

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

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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 02/12/2026
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 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 ensure RN coverage for 5 days during FY Quarter 4 2025 (July 1 to September 30). This failure could place residents at risk of harm due to being left without supervisory coverage for coordination of events such as emergency care and disasters. The findings included: Record review of the facility payroll-based journal for the fourth quarter of fiscal year 2025 reflected the facility did not have RN coverage on the following days: 08/28/2025, 08/29/2025, 09/01/2025, 09/02/2025, and 09/03/2025. Record review of the employee time sheets from August 2025 and September 2025, reflected no RN clock-in hours on 08/28/2025, 08/29/2025, 09/01/2025, 09/02/2025, and 09/03/2025. During an interview on 02/12/2026 beginning at 1:50 p.m., the Administrator stated the DON was on leave during the dates 08/28/2026, 08/29/2026, 09/01/2026, 09/02/2026, and 09/03/2026. She stated the facility partnered with a company of nurse practitioners. She stated that the nurse practitioner covered the 8 hours during those dates. The Administrator stated the company was unable to provide timesheets for the nurse practitioner because they were salary. The Administrator stated the company provided the nurse practitioner's check stub to show the hours worked within the timeframe and a picture of an excel spreadsheet with the number of visits listed on the dates in question. She stated that was the only evidence she had, and she was unable to verify the nurse practitioner covered the required 8-hour timeframe. She said it was important to ensure an RN worked 8 consecutive hours, 7 days a week because it was the regulatory requirement. She stated not having an RN working on staff would not have affected the residents. Record review of the Staffing, Sufficient and Competent Nursing policy, dated August 2022, reflected . A registered nurse provides services at least (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety.1. The facility failed to ensure equipment surfaces were kept clean.2. The facility failed to ensure that all food items in Refrigerator #1, Refrigerator #2, and Freezer #1 were dated and labeled.3. The facility failed to ensure that the outside of the fryer and the side of the range facing the fryer were kept free of grease build up. These failures could place residents at risk of foodborne illness and food contamination. Record review of a blank Daily Cleaning Schedule indicated the cooks were to clean the stove and cook area after each meal. Record review of a blank Weekly Cleaning Schedule indicated the deep fryer was to be cleaned by the cook on Wednesday. The Weekly Cleaning Schedule indicated refrigerators were to be cleaned on Tuesdays by an aide. Record review of Dietary Orientation Competency Checklists dated 01/19/26 - 01/20/26 indicated 7 staff members were educated on storing foods and length of time and how to clean kitchen equipment. Record review of a Customer Service Report from a commercial dishwashing and laundry service company dated 02/12/26 at 9:15 indicated, There was a soil and water build up on top of the dishwasher from the tops of the doors. There was too much gap between the top face opening and the door. I adjusted this. There was also a piece of eggshell in one of the end spray nozzles. This caused water to spray up at an angle on the door instead of up on the dishes. During an observation on 02/09/26 at 9:49 a.m., there was a brown dry crusty looking substance all over the top of the dishwasher. During an observation on 02/09/26 at 9:50 a.m., on the outside of Refrigerator #1 there were white smudges of an unknown substance on the outside doors near the door handles. The smudges were dry to the touch. Inside Refrigerator #1 there was two bags of a yellow substance in a clear plastic bin on a lower shelf with no date or label, one bag of sausage patties with no date and one bag of brown food patties with no label. On the bottom shelf there was one bag of an unknown red meat food item with no date or label. During an observation on 02/09/26 at 9:53 a.m., on the outside of Refrigerator #2, beside the ice machine, there were multiple white drip marks down the outside door. The drips were dry to the touch. Inside Refrigerator #2 there was one bag of a purple jelly substance with no date or label. During an observation on 02/09/26 at 9:55 a.m., on the outside of Freezer #1 there were light colored smudges of an unknown substance on the doors near the handles. Inside Freezer #1 was a plastic bag containing green, yellow, and orange food items with no label, one bag of an unknown light brown breaded food item with no label, one bag of an unknown pink meats with no label, one plastic bag with beige food items with no label, one bag of light beige unknown meats with no date or label, and a plastic bag of many round red food items with no label. During an observation on 02/10/26 at 11:28 a.m., the fryer in the kitchen had an excessive amount of grease buildup down the front of the fryer and down the sides of the fryer. There was an excessive amount of grease buildup on the range next to the fryer. There were food crumbs on the floor between the fryer and range. During an observation on 02/10/26 at 11:52 a.m., there was a light brown gritty looking substance on top of the dishwasher. The substance felt dry and [NAME] to the touch. During an observation 02/10/26 at 11:55 a.m., on the outside of Refrigerator #1 there were white smudges of an unknown substance on the outside doors near the door handles. The smudges were dry to the touch. During an observation on 02/10/26 at 11:26 a.m., on the outside of Freezer #1 there were light colored smudges of an unknown substance on the doors near the handles. During an observation and interview on 02/11/26 at 3:14 p.m., the Dietary Manager said he had told staff to clean the top of the dishwasher. He said water was washing up on the top of the dishwasher. He said the [NAME] substance was food particles. The Dietary Manager ran the dishwasher, and water was washing up out of the top side of the dishwasher. After this, there was water and food particles on the top of the dishwasher. He said the company had (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	previously been out and made adjustments to the machine.The Dietary Manager said years ago the deep fryer was painted. He said he did not know how long it had been since the deep fryer had been cleaned. He said it had been awhile. He said the deep fryer needed to be carried out of the kitchen and power washed. He said there was a weekly cleaning schedule that he expected staff to follow. He said he was responsible for making sure staff were cleaning equipment in the kitchen. He said dirty equipment could cause bacteria to grow and someone could get sick.He said that staff knew if food items came out of the box it had to be dated and labeled. He said he had recently in-serviced staff on dating and labeling foods. He said all staff should be dating and labeling foods. He said servicing undated food items could cause a resident to get sick. He said staff might not know what a food item was with no label.During an interview on 02/12/26 at 11:01 a.m., the Administrator said she expected for equipment surfaces to be kept clean. She said all kitchen staff were responsible for keeping equipment surfaces clean. She said she expected the deep fryer to be kept clean, along with the range sitting next to it. She said she expected for food in the freezers and refrigerators to be dated and labeled. She said you do not want dirty equipment to ensure sanitary conditions. She said food not being dated could not negatively affect a resident, but it helps ensure that the food was not spoiled. She said she felt food items not having labels could not negatively affect the residents.Record review of a Food Storage facility policy dated 2023 indicated, .Food should be dated as it is placed on the shelves if required by state regulation.Date marking should be visible on all high risk food.All refrigerator units should be kept clean.All foods should be covered, labeled and dated and routinely monitored to assure that foods.will be consumed by their use dates.All freezer units should be kept clean.Record review of a Cleaning and Sanitation of Dining and Food Service Areas facility policy dated 2023 indicated, .The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule.staff will be held accountable for cleaning assignments.Sample Cleaning Schedule.Daily.Exterior of dishwashers and other appliances.Weekly.Refrigerators.Twice per month.Ovens.Monthly.Freezers.Clean behind and under major appliances.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete the admission assessment for 5 of 18 (Resident #28, Resident #44, Resident #53, Resident #55, and Resident #72) residents reviewed for MDS completion. The facility failed to complete the admission MDS assessment for Resident #28, Resident #44, Resident #53, Resident #55, and Resident #72 within 14 calendar days. These failures could place residents at risk of not having records completed and submitted in a timely manner as required. The findings included: 1. Record review of a face sheet dated 02/11/26 indicated Resident #44 was [AGE] years old and had an admission date of 01/08/26 with diagnoses including chronic obstructive pulmonary disease (chronic lung disease), muscle weakness, and anxiety disorder. Record review of an MDS dated [DATE] for Resident #44 indicated the MDS was a new record. The MDS revealed Resident #44 had a BIMS of 13, which indicated intact cognition. The MDS indicated Resident #7 required moderate assistance with most ADLs. The completion date was 01/26/26 and was signed by the MDS Coordinator. Record review of a CMS Submission/Transmission Report dated 01/26/26 at 6:14 p.m. indicated Resident #44's admission assessment had an assessment reference date of 01/12/26. The report indicated the admission assessment was completed late. The assessment was completed more than 13 days after the entry date. 2. Record review of a face sheet dated 02/11/26 indicated Resident #53 was [AGE] years old and had an admission date of 01/13/26 with diagnoses including Alzheimer's Disease (a progressive, incurable neurological disorder and the most common form of dementia, primarily affecting memory, thinking, and behavior in older adults), diabetes, and anxiety disorder. Record review of an MDS dated [DATE] for Resident #53 indicated the MDS was a new record. The MDS revealed Resident #53 had a BIMS of 03, which indicated her cognition was severely impaired. The MDS indicated Resident #53 required maximal assistance with most ADLs. The completion date was 02/06/26 and was signed by the MDS Coordinator. Record review of a CMS Submission/Transmission Report dated 02/06/26 at 5:25 p.m. indicated Resident #53's admission assessment had a target date of 01/23/26. The report indicated a warning that the assessment was completed late. The admission assessment was completed more than 13 days after the entry date. 3. Record review of a face sheet dated 02/11/26 indicated Resident #55 was [AGE] years old and had an admission date of 01/21/26 with diagnoses including muscle weakness, generalized anxiety disorder, and breast cancer. Record review of an MDS dated [DATE] for Resident #55 indicated the MDS was a new record. The MDS revealed a BIMS was not conducted due to Resident #55 being rarely to never understood. The MDS indicated Resident #55 required maximal assistance with most ADLs. The completion signature date was 02/05/26 and was signed by the MDS Coordinator. Record review of a CMS Submission Report dated 02/05/26 at 2:11 p.m. indicated Resident #55's admission assessment had a target date of 01/27/26. The report indicated a warning that the assessment was completed late. The admission assessment was completed more than 13 days after the entry date. 4. Record review of a face sheet dated 02/11/26 indicated Resident #72 was [AGE] years old and had an admission date of 01/07/26 with diagnoses including pain, kidney failure, and muscle weakness. Record review of an MDS dated [DATE] for Resident #72 indicated the MDS was a new record. The MDS revealed Resident #72 had a BIMS of 15, which indicated her cognition was intact. The MDS indicated Resident #72 required maximal assistance with most ADLs. The completion signature date was 01/26/26 and was signed by the MDS Coordinator. Record review of a CMS Submission Report dated 01/26/26 at 6:14 p.m. indicated Resident #72's admission assessment had a target date of 01/12/26. The report indicated a warning that the assessment was completed late. The admission assessment was completed more than 13 days after the entry date. 5. Record review of a face sheet dated 02/11/26 indicated Resident #28 was [AGE] years old and had an admission date of 01/07/26 with diagnoses including repeated falls, urinary tract infection, and (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic kidney disease. Record review of an admission MDS assessment dated [DATE] for Resident #28 indicated the MDS was a new record. The MDS revealed Resident #28 had a BIMS of 10, which indicated moderate impaired cognition. The MDS indicated Resident #10 required maximal assistance with most ADLs. The completion date was 01/23/26 and was signed by the MDS Coordinator. Record review of a CMS Submission/Transmission Report dated 01/23/26 at 6:25 p.m. indicated Resident #28's admission assessment had an assessment reference date of 01/12/26. The report indicated a warning that the admission assessment for Resident #28 was completed late. The admission assessment was completed more than 13 days after the entry date. During an interview on 02/11/26 at 2:29 p.m., the MDS Coordinator said she was responsible for completing and submitting MDS assessments. She said the admission assessments should be signed when the assessment was completed. She said the transmission date was within 14 days of the signature date. She said she knew she had some late assessments. She said she had found out they were late when she went to sign them and realized they should have been done. She said the MDS did not directly affect resident care. During an interview on 02/12/26 at 9:21 a.m., the DON said the MDS Coordinator was responsible for completing and transmitting the admission MDSs in a timely manner. She said she expected the MDS assessments to be completed and transmitted in the appropriate timeframe. She said MDSs not being completed and transmitted in the appropriate timeframe would not negatively affect resident's care. During an interview on 02/12/26 at 11:01 a.m., the Administrator said the MDS Coordinator was responsible for completing MDS assessments and transmitting them in a timely manner. She said she did not feel like there could be a negative outcome for the assessments not being completed timely or being transmitted timely. Record review of an email from the Administrator on 02/13/26 at 1:17 p.m. indicated, .we follow the RAI manual as it pertains to MDS timing. Record review of a Comprehensive Assessments facility policy last updated 02/2025 indicated, .Comprehensive assessments are conducted to assist in developing person-centered care plans.Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1. Record Review of the CMS RAI Version 3.0 Manual, dated October 2025, indicated, in Chapter 2.8, page 2-22 01. The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1.The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.Chapter 5.2, page 5-2.For the admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600) .		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS admission assessment was transmitted to the CMS System within 7 days after completion for 1 of 18 residents (Resident #7) reviewed for admission MDS assessments. The facility failed to ensure Resident#7's admission MDS assessments were transmitted within 14 days of completion of admission assessment. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings included: 1. Record review of a face sheet dated 02/11/26 indicated Resident #7 was [AGE] years old and had an admission date of 12/24/25 with diagnoses including dementia, heart failure, and seizures. Record review of an admission MDS assessment dated [DATE] for Resident #7 indicated the MDS was a new record. The MDS revealed Resident #7 had a BIMS of 15, which indicated intact cognition. The MDS indicated Resident #7 required moderate to maximal assistance with most ADLs. The completion signature date was 01/02/26 and was signed by the MDS Coordinator. The MDS was to be transmitted by 01/16/26. Record review of a CMS Submission/Transmission Report dated 01/23/26 at 9:36 a.m. indicated Resident #7's admission assessment had an assessment reference date of 12/29/25. The report indicated a warning that the submission was transmitted on 01/23/26, more than 14 days after the completion signature date. During an interview on 02/11/26 at 2:29 p.m., the MDS Coordinator said she was responsible for completing and submitting MDS assessments. She said the admission assessments should be signed when the assessment was completed. She said the transmission date was within 14 days of the signature date. She said she knew she had some late assessments. She said she had found out they were late when she went to sign them and realized they should have been done. She said the MDS did not directly affect resident care. During an interview on 02/12/26 at 9:21 a.m., the DON said the MDS Coordinator was responsible for completing and transmitting the admission MDSs in a timely manner. She said she expected the MDS assessments to be completed and transmitted in the appropriate timeframe. She said MDSs not being completed and transmitted in the appropriate timeframe would not negatively affect resident's care. During an interview on 02/12/26 at 11:01 a.m., the Administrator said the MDS Coordinator was responsible for completing MDS assessments and transmitting them in a timely manner. She said she did not feel like there could be a negative outcome for the assessments not being completed timely or being transmitted timely. Record review of an email from the Administrator on 02/13/26 at 1:17 p.m. indicated, we follow the RAI manual as it pertains to MDS timing. Record review of a Comprehensive Assessments facility policy last updated 02/2025 indicated, Comprehensive assessments are conducted to assist in developing person-centered care plans. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1. Record Review of the CMS RAI Version 3.0 Manual, dated October 2025, indicated, in Chapter 2.8, page 2-22 - Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #5, Resident #14, Resident #41 and Resident #59) of 18 residents reviewed for care plans. 1. The facility failed to ensure Resident #5 had a complete comprehensive care plan. 2. The facility failed to ensure Resident #14 had a care plan for hospice services. 3. The facility failed to ensure Resident #41 had care plans for falls and psychotropic medication usage as coded on the MDS. 4. The facility failed to ensure Resident #59 had care plans for anticonvulsant usage and seizure disorder as coded on the MDS. These failures could place residents at risk of not having their individualized needs met, falls, decreased range of motion and a decline in their quality of care and life. Findings included: 1. Record review of the face sheet, dated 02/11/2026, reflected Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #5 had a principal diagnosis of unspecified dementia, unspecified severity, with anxiety (memory loss). Record review of the quarterly MDS assessment, dated 11/17/2025, reflected Resident #5 had clear speech, was understood, and was able to understand others. Resident #5 had a BIMS score of 13, which indicated she was cognitively intact. Resident #5 had a functional limitation in range of motion that interfered with daily functions or placed her at risk for injury to both lower extremities. Resident #5 required set-up assistance with eating, oral hygiene, and personal hygiene. She was dependent on staff for assistance with toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, bed mobility, and transfers. The MDS reflected Resident #5 was always incontinent of bowel and bladder. She had active diagnoses that included: hypertension (high blood pressure), malnutrition (problems with nutrient absorption), anxiety disorder (mental health conditions characterized by persistent, excessive, and irrational fear or worry that is out of proportion to actual, everyday situation), depression (mental illness characterized by persistent sadness, loss of interest in activities, and low energy lasting at least 2 weeks), and chronic embolism and thrombosis of deep vein right lower extremity (blood clot hardens causing scarring and permanently narrows or blocks blood flow). Resident #5 had a scheduled pain medication regime and received as needed pain medications. Resident #5's pain assessment reflected that she had occasional pain during the 5 day look-back period that occasionally made it hard to sleep. The MDS reflected Resident #5 was at risk for developing pressure ulcers/injuries and utilized a pressure reducing device for her bed. Resident #5 was taking an anticoagulant (blood thinner) and opioid (pain) medications. Record review of Resident #5's comprehensive care plan, dated 03/17/2025, reflected only one focus problem. She was dependent on staff to anticipate and meet personal activity needs related to physical limitations. The comprehensive care plan did not address range of motion limitations, ADL assistance, bowel/bladder incontinence, active diagnosis, pain, risk for pressure injury, or high-risk medication usage. 2. Record review of an undated face sheet revealed Resident #14 was a [AGE] year-old female (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted on [DATE] with diagnoses of malignant neoplasm of parotid (a cancerous tumor arising in the parotid gland), end stage heart disease (the most advanced, chronic phase where the heart pumps inefficiently, causing severe, persistent symptoms even at rest), and hemiplegia (a severe, often permanent, form of unilateral paralysis affecting one side of the body, caused by brain or spinal cord damage). Record review of a significant change MDS assessment dated [DATE] revealed Resident #14 had a BIMS of 05, which indicated severe cognitive impairment. Resident #14 required substantial (helper did more than half of the work) for ADLs such as bed mobility, dressing, and bathing. The MDS also revealed Resident #14 was taking antiplatelet medication, opioids, diuretics, and antibiotics. Record review of the consolidated physician orders dated February 2026, revealed Resident #14 had an order dated 01/08/2026 for hospice services. Record review of the comprehensive care plan dated 1/11/2026 revealed no care plan for hospice services. 3. Record review of an undated face sheet revealed Resident #41 was a [AGE] year-old male admitted on [DATE] with the diagnoses CVA (Cerebrovascular Accident (CVA), commonly known as a stroke, occurs when blood flow to the brain is interrupted, causing brain cells to die), hemiplegia (paralysis of one side of the body), and bipolar disorder (a chronic mental health condition characterized by extreme, often disabling, shifts in mood, energy, and activity levels, alternating between high (mania/hypomania) and low (depression) episodes). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #41 had a BIMS of 07 which indicated moderate cognitive impairment. Resident #41 required substantial assistance (helper does more than half of work) for ADLs such as toileting, transfer, and bathing. Resident #41 received high-risk drugs (antidepressants and anti-anxiety) during the look back. Record review of Resident #41's incident and accident reports revealed the following: 1. 12/08/2025- Resident #41 had a fall attempting to transfer from wheelchair to bed. 2. 01/05/2026- Resident #41 had a fall reaching to pick something up off the floor. Record review of the care plan dated 01/20/2026 revealed no care plan for Resident #41's high risk medication usage of antidepressants and anti-anxiety medications or for his falls on 12/08/2025 or 01/05/2026. 4. Record review of an undated face sheet revealed Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to widespread inflammation, organ damage, and potential failure), MRSA infection of sacral pressure ulcer (Methicillin-resistant Staphylococcus aureus) infection in a sacral pressure ulcer is a serious, potentially fatal complication, causing rapid tissue destruction, abscesses, and systemic infection), and gastrostomy status (refers to the presence of an artificial, surgically created opening (stoma) into the stomach for a feeding tube). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #59 had a BIMS of (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08, which indicated moderate cognitive impairment. Resident #59 required dependent assistance with ADLs. He received antidepressant, diuretic, and anticonvulsant medications during the look back. Resident #59 had a seizure disorder. Record review of the comprehensive care plan dated 01/20/2026 revealed no care plan for anticonvulsant usage or seizure activity. During an interview on 02/11/2026 at 3:40 p.m., the MDS Coordinator stated care plans were to include all things that were coded on the MDS. She stated the care plan should be reviewed by the nursing staff to know the individual care instructions for each resident. The MDS Coordinator stated items such as falls, high risk medication usage, hospice services, and diagnoses should be care planned for resident safety. She stated not care planning an important item with the interventions could result in the staff not knowing what is needed for the management of the individual resident condition. During an interview on 02/12/2026 at 11:00 a.m., the DON stated it was the floor nurse and the administrative nurses' responsibility to ensure that staff were educated about interventions for all aspects of the resident's care. She stated all major diagnoses, conditions, medications, and falls should be care planned with interventions to alert the staff of the potential of these situations recurring and to give instructions on what to do in those cases. The DON stated not care planning important information could lead to the residents not receiving personalized care. During an interview on 02/12/2026 at 2:00 p.m., the ADM stated she expected the staff to follow the interventions decided on by the MDS coordinator and interdisciplinary team. She stated the interventions were in place to keep everyone safe and prevent accidents. She stated not having the items care planned would not necessarily cause any ill effect to the residents. Record review of the Care Plans, Comprehensive Person-Centered policy, dated March 2022, reflected A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.the comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.the interdisciplinary team reviews and updates the care plan. at least quarterly.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to remove expired medications from active storage for 1 of 2 medication rooms (Medication room [ROOM NUMBER]). 1.The facility failed to ensure expired insulin and expired OTCs were removed from active storage in medication room [ROOM NUMBER]. 2.This failure could place residents at risk of expired medication being administered.3.Resident #15's Basaglar (long-acting insulin) 20 Units each morning was held for 19 of 41 days reviewed with no MD order to hold or notification of MD from 01/01/2026 through 02/10/2026. These failures could affect residents that are insulin dependent by placing them at risk for elevated blood glucose and poor glucose control.Findings included:1.Record review of Resident #15' s undated face sheet indicated she was an [AGE] year-old female admitted on [DATE], with the diagnoses which included, type II diabetes (refers to a group of diseases that affect how the body uses blood sugar (glucose) , retinopathy (disease of the retina which results in impairment or loss of vision), and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #15 had a BIMS of 05, which indicated severe cognitive impairment. Resident #15 was dependent for ADLs, received oral hypoglycemic medication, and insulin daily. Record review of the comprehensive care plan dated 01/12/2026 revealed Resident #15 had unstable glucose levels and medications were to be administered as prescribed. Record review of the consolidated physician orders revealed an order dated 09/25/2025 for Basaglar 20 Units every morning with a start date of 09/25/2025. Record review of the MAR dated January 2026 revealed Resident #15's Basaglar insulin was held on the following days: 01/01/2026 01/06/2026 01/07/2026 01/08/2026 01/10/2026 01/14/2026 01/16/2026 01/17/2026 01/18/2026 01/22/2026 01/23/2026 01/24/2026 01/27/2026 01/29/2026 Record review of the MAR dated February 2026 revealed Resident #15's Basaglar insulin was held the following days: 02/01/2026 02/02/2026 02/06/2026 02/07/2026 02/10/2026 Record review of the MAR dated January 2026 revealed Resident 15's morning blood glucose levels (in mg/dL) were as follows: 01/01/2026-77 01/06/2026-109 01/07/2026-124 01/08/2026-115 01/10/2026-98 01/14/2026- 94 01/16/2026- 82 01/17/2026-135 01/18/2026-138 01/22/2026-128 01/23/2026-123 01/24/2026-143 01/27/2026-140 01/29/2026-122 Record review of the MAR dated February 2026 revealed Resident #15's morning blood glucose levels (in mg/dL) were as follows: 02/01/2026-97 02/02/2026-98 02/06/2026-119 02/07/2026-123 02/10/2026-149 During an interview on 02/10/2026 at 10:00 a.m., LVN A stated she held the Basaglar insulin when she worked if Resident #15's blood sugar was not over 200mg/dL because she had an order not to administer Novolog insulin when her blood glucose was less than 200mg/dL. LVN A stated Basaglar was a long-acting insulin that affected the blood sugar several hours from administration. She stated Novolog insulin was short acting and affected the blood glucose levels immediately. LVN A stated that if a medication was held it was best practice to notify the MD of the held medication. She stated she had not notified the MD on the occasions she held the Basaglar insulin for Resident #15 because there was no change in the resident's level of consciousness or vital signs. During a telephone interview on 02/12/2026 at 9:00 a.m., MD E stated he had received no notification from the facility that Resident #15's Basaglar insulin was being held. He stated the only reason it should be held was if the resident's blood glucose was below 50 mg/dL or they were showing signs of hypoglycemia (sweating, change in level of consciousness, blurred vision, shaking). MD E explained that Basaglar insulin was long acting and it would keep the resident from getting spikes in her blood glucose later in the day when she had consumed her lunch and supper meals. MD E stated he expected the nurses to administer all insulins as ordered and notify him if there was a (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	need for the insulin to be held. He stated Resident #15 had not suffered any ill effects from not receiving the Basaglar because she had no wounds, infections, visual changes, and she received limited amounts of sliding scale insulin throughout the day. MD E stated elevated blood glucose levels could impair wound healing, make healing from infections difficult, and cause damage to the eyes and other organs. During an interview on 02/12/2026 at 10:00 a.m., the DON stated she was unaware that LVN A had held Resident #15's Basaglar insulin without contacting the MD and without an order to hold the long-acting insulin. She stated she would have to speak with the nurse about using nursing judgement and calling the MD when she felt the need to hold a medication. The DON stated her expectation was for the nurse to contact her and the MD when any medication was held. The DON stated Resident #15 had no adverse effect from missing the doses of Basaglar because her blood glucose levels were not seriously out of control like some diabetics. During an interview on 02/12/2026 at 11:00 a.m., the Administrator stated she expected the nurses to follow MD orders at all times and contact the administrative nurses with any held medications. The Administrator stated the ADON and DON were very familiar with the facility policies and procedures and would ensure they were followed.2. During an observation on 02/10/2026 at 8:15 a.m., in medication room [ROOM NUMBER] for the 300 and 400 halls, a Basaglar (long-acting insulin) pen was noted in the refrigerator with the expiration date of November 2025.3. During an observation on 02/10/2026 at 8:30 a.m., in medication room [ROOM NUMBER] for 300 and 400 halls, a box of OTC gas-relief medication was noted in the OTC active storage with the expiration date of August 2024. During an interview on 02/10/2026 at 8:35 a.m., ADON C stated she and the pharmacy consultant checked the medication room for expired medications. She stated she checked weekly and the pharmacy consultant checked monthly. ADON C stated the insulin and the OTC gas-relief medication were an oversight. She stated she did not feel like expired gas-relief medication would harm the resident. She stated expired insulin would be less effective and it was important to keep an eye on insulin expiration dates, so the resident received insulin that was in date and effective for the control of blood glucose. During an interview on 02/11/2026 at 10:00 a.m., the DON said the medication storage room should only have expired medication in the discontinued medication bins. She stated it was not acceptable to have expired medication in the active OTC cabinet or the refrigerator. The DON stated expired medication could be less effective and not remedy or control the symptoms it was meant to control. During an interview on 02/11/2026 at 11:00 a.m., the Administrator said the medication rooms to be free of expired medications. The Administrator stated it was nursing's job to ensure expired medications were disposed of properly. Review of the facility's policy titled Storage of Medications last revised 08-2024 reflected the following: . Policy statement. Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications.Procedures. 2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aids) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access. III. Expiration Dating (Beyond-use dating) indicated .8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that was palatable and attractive for 3 of 8 residents (Resident's #5, #32, and #39) reviewed for palatable food. The facility failed to provide food that was palatable and attractive to Resident #5, #32, and #39 who complained the food was served cool and bland. These failures could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. The findings included: 1. Record review of the face sheet, dated 02/11/2026, reflected Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #5 had a principal diagnosis of unspecified dementia, unspecified severity, with anxiety (memory loss). She had further diagnoses that included: protein-calorie malnutrition (a severe, life-threatening condition caused by insufficient intake of protein, calories, or both, leading to significant changes in body composition and function) and dysphagia, oropharyngeal phase (difficulty initiating a swallow and moving food from the mouth to the throat, often causing choking, coughing, or nasal regurgitation). Record review of the quarterly MDS assessment, dated 11/17/2025, reflected Resident #5 had clear speech, was understood, and was able to understand others. Resident #5 had a BIMS score of 13, which indicated she was cognitively intact. Resident #5 required set-up assistance with eating. Resident #5 had no signs or symptoms of a swallowing disorder or significant weight loss during the look-back period. Record review of Resident #5's order summary report, dated 02/09/2026, reflected an order, which started on 03/26/2025 for a regular diet texture and thin liquid consistency. During an interview on 02/09/2026 beginning at 3:51 p.m., Resident #5 stated the food was terrible. She stated the food was often cold and had no flavor. 2. Record review of the face sheet, dated 02/11/2026, reflected Resident #32 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of acute embolism (blockage) and thrombosis (blood clot) of deep veins of right upper extremity, ovarian and anal cancer, and obesity. Record review of the quarterly MDS assessment, dated 01/15/2026, reflected Resident #32 had clear speech, was understood, and was able to understand others. Resident #32 had a BIMS score of 15, which indicated she was cognitively intact. She was independent with eating. Record review of the order summary report, dated 02/09/2026, reflected Resident #32 had an order which started on 07/15/2025 for a regular diet texture and regular consistency. During an interview on 02/09/2026 beginning at 11:40 a.m., Resident #32 stated the food was awful. She said that the food was served cold and bland. She said that the lettuce was often served wilted and the sandwich meat tasted bad, like it had been left sitting out. 3. Record review of the face sheet, dated 02/11/2026, reflected Resident #39 was a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of stroke. Resident #39 had further diagnoses that included: end stage renal disease (final, permanent stage of kidney failure, where the kidney's no longer filter waste and balance fluids) and dependance on renal dialysis (life-sustaining medical treatment that filters blood to remove excess waste, toxins, and fluids when kidney's no longer work). Record review of the quarterly MDS assessment, dated 12/04/2025, reflected Resident #39 had clear speech, was understood, and was able to understand others. Resident #39 had a BIMS score of 15, which indicated she was cognitively intact. Resident #39 usually required setup or clean-up assistance with eating. Record review of the order summary report, dated 02/09/2026, reflected Resident #39 had an order which started on 06/10/2025, for a no added salt diet with regular diet texture and consistency, limit bananas, potatoes, tomatoes, and oranges at meals. During an interview on 02/09/2026 beginning at 11:40 a.m., Resident #39 stated the food had no seasoning and was cold by the time they got it. During an interview and observation on 02/10/2026 beginning at 9:02 a.m., Resident #32 and Resident #39 were eating breakfast. Resident #32 stated she was served pork sausage that appeared undercooked and was pale in the center, she held it up for surveyor to see. Resident #32 stated her toast was rubbery and cold. Resident #32 stated for lunch on 02/09/2026 she received chili con carne or (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	whatever it was. She said it looked like someone threw up on her tray and it tasted like it too. Resident #32 stated she had talked to the guy in the kitchen multiple times about the food, but nothing was done. She said sometimes they would ask her if she wanted something else, but she only had 3 choices to choose from, and they were all terrible. Resident #39 agreed with Resident #32 and stated her breakfast was cold and bland. During an observation and interview on 02/10/2026 at 1:06 p.m., Lunch tray was sampled with four surveyors and Dietary Manager. The hamburger steak was lukewarm. Some of the broccoli was bright and crunchy. The rest of the broccoli was dull-colored green and was soft. The broccoli was lukewarm. The mashed potatoes were lukewarm and bland. The peach cobbler was cold. The dietary manager said he agreed the potatoes were bland. He said the food could have been warmer. The Dietary Manager said he was not sure if the cobbler was supposed to have been served warm or cold, but the cook made the cobbler earlier in the morning. During an interview on 02/12/2026 beginning at 11:15 a.m., MA G stated she was aware of the complaints about the food. She stated some of the residents believed the food was nasty. She said when the residents did not like what was served, the staff was supposed to offer them a sandwich, or substitute. She said it was important to ensure the residents were served food that looked and tasted good to encourage them to eat and prevent weight loss. During an interview on 02/12/2026 beginning at 11:48 a.m., LVN H stated she had received complaints about the food. She said when she received complaints about the food, she took the tray back to the kitchen and offered them a substitute. She stated it was important to ensure the food looked and tasted good because this was their home and they did not have any other options for food; they should be able to get what they want. She said it could have caused nutrition issues. During an interview on 02/12/2026 beginning at 2:23 p.m., the Dietary Manager stated he had not received any food complaints recently. He stated he had not received complaints about the food being cold or bland. He stated when he did receive food complaints, he talked with the resident who made the complaint and tried to resolve the problem. He stated the person plating the food was responsible for monitoring to ensure the food looked good, tasted good, and was the appropriate temperature. He stated it was important to ensure the food looked good, tasted good, and was the appropriate temperature so the residents wanted to eat. During an interview on 02/12/2026 beginning at 3:30 p.m., the Administrator stated she was unaware of any food complaints recently. She stated they had previously made a lot of changes in the dietary department. She stated she expected the Dietary Manager to ensure the menu and recipe was followed and that food was served at the appropriate temperature. She said the Dietary Manager was responsible for monitoring to ensure the food looked good, tasted good, and was served at the appropriate temperatures. She said it was important to ensure the food looked good, tasted good, and was the appropriate temperature for resident satisfaction. Record review of the Food and Nutrition Services policy, dated October 2017, reflected Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and is served at a safe and appetizing temperature. if an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the food service manager so that a new food tray can be issued.		

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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 1 of 4 halls (hall 300) and 1 of 6 (Resident #59) residents reviewed for infection control practices. 1.The facility failed to ensure staff (CNA B) maintained infection control prevention while carrying soiled linen through the facility on 02/09/2026. 2. The facility failed to ensure staff (LVN A) wore PPE when providing direct care to a resident on EBP. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections.Findings included: 1.During an observation on 02/09/2026 at 9:35 a.m., CNA B walked down the 300 hall with soiled bedding held next to her body, not covered in a bag. ADON C ran behind her and stated you cannot carry dirty linen outside of the room if it is not in a bag and definitely not next to your body. During an interview on 02/09/2026 at 10:12 a.m., CNA B stated she was aware that it was an infection control issue if she held dirty linen next to her body and carried it out in the hallway. She stated germs could be transferred to another resident from her clothes during care. She stated she just walked out with the linen without thinking. During an interview on 02/09/2026 at 10:22 a.m., ADON C stated she saw CNA B coming out of the room and tried to stop her from carrying the soiled linen through the building and holding it next to her body. ADON C stated it was a big no, no to leave a resident room with soiled linen or clothing without it being contained in a bag or barrel. ADON C stated CNA B could potentially spread infection to the other 11 residents she worked with by having germs on her clothes. 2. Record review of an undated face sheet revealed Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to widespread inflammation, organ damage, and potential failure), MRSA infection of sacral pressure ulcer (Methicillin-resistant Staphylococcus aureus) infection in a sacral pressure ulcer is a serious, potentially fatal complication, causing rapid tissue destruction, abscesses, and systemic infection), and gastrostomy status (refers to the presence of an artificial, surgically created opening (stoma) into the stomach for a feeding tube). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #59 had a BIMS score of 08, which indicated moderate cognitive impairment. Resident #59 required dependent assistance with ADLs. He received antidepressant, diuretic, and anticonvulsant medications during the look back. Resident #59 had a seizure disorder. Record review of a care plan dated 02/06/2026 revealed Resident #59 had EBP related to PEG tube and sacral wound. The intervention was that staff must use gowns and gloves during high contact resident care activities that could possibly result in the transfer of MDROs from hand and clothing of staff. Record review of consolidated physician orders dated February 2026 revealed on order for EBP related to gastrostomy tube. During an observation on 02/10/2026 at 8:00 a.m., a sign for EBP precautions and PPE was noted outside of Resident #59's room. During an observation on 02/10/2026 at 8:30 a.m., LVN A entered Resident #59's room and adjusted him in the bed and untucked his PEG tube with no gown or gloves on. During an observation on 02/10/2026 at 9:01 a.m., LVN A reentered Resident #59's room and adjusted his sheets and covers, repositioned his PEG tube with no gown on. During an observation on 02/10/2026 at 9:31 a.m., LVN A completed administration of PEG meds, removed her gloves and reconnected Resident #59's tube feeding with no gloves on and without washing her hands. During an interview on 02/10/2026 at 9:33 a.m., LVN A stated she was under the impression dressing in the gown and gloves were only for incontinent care, wound care, or bathing was occurring. She stated she realized she went into the room without PPE to adjust him in the bed and make sure his PEG tube was not under his body before PEG medication administration. She stated she did not realize she took her gloves off before reconnecting his PEG feeding. LVN A stated she was aware (continued on next page)		

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that gloves had to be worn to prevent the spread of disease and infection and protect the resident. During an interview on 02/12/2026 at 10:00 a.m., the DON stated it was her expectation that the staff would wear a gown and gloves for EBP when their task required touching the resident. She stated EBP was to protect the residents from any germs that the staff brought in on their clothing and hands. The DON stated Resident #59 was compromised because he has a history of MRSA infections. She stated it was best practice to wear gloves when touching the residents in any manner to prevent transfer of disease-causing bacteria. During an interview on 02/12/2026 at 11:00 a.m., the Administrator stated she expected the nurses and CNAs to follow the facility policy on infection control and EBP. Review of a policy dated 2001 titled Enhanced Barrier Precaution, revealed Enhanced barrier precautions (EPBs) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Record review of the facility Infection Prevention and Control Program Policy, date 2001, revealed an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary.		

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the residents received services in the facility with reasonable accommodation of resident needs 2 of 18 residents reviewed for accommodation of needs (Resident #14 and #26). The facility failed to ensure the call light was in reach on multiple occasions on 02/09/2026-02/10/2026 to call for assistance for Resident #14 and Resident #26. This failure could place residents at risk of decreased physical and psychosocial wellbeing and decreased quality of life. Findings included: 1. Record review of an undated face sheet revealed Resident #14 was a [AGE] year-old female admitted on [DATE] with diagnoses of malignant neoplasm of parotid (a cancerous tumor arising in the parotid gland), end stage heart disease (the most advanced, chronic phase where the heart pumps inefficiently, causing severe, persistent symptoms even at rest), and hemiplegia (a severe, often permanent, form of unilateral paralysis affecting one side of the body, caused by brain or spinal cord damage). Record review of a significant change MDS assessment dated [DATE] revealed Resident #14 had a BIMS of 05, which indicated severe cognitive impairment. Resident #14 required substantial (helper did more than half of the work) for ADLs such as bed mobility, dressing, and bathing. The MDS also revealed Resident #14 was taking antiplatelet, opioids, diuretics, and antibiotic medications. During an observation and interview on 02/09/2026 at 9:50 a.m., Resident #14 stated she could not find her call light. She stated she needed her call light to call her nurse to be cleaned up. The call light was in a closed drawer of her bedside dresser, approximately 3 feet behind the head of the bed and out of reach and sight of Resident #14. There was no sitter, family, or roommate present at that time. During an observation and interview on 02/09/2026 at 12:20 p.m., Resident #14 stated she was awaiting her lunch tray and still could not find her call light. The call light remained closed in the top drawer of her bedside dresser, approximately 3 feet behind the head of the bed and out of reach and sight of Resident #14. There remained no sitter, family, or roommate present at that time. During an interview on 02/09/2026 at 12:30 p.m., CNA D stated she was unsure how the call light was placed out of reach of the resident. She stated the facility staff tried very hard to keep a watchful eye on call light placement for all the residents. She stated the call light being in place for Resident #14 was important to ensure she did not fall out of bed reaching for it and her needs were met. 2. Record review of the face sheet, dated 02/11/2026, reflected Resident #26 was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #26 had a principal diagnosis of hemiplegia (paralysis) and hemiparesis (weakness) following a stroke that affected the left non-dominant side. Record review of the quarterly MDS assessment, dated 12/20/2025, reflected Resident #26 had clear speech, was usually understood, and was able to understand others. Resident #26 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS reflected Resident #26 had a functional limitation in range of motion that interfered with daily functions, to one side of both the upper and lower extremities. Resident #26 was dependent upon staff for assistance with ADLs. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #26's comprehensive care plan, dated 04/01/2025, did not address keeping the call light in reach. During an observation on 02/09/2026 at 3:48 p.m., revealed Resident #26 was lying in the bed on her right side facing the door. Her call light was on the left side of her bed inside the bedside table with the drawer shut. Resident #26 was unable to reach the call light. During an observation on 02/10/2026 at 9:02 a.m., revealed Resident #26 was lying in her bed with the head of the bed elevated. The call light cord was behind the head of her bed, and the call light button was on the ground out of Resident #26's reach. During an interview on 02/12/2026 beginning at 11:15 a.m., MA G said she normally worked with Resident #26. She stated everyone was responsible for making sure call lights were in reach. She said it was important to ensure call lights were in reach so staff would know when residents needed assistance. She said the residents could have an emergency and no one would have known. During an interview on 02/12/2026 beginning at 11:31 a.m., CNA B stated she normally worked with Resident #26. CNA B stated she worked on 02/09/2026 and 02/10/2026. CNA B stated everyone was responsible for making sure the call lights were in reach. She stated Resident #26's call light might have fallen or been moved during care. CNA B stated it was important to ensure the call lights were in reach so the residents could have called for assistance. She said the residents might not have gotten care or assistance fast enough without their call lights. During an interview on 02/12/2026 beginning at 11:48 a.m., LVN H stated the CNAs were responsible for making sure the call lights were in reach. She stated all staff should have been making sure the call lights remain in place. LVN H stated it was important to ensure call lights were in reach so the residents' needs could have been addressed timely and to ensure nothing was wrong. During an interview on 02/12/2026 beginning at 2:34 p.m., ADON C stated everyone was responsible for making sure call lights were in reach. ADON C said she expected the CNAs to make sure the call lights were in reach when they left the resident's room. She said she performed spot checks at random to ensure call lights were in reach. ADON C stated she would ensure Resident #26's call light had a clamp to attach to her bed. She said it was important to ensure the call light was in reach so the residents could have called for help and assistance as needed. During an interview on 02/12/2026 at 10:00 a.m., the DON stated all staff, even housekeeping and maintenance, were responsible for looking to see if the call light was in place when they were in the resident's room. She stated all residents needed their call lights in place, but especially the residents that were dependent on staff for their care needs. The DON stated the residents could feel scared and neglected if they could not contact the staff to request assistance. During an interview on 02/12/2026 at 1:30 p.m., the Administrator stated she was shocked that Resident #14's family was not in the room and that the call light would have been in a drawer. She stated it was the responsibility of all staff to ensure all residents had their call light in reach. She stated several rounds were made each day to ensure the call lights were in place. The Administrator stated not having the call light in place could result in a delay in care for the residents. Record review of the Accommodation of Needs policy, dated March 2021, reflected .In order to accommodate individual needs and preferences, adaptations may be made to the physical (continued on next page)		

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. The policy did not address call light placement.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had a right to organize and participate in resident groups in the facility for 1 of 8 residents reviewed for resident council. (Resident #39) The facility did not ensure Resident #39 was able to attend resident council meetings, as they were scheduled on her dialysis days. This failure could place residents at risk for decreased quality of life and resident rights not being honored. The finding included: Record review of the face sheet, dated 02/11/2026, reflected Resident #39 was a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of stroke. Resident #39 had further diagnoses that included: end stage renal disease (final, permanent stage of kidney failure, where the kidney's no longer filter waste and balance fluids) and dependence on renal dialysis (life-sustaining medical treatment that filters blood to remove excess waste, toxins, and fluids when kidney's no longer work). Record review of the quarterly MDS assessment, dated 12/04/2025, reflected Resident #39 had clear speech, was understood, and was able to understand others. Resident #39 had a BIMS score of 15, which indicated she was cognitively intact. Resident #39 received dialysis. Record review of the comprehensive care plan, dated 06/21/2025, reflected Resident #39 was diagnosed with renal failure and required dialysis. Resident #39 received dialysis on Tuesdays, Thursdays, and Saturdays. Record review of the resident council minutes reflected the resident council meetings were conducted on 08/12/2025 (Tuesday), 09/09/2025 (Tuesday), 10/07/2025 (Tuesday), 11/11/2025 (Tuesday), 12/09/2025 (Tuesday), and 01/06/2026 (Tuesday). Resident #39 was not listed in attendance at any of the meeting minutes. During an observation and interview on 02/10/2026 beginning at 9:13 a.m., Resident #39 was sitting up on the side of her bed, eating breakfast. She said that she had been asking to be part of resident council since being admitted to the facility. Resident #39 said she had been a part of resident council at every facility she had been at, and this facility continued to schedule resident council meetings on the days she attended dialysis. She said she had told the AD and the resident council president she wished to attend. Resident #39 stated she wanted her voice to be heard. During an interview on 02/12/2026 beginning at 2:03 p.m., the AD stated resident council was scheduled for the first Tuesday of every month. She said Resident #39 had expressed interest in attending the resident council meetings but declined because she was at dialysis. The AD stated she had not thought about changing the resident council meeting days so Resident #39 could have attended. She said it was important to ensure accommodations were made for residents who wished to attend resident council meeting because it made them feel positive about their community. She said it was important to have their suggestions heard. During an interview on 02/12/2026 beginning at 3:30 p.m., the Administrator said she expected the staff to ensure accommodations were made for residents who wished to attend resident council. She said she was unaware Resident #39 wished to attend resident council meetings. She said it would be difficult to accommodate every person because there were some residents who attended dialysis on Monday, Wednesday, and Friday. She said that it was important to ensure accommodations were made as appropriate, so the residents were satisfied with participating. Record review of the Resident Council policy, dated February 2021, reflected The facility supports residents' rights to organize and participate in the resident council. all residents are eligible to participate in the resident council. the facility staff encourages residents who are willing to participate. council meetings are scheduled monthly or more frequently if requested by residents.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 1 of 3 residents (Resident #74) reviewed for Medicare/Medicaid coverage. The facility failed to ensure Resident #74 was given a SNF ABN (is document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility prior to covered days being exhausted. This failure could place residents at risk for not being aware of changes to provided services. The findings included: Record review of the face sheet, dated 02/11/2026, reflected Resident #74 was an [AGE] year-old male who admitted to the facility on [DATE]. Resident #74 had a primary diagnosis of sepsis (blood infection). Resident #74 had a responsible party representative. Record review of the annual MDS assessment, dated 01/16/2026, reflected Resident #74 had a recent Medicare stay which started on 11/09/2025 and ended on 01/16/2026. Resident #74 had clear speech, was understood, and was able to understand others. Resident #74 had a BIMS score of 7, which indicated severe cognitive impairment. Record review of Resident #74's NOMNC, dated 01/14/2026, reflected it had been completed with signature confirmation of understanding from Resident #74's representative on 01/14/2026 with services ending on 01/16/2026. However, the SNF ABN CMS form 10055 was not completed, which would have informed Resident #74 and his representative of the option to continue services at a private pay rate. During an interview on 02/12/2026 beginning at 1:40 p.m., the Social Worker stated she was responsible for issuing the beneficiary notices, which included the NOMNC, to residents or their families when they were coming off skilled services. The Social Worker stated she was unsure who was responsible for completing the SNF ABNs, but she only completed the NOMNC. During an interview on 02/12/2026 beginning at 1:50 p.m., the Administrator stated the Social Worker was responsible for completing the beneficiary notices, which included NOMNC, and the SNF ABN form. She was unfamiliar with the SNF ABN form but stated she was aware it needed to be completed. The Administrator was unsure why Resident #74 was not given a SNF ABN form. The Administrator stated it was important to ensure the SNF ABN forms were given when required so the resident or family understood their benefits. Record review of the Medicare Advance Beneficiary and Medicare Non-Coverage Notices policy, dated September 2022, reflected Residents are informed in advance when changes will occur to their bills. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) for the following triggering events: .termination - in the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF ABN is issued to the beneficiary before such extended are items or services are terminated. The resident (or representative) is informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare, and assume financial responsibility.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident who experienced a significant change in status is comprehensively assessed using the CMS-specified Resident Assessment Instrument (RAI) process for 1 of 8 residents reviewed for significant changes in status (Resident #14). The facility failed to comprehensively assess Resident #14 when she elected hospice services using the CMS-specified RAI process. This failure could place residents at risk of not receiving needed care and services. Findings included: Record review of an undated face sheet revealed Resident #14 was a [AGE] year-old female admitted on [DATE] with diagnoses of malignant neoplasm of parotid (a cancerous tumor arising in the parotid gland), end stage heart disease (the most advanced, chronic phase where the heart pumps inefficiently, causing severe, persistent symptoms even at rest), and hemiplegia (a severe, often permanent, form of unilateral paralysis affecting one side of the body, caused by brain or spinal cord damage). Record review of a significant change MDS assessment dated [DATE] revealed Resident #14 had a BIMS of 05, which indicated severe cognitive impairment. Resident #14 required substantial (helper did more than half of the work) for ADLs such as bed mobility, dressing, and bathing. The MDS also revealed Resident #14 was taking antiplatelet, opioids, diuretics, and antibiotic medications. Record review of the consolidated physician's orders dated February 2026, revealed Resident #14 had an order dated 01/08/2026 for hospice services. During an interview on 02/11/2026 at 4:00 p.m., the MDS Coordinator stated Resident #14 went back on hospice on 01/08/2026. She stated she came off hospice in November of 2025 to receive radiation for cancer and elected hospice again after radiation treatment was completed. The MDS Coordinator stated a significant change assessment was to be done anytime someone elected hospice services or was put on hospice services. She stated she overlooked the need for a significant change assessment to be completed on Resident #14. She stated the assessment was due by 01/22/2026, 14 days after the hospice services were elected for Resident #14. She stated the facility had weekly standard of care meetings and she should have caught on to the fact that Resident #14 needed a significant change, but she did not. The MDS Coordinator stated the resident could not be negatively affected by not completing the MDS assessment. The MDS Coordinator stated the MDS was what was used to create the care plan, and the care plan was a map for individualized care for each resident, but she did not feel the resident would be negatively affected by missed paperwork. During an interview on 02/12/2026 at 10:00 a.m., the DON stated she relied on the MDS Coordinator to complete the MDSs and comprehensive care plans timely. The DON stated the administrative nurses met daily to go over orders and weekly for standard of care meetings and that was the time that items were care planned and discussed for significant changes. She stated she was unaware of the regulation to complete significant change assessments on residents that elected hospice. She stated she knew they discussed Resident #14 going hospice on more than one occasion. The DON stated not completing the significant change MDS could potentially cause the care plan to not be completed and services to be overlooked and interventions to be overlooked. She stated Resident #14 not having hospice coded on the MDS could affect quality measures and affect billing, as well. During an interview on 02/12/2026 at 1:00 p.m., the Administrator stated she was unaware of the missing significant change MDS for Resident #14. She stated the administrative nursing staff meet weekly to discuss all orders and changes in resident status, such as falls and weight loss. She stated the MDS Coordinator was present for the meetings. The Administrator stated she did not feel the missed significant change assessment could negatively impact the residents. During a record review of the facility's undated Minimum Data Set Policy for MDS assessment Data Accuracy, revealed the purpose of the MDS policy was to ensure each resident received an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. The assessment should accurately reflect the resident's status.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an accurate MDS assessment was completed for 1 of 18 residents reviewed for MDS accuracy. (Resident #1) The facility failed to accurately code Resident #1's significant weight loss of 12.8% in 180 days. This failure could place residents at risk of not receiving needed care and services. Findings included: Record review of an undated face sheet revealed Resident #01 was a [AGE] year-old male, admitted on [DATE] with the diagnoses of cerebral infarction (a type of ischemic stroke where a blockage in a blood vessel disrupts blood flow, causing brain or retinal cell death (necrosis) due to lack of oxygen), pulmonary embolus (a sudden, often life-threatening blockage in one or more of the pulmonary arteries in the lungs, usually caused by a blood clot that travels from the legs or other parts of the body), gout (a disease in which defective metabolism of uric acid causes arthritis, especially in the smaller bones of the feet, deposition of chalkstones, and episodes of acute pain). Record review of an annual MDS assessment dated [DATE] for Resident #01 revealed a BIMS of 09, which indicated moderate cognitive impairment. The MDS also revealed Resident #01 required a substantial (helper did more than half the work) level assistance with bed mobility, transfer, and toileting. The MDS revealed Resident #01 weighed 176 pounds and had no weight loss of 5% or more in the last month and no weight loss of 10% or more in the last 6 months. Record review of the EHR vital signs revealed the following weights for Resident #1: 06/07/2025-198 lbs. 11/07/2025-178 lbs. 12/07/2025-175.5lbs. down 2.5 lbs./1% in 30 days; down 22.5 lbs./12.8 % in 180 days Record review of a nutrition care plan dated 10/03/2025 revealed Resident #01 had a nutritional problem or potential for nutritional problem related to requiring mechanically altered diet related to a CVA (stroke). During an interview on 02/11/2026 at 4:15 p.m., the MDS Coordinator revealed she was unaware until recently about how to calculate weight loss in the EHR. She stated she now understood where to look and how to calculate the weight loss for section K coding. The MDS Coordinator stated Resident #01 should have been coded for non-physician ordered weight loss on his annual MDS from 12/28/2025. She stated it was important to code accurate assessments, but she did not feel there would be any impact on the residents from an inaccurate assessment. During an interview on 02/12/2026 at 1:00p.m., the Administrator stated it was the responsibility of the MDS Nurse to produce accurate MDSs and care plans. The Administrator stated accuracy was important for revenue as well as to ensure the facility was reporting the correct information to CMS on the quality measures. She stated there would be no negative impact from miscoded information on the residents. During a record review of the facility's undated Minimum Data Set Policy for MDS assessment Data Accuracy, revealed the purpose of the MDS policy was to ensure each resident received an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. The assessment should accurately reflect the resident's status.		

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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 coordinate assessments with the pre-admission screening and resident review (PASRR) program to include all residents with newly evident or possible serious mental disorder for 1 of 5 residents (Resident #9) reviewed for the PASRR program. The facility failed to ensure Resident #9 was referred for a PASRR (Level II) evaluation when she received a new mental illness diagnosis. This failure could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Record review of the face sheet, dated 02/10/26, indicated Resident #9 was [AGE] years old. The face sheet indicated an admission date of 01/19/22 with an original admission date of 09/01/20. The face sheet indicated Resident #9 had diagnoses including dementia, paranoid schizophrenia with an onset date of 09/24/24, and pain. Record review of a hospital history and physical dated 01/16/22 indicated a problem of paranoid schizophrenia. Record review of quarterly MDS assessment, dated 10/24/25, indicated Resident #9 had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS indicated Resident #9 had an active diagnosis of Schizophrenia. Record review of the comprehensive care plan last revised on 11/07/25 indicated Resident #9 was prescribed an antipsychotic medication related to a diagnosis of paranoid schizophrenia. Record review of the PASRR Level 1 Screening form, dated 09/01/20, reflected Resident #9 had no evidence or indicator of a mental illness. Record review of the PASRR Level 1 Screening form, dated 02/10/26, reflected Resident #9 had no evidence or indicator of a mental illness. Record review of Resident #9's electronic medical record accessed on 02/10/26 did not indicate a PASRR Evaluation. A PASRR Evaluation was not provided by the facility. During an interview on 02/11/26 at 9:32 a.m., the MDS Coordinator said Resident #9 received the diagnosis of paranoid schizophrenia on 9/24/24. She said normally when an MDS assessment was completed for a resident, if there was a new diagnosis then a PASRR Level 1 Screening would need to be updated. The MDS Coordinator said she was new to this position and did not know why this had been done for the resident. She said she had only been the MDS Coordinator since November 2025. She said she had just completed the MDS Assessment on 2/10/26 for Resident #9. She said a resident not receiving an appropriate PASRR screening could potentially cause them to not receive PASRR services. During an interview on 02/12/26 at 9:21 a.m., the DON said she would have expected Resident #9's paranoid schizophrenia diagnosis to have been on her chart several years ago. The DON said she would have expected for her to have a positive PASRR Level 1 for mental illness. She said the MDS Coordinator was responsible for catching new diagnosis and making sure there was a revised PASRR Level 1 to reflect the diagnosis. She said Resident #9 had been at the facility since 2020. She said she had always had a diagnosis of paranoid schizophrenia and would have expected for the original PASRR Level 1 to have reflected that. She said by the PASRR Level 1 not being corrected meant her mental needs were not being addressed. During an interview on 02/12/26 at 11:01 a.m., the Administrator said when a someone received a new mental illness diagnosis the PASRR Level 1 Screening should be updated to reflect the new diagnosis. She said the MDS Coordinator was responsible for identifying a new diagnosis and updating the PASRR Level 1 Screening so that a PASRR Level II screening could be conducted. She said she would have expected for the PASRR Level 1 to have been updated when the diagnosis was first identified. She said she did not feel like not having a correct PASRR Level I Screening or a PASRR Level II Screening could negatively affect a resident. Record review of a PASRR facility policy dated 07/29/25 indicated, .The PASRR program aims to ensure that individuals with mental illness or intellectual disabilities receive appropriate care and services. It assesses whether the nursing home is the most suitable setting for the individual's needs. Nursing homes must comply with all federal and state regulations regarding PASRR. Failure to do so can result in penalties or loss of funding. The facility follows HHS (Health and Human Services) PASRR for Nursing Facility guidelines.		

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for 1 of 4 residents reviewed for ADLs. (Resident #39) The facility did not ensure Resident #39 was assisted with brushing her hair. These failures could place residents at risk of not receiving care or services, decreased quality of life, embarrassment, and decreased self-esteem. The findings included: Record review of the face sheet, dated 02/11/2026, reflected Resident #39 was a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of stroke. Resident #39 had further diagnoses that included: end stage renal disease (final, permanent stage of kidney failure, where the kidney's no longer filter waste and balance fluids) and dependence on renal dialysis (life-sustaining medical treatment that filters blood to remove excess waste, toxins, and fluids when kidney's no longer work). Record review of the quarterly MDS assessment, dated 12/04/2025, reflected Resident #39 had clear speech, was understood, and was able to understand others. Resident #39 had a BIMS score of 15, which indicated she was cognitively intact. Resident #39 usually required setup or clean-up assistance with personal hygiene. Record review of the comprehensive care plan, dated 02/10/2026, reflected Resident #39 had a self-care deficit with bathing, dressing, and feeding. The interventions included: encourage resident to participate in planning day to day care, maintain consistent schedule with daily routine, and provide assistance with ADLs as needed. During an observation and interview on 02/11/2026 beginning at 12:50 p.m., Resident #39 stated she felt the facility staff believed she could do more for herself than she actually could. She was sitting up on the side of her bed and during the interview she was having trouble holding her head up. She stated she had problems with her neck and was going to be getting surgery on it soon. Resident #39 used her right hand to lift up her left arm and let her arm drop at her side. She said since her stroke the left side did not function properly. She said because of the deficits on her left side she was unable to brush her hair properly and she said the staff did not help her with brushing her hair. Resident #39's hair was sticking up in the air and had tangles in some areas. She became tearful during the interview and stated if she did not need assistance she would be at home. During an interview on 02/12/2026 beginning at 11:31 a.m., CNA B stated she normally worked with Resident #39. She said she normally helped Resident #39 get dressed and wiped down on dialysis days. She stated she helped Resident #39 comb her hair, if she asked. She stated she was unsure if she assisted Resident #39 with her hair during this week. CNA B stated it was important to ensure residents received assistance with ADLs for personal hygiene and dignity. During an interview on 02/12/2026 beginning at 11:48 a.m., LVN H stated she expected the CNAs to provide ADL assistance for residents who needed it. LVN H stated Resident #39 normally did things independently. LVN H stated she was unaware Resident #39 required assistance for ADLs. She said it was important to ensure ADL care was provided for residents who needed it, so they could feel good about themselves. During an interview on 02/12/2026 beginning at 2:34 p.m., ADON C stated she expected the CNAs to provide ADL assistance with grooming. ADON C stated Resident #39 did not usually require assistance with ADLs. ADON C stated she was unaware Resident #39 was having problems brushing her hair because of her neck and deficits from her stroke. She said it was important to ensure assistance with ADLs were provided to residents who needed help to maintain good hygiene, prevent infections, and prevent a decrease in mood. During an interview on 02/12/2026 beginning at 3:02 p.m., the DON stated she expected the staff to provide assistance with grooming as it was needed. She stated Resident #39 normally did not require assistance with ADLs. She stated she was independent. She said she was unaware Resident #39 was having trouble completing her ADLs because of her neck and stroke deficits. She said the ADONs were responsible for monitoring to ensure ADL assistance was provided. She said it was important to ensure ADL assistance was provided because it was what the residents were at the facility for. During an interview on (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/12/2026 beginning at 3:30 p.m., the Administrator stated she expected the nursing staff to assist the residents with grooming when it was needed. She stated the clinical staff were responsible for monitoring to ensure ADL assistance was provided. She stated it was important to ensure ADLs assistance was provided to boost confidence. Record review of the Activities of Daily Living (ADL), supporting policy, dated February 2025, reflected Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.appropriate care and services will be provided for residents who are unable to carry out ADLs independently.including appropriate support and assistance with. hygiene (bathing, dressing, grooming, and oral care).		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that 1 of 17 residents reviewed for vision services, received proper treatment and assistive devices to maintain vision abilities. (Resident #9)The facility failed to follow up on an eye doctor's recommendation to order glasses for Resident #9. This failure could affect residents by causing them to have decreased vision awareness when ambulating, difficulty seeing and participating in activities, and decreased self-esteem.Record review of the face sheet, dated 02/10/26, indicated Resident #9 was [AGE] years old. The face sheet indicated an admission date of 01/19/22 with an original admission date of 09/01/20. The face sheet indicated Resident #9 had diagnoses including dementia, paranoid schizophrenia (a chronic mental disorder dominated by intense, irrational delusions (false beliefs) and auditory hallucinations (hearing voices), and pain. Record review of quarterly MDS assessment, dated 10/24/25, indicated Resident #9 had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS indicated Resident #9 had impaired vision. The MDS indicated Resident #9 required maximal assistance from staff for most ADLs.Record review of the comprehensive care plan last revised on 11/07/25 did not indicate Resident #9 had visual impairment.Record review of a Complete Eye Exam Health Record for Resident #9 dated 01/09/26 indicated, .Patient also states that she did not receive her glasses. The review of Ocular (eyes or vision) Systems indicated there was no ocular history. The record contained a prescription for glasses. There was a note to order glasses.During an observation and interview on 02/09/26 at 11:30 a.m., Resident #9 said she did not have her glasses. She said she had been without glasses for a long time. She said she saw the eye doctor when they were in the facility, but she had not received her glasses. The resident did not have on glasses and there were not any glasses near her bed or wheelchair.During an interview on 02/11/26 at 10:22 a.m., Resident #9 said without her glasses she could not see the television or read. She said she had been without glasses for approximately 2 1/2 months. She said her roommate saw the eye doctor the same day she did, and she had received her glasses. She said she has been asking staff at the nurse's station about her glasses. She said she had been praying for her glasses.During an interview on 02/11/26 at 10:26 a.m., LVN A said she had never seen Resident #9 with glasses. She said the eye doctor had just come to the facility. She said the resident mentioned her glasses to her for the first time on 02/10/26. She said the mobile vision company was the one to order the glasses if they were recommended. She said she thought it would be the ADONs job to follow up.During an interview on 02/11/26 at 10:41 a.m., ADON C said the Social Worker was the one that followed up with eye doctor's appointments and ordering glasses. She said she did not remember Resident #9 ever wearing glasses.During an interview on 02/11/26 at 10:44 a.m., the Social Worker said she did not know if the glasses had been ordered for Resident #9. She said normally if the mobile vision company said a resident needed glasses, they mail them to the facility. She said she would call to see if she could get tracking information concerning the glasses.During an interview on 02/11/26 at 11:16 a.m., the Social Worker said the mobile vision company was tracking the glasses order. She said she was waiting for them to call her back. She said if they did not have a tracking order the glasses would be re-ordered.During an interview on 02/11/26 at 12:31 p.m., the Social Worker said the mobile vision office said the order had fallen through the cracks. She said the first time she was asked about Resident #9's glasses was late on 02/10/26. She said she did not have a process to follow up on eye glass orders. She said normally she would not follow up on eye glass orders unless someone brought it to her attention. She said the mobile vision office told her that it normally took 10 - 14 days for a resident to get their glasses. She said she was responsible for making sure residents have the proper vision equipment. She said it was important to follow up in in case orders fall through the cracks.During an interview on 02/12/26 at 9:21 a.m., the DON said the Social Worker handled obtaining eyeglasses for residents. She said the Social Worker sat up the appointment for mobile vision services. She said she would have expected (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Social Worker to have followed up to make sure Resident #9 got her glasses. She said she could not say in what time frame the Social Worker should do a follow up. She said she did not know Resident #9 was missing her glasses. She said a resident not having glasses could cause them to not be able to see. During an interview on 02/12/26 at 11:01 a.m., the Administrator said the Social Worker made the referrals to mobile vision company. She said the mobile vision company then shipped the glasses to the facility. She said if Resident #9 had made it known that she did not have her glasses the Social Worker would have followed up on the order. She said when the mobile vision company came to the facility for their routine visit, staff would have inquired about the glasses. She said a resident not having their glasses could cause them to not see as well. Record review of an Assistive Devices and Equipment facility policy last revised on January 2020 indicated, .Our facility maintains and supervises the use of assistive devices and equipment for residents. The facility provides the resident with assistance in locating available resources to obtain assistive devices that are not provide by the facility including.glasses.Request or the need for special equipment are referred to the social services department.		

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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 adequate supervision and assistance devices to prevent accidents for 1 out of 2 residents (Resident #47) reviewed for transfers. The facility failed to ensure CNA D and CNA F performed a proper gait belt transfer on Resident #47 on 02/09/2026. This failure could place residents at risk of injuries, such as arm dislocation and fractures, during transfers. The findings included: Record review of the face sheet, dated 02/11/2026, reflected Resident #47 was a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of hemiplegia (paralysis) and hemiparesis (weakness) following a brain bleed that affected the right-dominant side. Record review of the quarterly MDS assessment, dated 01/24/2026, reflected Resident #47 had unclear speech, was sometimes understood, and was able to understand others. Resident #47 had a BIMS score of 8, which indicated moderately impaired cognition. The MDS reflected Resident #47 had a functional limitation in range of motion that interfered with daily function and affected one side of the upper and lower extremities. Resident #47 usually required total staff assistance with transfers. Record review of the comprehensive care plan, dated 06/15/2025, reflected Resident #47 had an ADL self-care performance deficit related to a stroke. The interventions included extensive assistance by one staff member for transfers. During an observation on 02/09/2026 at 12:18 p.m., CNA D and CNA F entered Resident #47's room and explained they were going to transfer her from the wheelchair to the bed. CNA D applied a gait belt around Resident #47's waist. CNA D placed her arm under Resident #47's right armpit and CNA F placed her arm under Resident #47's left armpit. CNA D and CNA F lifted Resident #47 by applying pressure underneath her armpits and pulling up, while using the other hand to pull on the gait belt. Resident #47 was pivoted from her wheelchair to the bed during the transfer. Care was provided in the bed and after care was provided CNA D and CNA F transferred Resident #47 back to her wheelchair in the same manner. CNA D and CNA F applied pressure underneath Resident #47's armpits and pulled up while using the other hand to grab the gait belt. Resident #47 was pivoted from the bed to her wheelchair. During an interview on 02/12/2026 beginning at 11:04 a.m., CNA F stated she did not normally work with Resident #47, but she had provided care to her on several occasions. CNA F stated it was normal for her to apply the gait belt and still lift residents underneath their arms during a two person transfer, especially when the resident grabs onto her arm. CNA F stated she lifted using the gait belt only during a one-person transfer. She stated lifting residents underneath their arms could have caused a dislocation. During an interview on 02/12/2026 beginning at 11:48 a.m., LVN H stated she had not been trained recently on gait belt transfers and was unsure when the last in-service was. She stated the gait belt should have been used to lift the resident. LVN H stated it was inappropriate to lift Resident #47 underneath her arms. She said lifting residents by pulling them under their arms could have caused dislocation to their shoulder. During an interview on 02/12/2026 beginning at 2:34 p.m., ADON C stated the proper way to apply and use the gait belt was to place the gait belt around the resident's waist, ensure a hand could fit in between the belt and waist, and then lift using the gait belt to give stability. She said she expected the nursing staff to ensure the gait belt was used properly. ADON C stated she was responsible for monitoring to ensure the CNAs were using the gait belt properly. ADON C stated check offs were completed upon hire and annually. She said spot checks were completed and addressed in real time. She stated it was important to ensure the residents were not lifted under their arms to prevent a broken arm or dislocation. During an interview on 02/12/2026 beginning at 3:02 p.m., the DON stated she expected the nursing staff to utilize gait belts during transfers. The DON stated the ADONs were responsible for monitoring to ensure gait belts were utilized appropriately. She stated it was important to ensure gait belts were used properly for resident safety. CNA D and CNA F's competencies were requested. The DON provided CNA D's (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	competencies but was unable to locate competencies for CNA F. During an interview on 02/12/2026 beginning at 3:30 p.m., the Administrator stated she expected nursing staff to use the gait belt appropriately. She said clinical leadership was responsible for monitoring to ensure gait belts were used appropriately. She stated it was important to ensure gait belts were used properly so residents were transferred safely. Record review of CNA D's competencies, signed and dated 10/29/2025, reflected CNA D met all steps for resident transfer. The steps included: .7. positioned wheelchair/chair correctly and locked wheels. 8. Used proper body mechanics (back straight, knees bent). 9. Used gait belt or mechanical lift as per care plan.10. Encouraged resident participation, if appropriate. 11. Pivoted safely, avoiding twisting motions, uses small pivot steps. 12. Two persons assist: position on each side of resident and grasps belt on front and back, uses small pivot steps. 13. Gently lowered resident into chair, ensuring resident is comfortable, repositioned properly, and checked alignment. Record review of the Safe Lifting and Movement of Residents policy, dated July 2017, reflected In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents.staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 8.0%, based on 3 errors out of 25 opportunities, which involved 2 of 4 residents (Resident #15, Resident #59) reviewed for medication administration. 1. The facility failed to administer Resident # 15's Basaglar Insulin (a long-acting insulin injected once daily to improve blood sugar control in adults with type 2 diabetes and adults/children (6+ years) with type 1 diabetes) 20 Units every morning. 2. The facility administered (2) sprays per nostril of fluticasone propionate nasal spray (a corticosteroid used to relieve nasal symptoms like congestion, sneezing, itching, and a runny nose caused by seasonal allergies, year-round allergies, or non-allergic rhinitis) instead of the (1) spray per nostril ordered and the facility failed to check the expiration date on Resident #59's loratadine (to temporarily relieve indoor and outdoor allergy symptoms, including sneezing, runny nose, itchy/watery eyes, and itchy throat or nose) 10mg administer one tab daily which expired 03/2025. These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders. Findings included: 1. Record review of Resident #15's undated face sheet indicated she was an [AGE] year-old female admitted on [DATE], with the diagnoses which included, type II diabetes (refers to a group of diseases that affect how the body uses blood sugar (glucose) , retinopathy (disease of the retina which results in impairment or loss of vision), and dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #15 had a BIMS score of 05, which indicated severe cognitive impairment. Resident #15 was dependent for ADLs, received oral hypoglycemic medication, and insulin daily. Record review of the comprehensive care plan dated 01/12/2026 revealed Resident #15 had unstable glucose level and medications were to be administered as prescribed. Record review of the MAR dated February 2026 revealed Basaglar Insulin 20 U was held on 02/10/2026 at 7:00 a.m. related to vitals being outside of parameters. There were no directions on the MAR for holding the Basaglar Insulin During observation and interview on 02/10/2026 at 7:40 a.m., LVN A checked Resident #15's blood glucose and recorded the result as 149 on the MAR. LVN A stated Resident #15 had no order for insulin when her blood glucose was 149. Resident #15 was alert and responsive during glucose check. During an interview on 02/10/2026 at 9:30 a.m., LVN A stated Resident #15 had an order for Novolin R on a sliding scale that stated insulin should be held if blood glucose was less than 200. She stated she thought that meant all insulin should be held. LVN A stated there was no specific order to hold the Basaglar insulin. She stated now that she looked at it, she should have given it. LVN A stated not giving the long-acting insulin could keep Resident #15's blood glucose from leveling out and remaining high. 2. Record review of an undated face sheet revealed Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to widespread inflammation, organ damage, and potential failure), MRSA infection of sacral pressure ulcer (Methicillin-resistant Staphylococcus aureus) infection in a sacral pressure ulcer is a serious, potentially fatal complication, causing rapid tissue destruction, abscesses, and systemic infection), and gastrostomy status (refers to the presence of an artificial, surgically created opening (stoma) into the stomach for a feeding tube). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #59 had a BIMS score of 08, which indicated moderate cognitive impairment. Resident #59 required dependent assistance with ADLs. He received antidepressant, diuretic, and anticonvulsant medications during the look back. Resident #59 had a seizure disorder. Record review of Resident #59's the comprehensive care plan dated 01/20/2026 revealed no care (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan for anticonvulsant usage or seizure activity. Record review of Resident #59's consolidated physician orders dated February 2026 revealed and order for fluticasone propionate nasal spray (1) spray per nostril daily and loratadine 10mg once daily per PEG tube. Record review of Resident #59's MAR revealed an order for fluticasone propionate nasal spray (1) spray per nostril daily and loratadine 10mg per PEG tube daily. During an observation on 02/10/2026 at 9:20 a.m., LVN A administered (2) sprays of fluticasone propionate per nostril to resident #59 and failed to check the expiration date of 03/2024 on the loratadine 10mg administered once daily per PEG tube. During an interview on 02/10/2026 at 9:30 a.m., LVN A stated the order for the fluticasone nasal spray was for (1) spray per nostril. She stated administering (2) sprays per nostril would not negatively affect the resident. LVN A stated she should check all medications for expiration prior to administering the medication. She stated the ADON and pharmacy consultant go through the carts and check for expired medications also. LVN A stated if anything the loratadine was probably less effective being expired but no real harm would come to the resident from receiving an expired loratadine pill. During an interview on 02/12/2026 at 10:00 a.m., the DON said she expected medication orders to be followed by the nurses as written by the MD. She stated she expected the MD to be notified if medications were held, missed, or given in error. She stated depending on the medication type, some medications being missed can cause issues with the residents. The DON stated missing long-acting insulin could lead to increased blood sugar and need for more short acting insulin coverage. She stated she did not think an extra spray of fluticasone nasal spray would hurt anyone and expired loratadine would be less effective if anything. During an interview on 02/12/2026 at 11:00 a.m., the Administrator stated the ADON and pharmacy consultants, as well as the nurses were to check the medication carts and rooms for expired medication. She said the nurses were responsible for reordering the prescription medications. The Administrator stated that not giving insulin and not following MD orders was not best practice for nursing and the facility strived to do what was best for each resident. Record review of the facility's policy Medication Administration undated stated: .To provide practice standards for safe administration of medication for residents in the facility. Medication must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law. The licensed nurse must know the following information about any medication they are administering A: The drug name.B. the drug's route of administration. C The drug's action.D. The drug's indication for use and desired outcome.E. The drug's usual dosage.F. The drug's side effects .G. Any precautions and special considerations. VIII. Medication will not be left at the bedside. VIII. Compare the Licensed Practitioner's prescription and order with the MAR. XVII. Holding medications.A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason the medication was help on the back of the MAR.		

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 02/12/2026
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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that accommodates resident allergies, intolerances, and preferences 1 of 8 residents (Resident #32) reviewed for resident food preferences. The facility failed to ensure Resident #32's dislike of pork was honored during the breakfast meal on 02/10/2026 and the lunch meal on 02/11/2026. This failure placed residents at risk for not having their nutritional needs met and a decreased quality of life. The findings included: Record review of the face sheet, dated 02/11/2026, reflected Resident #32 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of acute embolism (blockage) and thrombosis (blood clot) of deep veins of right upper extremity, ovarian and anal cancer, and obesity. The face sheet reflected Resident #32's allergies were penicillin, grapefruit extract, mango flavor, onions, and latex. Pork was not listed as an allergy. Record review of the quarterly MDS assessment, dated 01/15/2026, reflected Resident #32 had clear speech, was understood, and was able to understand others. Resident #32 had a BIMS score of 15, which indicated she was cognitively intact. She was independent with eating. Record review of the comprehensive care plan, dated 10/03/2025, reflected Resident #32 had a nutritional problems or potential nutritional problem related to diagnosis of cancer. The interventions did not address preferences. Record review of the comprehensive care plan, dated 12/30/2025, reflected Resident #32 had the potential for injury related to multiple reported allergies. The allergies were not listed. The intervention was allergies to be listed on MAR and on chart. Record review of the order summary report, dated 02/09/2026, reflected Resident #32 had an order which started on 07/15/2025 for a regular diet texture and regular consistency. During an interview on 02/09/2026 beginning at 11:40 a.m., Resident #32 stated she was allergic to pork, but she ate it anyways because the portion sizes were small and she did not want to get hungry. Resident #32 stated when she ate pork she got a headache, became dizzy, and became sleepy. During an observation and interview on 02/10/2026 beginning at 9:02 a.m., Resident #32 was eating breakfast. Resident #32 stated she was served pork sausage that appeared undercooked and was pale in the center. She held the sausage up for surveyor to see. She said she was allergic to pork. She stated she told the guy in the kitchen about her allergies but they still kept sending it to her. She said I think to myself are they trying to kill me? She said she has never been hospitalized or required medical attention over eating pork. During an interview on 02/10/2026 beginning at 9:59 a.m., the Dietary Manager stated he looked for allergies in the electronic charting system or was verbally told by nursing staff. He stated the residents also reported allergies when he talked to them on admission. He stated when a resident was admitted to the facility, he spoke with them regarding food preferences and allergies. The Dietary Manager stated he spoke with Resident #32 on multiple occasions regarding the food. He said she never reported pork as an allergy, but she did not like it. He said when a resident did not like something or had allergies it would have been listed on the tray card. He said when the dietary staff prepared the food, they were supposed to look at the tray card. He said if they have an allergy or if they dislike an item, the tray card system will mark it off the ticket. He said when an item was marked off the ticket it should not have been included on the meal tray. The Dietary Manager stated it was important to ensure the residents' preferences were honored because it was their right. During an interview on 02/10/2026 beginning at 10:10 a.m., LVN A stated Resident #32 had never reported that she was allergic to pork. LVN A stated Resident #32 did have allergies that were listed on her face sheet. During an interview on 02/10/2026 beginning at 11:10 a.m., ADON C stated Resident #32 had not mentioned that she was allergic to pork. She stated when the residents come into the facility they get an allergy list from the hospital, and they also verify with the resident. She stated she cannot recall if Resident #32 mentioned she did not like pork. During an observation and interview on 02/11/2026 beginning at (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:50 p.m., Resident #32 had her lunch tray in front of her. All the food was gone. She stated she was served ham, which she ate because she did not want to go hungry. She was alert, non-drowsy. Her breathing was even, normal. She had no evidence of distress observed. Her meal ticket reflected she disliked pork. The baked ham was not marked off. During an interview on 02/12/2026 beginning at 11:15 a.m., MA G stated Resident #32 had never reported she was allergic to pork but stated she was allergic to pepper. She said if someone had an allergy or disliked a food item, it would have been noted on the meal tray card. She stated the dietary staff were supposed to use the tray card when making the tray, then whoever took the tray was responsible for making sure the meal tray matched the tray card. She stated if the meal tray ticket did not match or if the residents had something they did not want, then the staff took it back to the kitchen. She stated it was important to ensure residents' food likes and dislikes were honored because the facility was their house and they should honor what they want and don't want. During an interview on 02/12/2026 beginning at 11:31 a.m., CNA B stated Resident #32 did report that she was allergic to pork. CNA B stated she was unsure if it was an actual allergy because she ate pork when it was served. CNA B stated Resident #32 had no signs of an allergic reaction, like hives, facial swelling, or any other distress. She stated the residents' likes and dislikes were printed on the meal tray card. She stated she did not notice that Resident #32's tray card reflected a dislike for pork. She said she normally took a meal tray back to the kitchen if a resident did not like it. She said it was important to ensure residents' likes and dislikes were honored so they were satisfied. During an interview on 02/12/2026 beginning at 11:48 a.m., LVN H stated Resident #32 had not reported she was allergic to pork. She stated that when passing meal trays, they check the tray to the card and make sure the diet is correct. She said they also check to ensure likes and dislikes were honored. She was unsure why Resident #32 received pork when it was listed as a dislike on her tray card. She stated it was important to ensure residents' likes and dislikes were honored so the residents ate something they liked. During an interview on 02/12/2026 beginning at 2:23 p.m., the Dietary Manager stated the dietary staff were responsible for looking at the meal tray cards for likes and dislikes. He said the nursing staff also checked the cards to the meal tray before serving. He said Resident #32 had not specified what pork she specifically did not like and he did not ask or clarify. He stated he had to put the specific pork products for it to mark it off the ticket as a dislike. During an interview on 02/12/2026 beginning at 2:34 p.m., ADON C stated during meal services she did not check the residents' likes or dislikes. She stated she depended on the dietary staff or the resident to ensure their likes and dislikes were honored. She stated if the resident told her they did not like the meal, then she would get them something else. She said it was important to ensure the residents' likes and dislikes were honored because they were human and it was their right. During an interview on 02/12/2026 beginning at 3:02 p.m., the DON stated she expected the nursing staff to look at the meal tray cards to ensure residents' likes and dislikes were honored. The DON stated dietary staff, nursing staff, and the resident were responsible for making sure the preferences were honored. She stated it was important to ensure residents' preferences were honored because it was their right. During an interview on 02/12/2026 beginning at 3:30 p.m., the Administrator stated she expected the Dietary Manager to ensure he had an understanding of what the residents' likes and dislikes were. She stated the Dietary Manager was responsible for monitoring to ensure residents' preferences were honored. She stated it was important to ensure the residents' likes and dislikes were honored to maintain resident satisfaction. Record review of the Food and Nutrition Services policy, dated October 2017, reflected The multidisciplinary staff, including nursing staff, the attending physician, and the dietician will assess each resident's nutritional needs, food likes, dislikes, and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. a resident-centered diet and nutrition place will be based on this assessment. reasonable efforts will be made to accommodate resident choices and preferences.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 2 of 5 resident personal refrigerators reviewed for food safety (Resident #12 and Resident #63). The facility failed to ensure the refrigerator for Resident #12 and Resident # 63 were clean and did not contain expired food. This failure could place residents at risk for food borne illnesses. Findings include: Record review of an undated face sheet indicated Resident #12 was a [AGE] year-old female, admitted on [DATE] with diagnoses including major depression (a serious, common mental health condition characterized by persistent sadness, hopelessness, and loss of interest in activities lasting at least two weeks), chronic kidney disease (a long-term, progressive loss of kidney function, often causing waste to build up in the body), and diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #12 had a BIMS score of 15 which indicated no cognitive impairment. Resident #12 was independent with all ADLS. During an interview and observation on 02/09/2026 at 10:00 a.m., Resident #12 stated there were two personal refrigerators in her room. She stated one belonged to her and one belonged to her roommate. Refrigerator #1 belonged to Resident #12 and contained half of a 16-ounce container of a dairy based vegetable dip that expired 08/2025. The refrigerator appeared dirty on the inside with spilled brown liquid and food wrappers crumbled up inside. There was no thermometer or thermometer log noted for the refrigerator. Resident #12 stated she last ate the vegetable dip around Christmas. She stated she had not gotten sick but did think the dip tasted funny. Resident #12 stated no staff members opened her refrigerator to look at the food or look at the temperature. 2. Record review of an undated face sheet revealed Resident #63 was a [AGE] year-old female admitted on [DATE] with the diagnoses of anxiety (persistent, excessive fear or worry that interferes with daily life, characterized by symptoms like rapid heart rate, dizziness, restlessness, and insomnia), depression (a serious, common mood disorder causing persistent sadness, loss of interest, and physical symptoms that impair daily life), and hypoxemia (a condition characterized by abnormally low levels of oxygen in the arterial blood). Record review of the quarterly MDS assessment dated [DATE] revealed Resident #63 had a BIMS score of 11 which indicated moderate cognitive impairment. She required partial (helper does less than half the work) assistance with ADLs. During an observation and interview on 02/09/2026 at 10:10 a.m., Resident #63 stated her family brought her food and put it in the fridge. She stated no one cleaned her fridge or checked the temperature. A 10-ounce container of potato salad that expired 12/2025 with green and brown fuzzy substance covering it was noted in Refrigerator #2. She stated the orange stuff in the freezer area was sherbert that melted and no one cleaned. She stated it had been there since the summer. Resident #63 stated she was unsure if housekeeping or nursing were supposed to clean the fridge. No thermometer and no temperature logs were noted for Resident #63's refrigerator. During an interview on 02/10/2026 at 11:20 a.m., LVN A stated that it was the responsibility of housekeeping to keep up with cleaning the refrigerators and keeping the temperature logs. During an interview on 02/12/2026 at 11:00 a.m., the Administrator said it was the responsibility of nursing to ensure that personal refrigerators were clean and free of expired foods. She stated there was no follow up done to ensure it was happening. She said in extreme cases that residents could get sick if they eat expired foods. During an interview on 02/12/2026 at 11:27 a.m. the DON said that housekeeping was responsible for cleaning out the personal refrigerators for residents. She said that residents could be placed at risk for foodborne illness, an upset stomach or intestinal tract if they ate expired or moldy food. She said she expects housekeeping to clean out the personal refrigerators of all residents. Review of the policy titled ?Food Brought by Family indicated the nursing staff will discard perishable food on or before the expiration date.		