on [DATE]. CNA A said the best he could remember was the lift quit working, but he did not know what was wrong with it. CNA A said it would not work up and down. CNA A said he guessed it was the battery. CNA A said he did not remember exactly how they transferred Resident #1 in the shower room. CNA A said him and CNA C were on each side of Resident #1 and as far as he could remember, she had a gait belt on Resident #1. CNA A said he did not remember him and CNA C lifting Resident #1 under her arms to transfer her. CNA A said there were no issues with the transfer to his knowledge. CNA A said he did not remember trying to lift Resident #1 under her arms by himself without a gait belt or other equipment. CNA A said he thought there was a gait belt, as much as he could remember. CNA A said he did not know how to answer how it could have affected the resident by trying to lift her by himself or without the proper equipment. CNA A said he had been trained by the DON on the use of a gait belt. CNA A said they should use a gait belt during transfers to balance the weight, so not to have all the weight on the resident. During an interview on [DATE] at 9:19 AM, ADON E said she assessed Resident #1 after one of the CNAs told her, they almost dropped Resident #1 during the transfer on [DATE] after they transferred her. ADON E said there were not any issues, and she did not do an incident report because she did not have anything to document. ADON E said Resident #1's family member did show her the video later, but she did not remember what day he showed it to her. ADON E said the video showed one staff member was trying to transfer Resident #1 by himself and Resident #1 slid down. ADON E said they got her back into the wheelchair and then two staff members transferred Resident #1 to the bed. ADON E said she did not see anything in the transfer that she thought needed to be put in an incident report because Resident #1 did not fall. ADON E said she reported to the DON/ADM, but she did not remember what day that was, that she had seen the video but Resident #1 did not fall. ADON E said she assessed Resident #1 and did not see anything that needed to be documented. ADON E said she talked to the staff members and asked them why they did not use the mechanical lift and they said the battery went out. ADON E said she would not think all the batteries were dead. ADON E said after staff told her they had to manually transfer Resident # 1, she checked the mechanical lift and said all she did was put another battery on it and there was a charged battery available. ADON E said there were other ways to transfer a resident with 2-4 people if the mechanical lift was not working, so not sure what the risk to the resident would be. ADON E said staff should use a gait belt during manual transfers but using a gait belt on Resident #1 could cause her more harm because she could not stand. ADON E said if they had to manually transfer a resident that was a mechanical lift, then they should use a sheet or the mechanical lift pad for a safe transfer with one person on each corner. ADON E said she had trained them on that through demonstration after watching the video. ADON E said she did not document the in-service with demonstration and did not have the staff sign that they had received the in-service. ADON E said she felt they did a safe transfer. ADON E said they should not have lifted Resident #1 from under her arms. During an interview on [DATE] at 11:50 AM, LVN F said staff could not safely transfer Resident #1 by getting under her arms and without a gait belt or a lift pad. LVN F said she would have never approved or suggested it. LVN F said it could have caused a fall and risk of injury to Resident #1. During an interview on [DATE] at 1:14 PM, ADON D said she was the ADON for halls 100 and 200. ADON D said Resident #1 required a mechanical lift for transfers. ADON D said it would not be safe for one person to transfer Resident #1 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by lifting under her arms. ADON D said Resident #1 would require 2-3 persons with a gait belt to transfer without a mechanical lift. ADON D said it would not be a proper transfer if two staff members lifted Resident #1 from under her arms. ADON D said it would be a risk of injury to the resident and staff. ADON D said they should use a gait belt for safety. ADON D said she was not aware of any issues with the mechanical lift not functioning, but they did have to change out the batteries when they were dead. ADON D said they had multiple batteries, so there should always be an extra charged battery. ADON D said if a staff member told her that they almost dropped the resident, she would report it to the DON. ADON D said she did not know if she would do an incident report but would assess the resident and investigate the incident and would document any findings in the resident's chart. ADON D said if a family member showed her a video that showed the staff almost dropped the resident and the improper transfer, she would notify DON and assess the resident, investigate, document any findings, notify the family and physician if needed. During an interview on [DATE] at 2:17 PM, the DON said the resident could be transferred manually if there was an issue with the mechanical lift, only as a backup. The DON said she would expect the manual lift to be done safely and with the proper equipment. The DON said she would expect to be notified of any issues if a staff member reported they almost dropped a resident or did an unsafe transfer, so she could in-service staff. The DON said her ADONs were pretty good about reporting stuff to her. The DON said she did not recall ADON E reporting any incident related to a staff member reporting almost dropping the resident or doing an unsafe transfer. The DON said ADON E did report that the battery died on the mechanical lift, but they had a lot batteries and the staff must have not gone and got another battery. The DON said ADON E said there was a charged battery, but she could not say that was on [DATE]. The DON said ADON E did not tell her about the video shown to her previously and she was not aware of the video until the [DATE]. The DON viewed the video from [DATE] and said it was not so much of a good transfer. The DON said all three of the staff should have done a body lift with sheet under the resident to lift Resident #1. The DON said they did not perform a safe transfer. The DON said Resident #1 was dead weight and she would not use a gait belt because she could not stand and pivot. The DON said there were several possible things that could possibly happen if transferred improperly, such as harming the resident. The DON said ADON E would not have done an incident report because the resident fall and there was no injury related to the [DATE] manual transfer. During an interview on [DATE] at 2:51 PM, the ADM said if there was a reason the mechanical lift was not feasible, then she would expect the staff to do a manual lift in the safest way possible. The ADM viewed the [DATE] transfer video and said obviously they should have used a mechanical lift. The ADM said she would expect the facility policies to be followed. She said the video showed they should have used a mechanical lift. During an interview on [DATE] at 3:10 PM, the Regional Nurse viewed the video footage of the [DATE] transfer. She said the staff should have used a sheet under Resident #1 to transfer her. She said it was not a good body lift. The Regional Nurse said Resident #1 was at risk of falling. She said ADON E should have done an incident report because there was a change in the plane which was the definition of a fall. She explained that to the DON and said she would be in-servicing staff. She said at the very least ADON E should have documented her assessment and no findings. Record review of the facility's Competency Assessment check-off titled Transferring the Resident dated [DATE], indicated CNA A had successfully demonstrated Transfer Performance (Bed to Chair/Wheelchair) which included Positioned wheelchair/chair correctly and locked wheels . used gait belt or mechanical lift as per care plan/Kardex . pivoted safely, avoiding twisting motions, uses small pivot steps . two-person assists: position on each side of the resident and grasps belt on front and back, used small pivot steps . gently lowed resident into chair, ensuring resident was (continued on next page)		

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