

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: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed. The facility did not ensure: 1. Food items were labeled and dated. 2. The microwave was clean and free of food debris. 3. The toaster was clean and free of food debris 4. The juice machine spigot was free from a red gooey substance where the juice was dispersed. 5. The deep fryer was clean and had clear grease. 6. [NAME] Q personal cell phone was stored properly. 7. A personal drink was stored properly. These failures could place residents at risk for foodborne illness. Findings included: During the initial tour observation and interview with the Dietary Manager on 09/22/25 beginning at 9:31 a.m. until 10:00 a.m. the following was revealed: 1. Two bags of frozen zucchini that were identified by the Dietary Manager unlabeled and undated. 2. Three bags of frozen tater tots that were identified by the Dietary Manager unlabeled. 3. One bag of frozen steak fries that was identified by the Dietary Manager unlabeled and undated. 4. Three frozen dish pie shells undated. 5. Three frozen chocolate creme pies undated. 6. One frozen pecan pie undated. 7. Inside the microwave was a brown buildup. 8. The toaster had brown buildup. 9. The deep fryer had golden food crumbs of various sizes observed on the inside surfaces. 10. The juice machine spigot with a thick gooey red substance. 11. A cell phone was observed next to the toaster charging. [NAME] Q stated the cell phone belonged to her and it should be stored in her bag. [NAME] Q stated it could put residents at risk for food borne illness and contamination. 12. A blue vitamin water was observed in the stand-alone refrigerator without a name and date. During an interview on 09/24/25 at 12:35 p.m., Dietary Aide W stated all staff were responsible for labeling and dating. Dietary Aide W stated the aides were responsible for cleaning the microwave, and juice nozzles after every use. Dietary Aide W stated personal drinks could be stored in the walk-in cooler, but it must be labeled and dated. Dietary Aide W stated personal cell phones should be stored away from the work area. Dietary Aide W stated these failures put residents at risk for food borne illness and cross contamination. During an interview on 09/24/25 at 12:57 p.m., [NAME] V stated all staff were responsible for labeling and dating food products. [NAME] V stated the cooks were responsible for cleaning the fryer and changing the grease once a week. [NAME] V stated the cooks should clean the toaster after every use. [NAME] V stated personal drinks should be stored in the walk-in fridge with date and name. [NAME] V stated personal cell phones should be stored in their personal bag away from the work area. [NAME] V stated these failures could possibly cause food borne illness and cross contamination. During an interview on 09/24/25 at 2:31 p.m., the Dietary Manager stated cleanliness was important in the kitchen so staff were not spreading germs or contaminating anything. The Dietary Manager stated she was responsible for making sure the kitchen was cleaned appropriately. The Dietary Manager stated all food should be labeled and dated by the date received and the date it was opened. The Dietary Manager stated the aides were responsible for cleaning juice nozzles after every use. The Dietary Manager stated all staff were responsible for cleaning the microwave after every use. The Dietary Manager stated the cooks were responsible for cleaning the dryer weekly and toaster after every use. The Dietary Manager stated cell phones should be stored in the room that was at the back of the (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kitchen in their personal bag. The Dietary Manager stated personal drinks should be stored in the walk-in refrigerator labeled and dated. The Dietary Manager stated she was responsible for monitoring and overseeing daily walk throughs and when there was an isolated issue that staff were verbally in serviced and if a widespread issue a paper in service was completed. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination and food borne illness. During an interview on 09/24/25 at 4:51 p.m., the Administrator stated food items should be labeled and dated to effectively manage spoilage. The Administrator stated kitchen equipment should be cleaned daily for sanitization purposes. The Administrator stated personal drinks should be kept in the employee break room or in their personal vehicle. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing the kitchen. The Administrator stated phones should be stored on the person or in their personal vehicle. The Administrator stated these failures could potentially put residents at risk for cross contamination, and food borne illness. Record review of the facility's policy titled, Food Receiving and Storage revised 11/2022 reflected. Food shall be received and stored in a manner that complies with safe food handling practices. Refrigerated/Frozen Storage. 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) . Record review of the facility's policy titled, Sanitation revised 11/2022 reflected. the food service area is maintained in a clean and sanitary manner. 2. All utensils, counter, shelves, and equipment are kept clean, maintained in good repair.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 effectively maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 3 of 5 (Resident's #2, #31, and Resident #3) residents and 1 of 1 linen cart reviewed for infection control. 1. The facility did not ensure RN A had prepared a barrier to place supplies on when checking Resident #2 and 31's blood sugar. The facility did not ensure RN A cleaned the glucometer between Resident #2 and Resident #31's blood sugar. The facility did not ensure RN A performed hand hygiene while checking Resident #2's blood sugar. 2. The facility did not ensure linen carts were covered. 3. The facility did not ensure A/C wing nurses' carts were cleaned. 4. The facility failed to ensure CNA F did not place a black trash bag on the floor in the hallway on A-Wing to collect trash from the residents' rooms on 09/22/2025. 5. The facility failed to ensure LVN L followed enhanced barrier precautions while disconnecting Resident #3's g-tube (tube inserted directly into the stomach through the abdominal wall to provide nutrition, hydration, and medications) on 09/24/2025. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: 1. During an observation on 09/22/25 at 11:35 a.m., RN A performed hand hygiene, applied a set of gloves and prepared to obtain fingerstick blood sugar for Resident #31. RN A gathered a glucometer (measures the amount of sugar in the bloodstream at a specific time), lancet (device used to prick the skin for a small blood sample), 1 test strip, and alcohol wipe and placed them on the dining table where Resident #31 was sitting at. After using the glucometer, RN A placed the glucometer back on top of the medication cart without disinfecting it. During an observation on 09/22/25 at 11:42 a.m., RN A performed hand hygiene, applied a set of gloves and prepared to obtain fingerstick blood sugar for Resident #2. RN A gathered a glucometer (measures the amount of sugar in the bloodstream at a specific time), lancet (device used to prick the skin for a small blood sample), 1 test strip, and alcohol wipe and placed them on the dining table where Resident #2 was sitting at. RN A pricked Resident #2's index finger with a lancet needle but was unable to get blood. RN A doffed (off) and don (on) new gloves without cleansing her hands or using hand sanitizer. RN A gathered another lancet, test strip and alcohol wipe and placed it on the dining table again. RN A pricked Resident #2's middle finger with a lancet needle then wiped off the blood from the finger using a small alcohol wipe. RN A squeezed the pricked finger to collect blood for glucose testing. During an interview on 09/22/25 at 11:50 a.m., RN A stated she should have performed hand hygiene between gloves changes and clean the glucometer between each resident. RN A stated she believed there was not a problem with placing the glucometer, lancet, alcohol wipe and test strip on the resident's dining table without having a barrier. RN A stated this failure was an infection control issue. 2. During an observation on 09/22/25 at 11:29 a.m., the linen cart on wing A was uncovered which included sheets, pillowcases, gowns, under pads, blankets, briefs and wash cloths. During an interview on 09/22/25 at 11:31 a.m., CNA G stated clean linen carts should always be covered when not being used. CNA G stated the cart was not covered this morning when she came in. CNA G stated all staff were responsible for ensuring the cart was covered when not in use. CNA G stated this was important to prevent germs contaminating the linens. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/22/25 at 11:32 a.m., RN A stated clean linen carts should always be covered when not being used. RN A stated all nursing staff were responsible for ensuring the front flap of the linen cart was down when not in use. RN A stated this failure could allow germs to enter and contaminate the linens. 3. During an observation and interview on 09/23/25 at 3:45 p.m., the state surveyor observed wing C medication cart with LVN C. There were multiple brown gooey substances noted in the drawer where the liquid medications were kept. LVN C stated nurses and MAs were responsible for keeping the cart cleaned. LVN C stated the cart should be cleaned whenever they noticed it was dirty. LVN C stated it was important to ensure the cart was cleaned to prevent infection control issues. During an observation and interview on 09/23/25 at 4:03 p.m., the state surveyor observed wing A medication cart with RN A. There were multiple brown gooey substances noted in the drawer where the liquid medications were kept. RN A stated nurses and MAs were responsible for cleaning the cart every shift. RN A stated this failure was an infection control issue. During an interview on 09/24/25 at 3:21 p.m., the Regional Nurse Consultant stated she expected the glucometer to be cleaned before and after each resident use. The Regional Nurse Consultant stated she expected hand hygiene to be performed with every glove change. The Regional Nurse Consultant stated she expected the glucometer, test strip, lancet and alcohol wipe to be on a clean surface that can be achieved with a barrier. The Regional Nurse Consultant stated she expected medication carts to be kept clean and organized daily by the charge nurse and medication aide. The Regional Nurse stated the DON was responsible for ensuring proper cleaning occurs by random observations and education when needed. The Regional Nurse Consultant stated it was important to ensure infection control practices were done to prevent the spread of infection. During an interview on 09/24/25 at 4:16 p.m., the DON stated her expectation was for RN A to wipe off a space and place a barrier (wax paper) and then set the supplies to check the blood sugar on it. The DON stated she expected the glucometer to be cleaned between residents and after each use. The DON stated she expected all staff to wash or sanitize their hands between glove changes. The DON stated RN A's insulin administration check-off should have been completed April 2025. RN A stated she had not been checked off this year. When asked why she had not been checked off for her annual, stated I don't have an answer. The DON stated should be always covered when not in use. The DON stated her expectation was for the nurses/med aides to keep the medication cart by cleaning as needed. The DON stated she was responsible for monitoring by random spot checks and check offs. The DON stated that there had been a change in ownership and not having an ADON in place to assist her had placed a barrier to monitoring these tasks. The DON stated it was important to ensure infection control practice was followed to prevent the spread of infection. The DON stated there was not a policy and procedure regarding linen carts. During an interview on 09/24/25 at 4:51 p.m., the Administrator stated medication carts need to remain clean so that they were provided with sanitary services. The Administrator stated linen carts should be covered when not being accessed. The Administrator stated the glucometer should be cleaned between residents. The Administrator stated there should be a barrier between the tablecloth or place the items on a sanitized surface such as the medication cart. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated these failures were an infection control issue. 4. During an observation on 09/22/2025 starting at 12:32 AM, there was a black trash bag on the floor (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the hallway on A-Wing. CNA F was observed coming in and out of the residents' rooms on A-Wing with clear trash bags which contained trash from the residents' rooms including dirty briefs and placing the clear trash bags in the black trash bag on the floor in the hallway. During an interview on 09/22/2025 at 12:38 AM, CNA F said she did not have a barrel to put the trash from the residents' rooms in. CNA F said she should not place trash bags on the floor because the trash was dirty, and the residents could get into it. CNA F said it could also cause spreading of the dirty. CNA F said she should be disposing of the trash in the biohazard room when it was taken out of the residents' rooms. During an interview on 09/22/2025 at 12:45 AM, RN E said the CNAs should not have trash bags on the floor in the hallway. RN E said the CNAs were supposed to take the trash from the residents' rooms to the biohazard room. RN E said she had not noticed CNA F had the trash bag in the hallway. RN E said the bags with trash should not be on the floor for infection control. 5. Record review of Resident #3's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and gastrostomy status (creation of an external opening into the stomach to provide nutrition). Record review of Resident #3's Comprehensive MDS assessment dated [DATE] indicated she was rarely/never understood and sometimes understood others. The MDS assessment indicated Resident #3 had a short-term and long-term memory problem. The MDS assessment indicated Resident #3 was dependent on staff for all ADLs, and she had a feeding tube. The MDS assessment indicated Resident #3 had one or more unhealed pressure ulcers/injuries and received pressure ulcer/injury care. Record review of Resident #3's Order Summary Report dated 09/23/2025 indicated she had an order for enhanced barrier precautions with high contact resident care due to gastrostomy tube (tube inserted directly into the stomach through the abdominal wall to provide nutrition, hydration, and medications) with a start date of 09/08/2025. Record review of Resident #3's care plan reviewed 07/24/2025, did not address the use of enhanced barrier precautions. During an observation on 09/24/2025 at 9:06 AM, LVN L put on gloves, uncovered Resident #3, and disconnected Resident #3's feeding from her g-tube. LVN L failed to put on a gown while providing direct care to Resident #3. During an interview on 09/24/2025 at 9:57 AM, LVN L said she was not aware of the requirement for enhanced barrier precautions when accessing a feeding tube. LVN L said she did not remember receiving any training regarding enhanced barrier precautions. LVN L said standard and isolation precautions should be followed when providing care to residents for infection control. During an interview on 09/24/2025 at 5:18 PM, the DON said the CNAs should not place trash bags on the floor. She said the CNAs should have a barrel with a bag inside of the barrel so they could place the trash inside the barrel and then place the barrel in the soiled utility room until the end of their shift. The DON said the charge nurse was responsible for ensuring the CNAs were disposing of the trash properly. The DON said placing dirty things, like bags with trash, on the floor was an infection control issue. The DON said LVN L should have followed enhanced barrier precautions when providing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	care to Resident #3. The DON said a gown and gloves were required when disconnecting a feeding tube. The DON said she was responsible for ensuring the staff were following enhanced barrier precautions, and she conducted random spot checks to ensure they were being followed. The DON said she had not noticed any issues with the staff not wearing the appropriate PPE. The DON said she had conducted an in-service with the staff regarding enhanced barrier precautions, and she would provide it. The DON said not wearing the appropriate PPE for enhanced barrier precautions placed the residents at risk for transmission of different infections. During an interview on 09/24/2025 at 5:58 PM, the Administrator said he expected for the trash to be disposed of properly. The Administrator said bags with trash should not be on the floor. The Administrator said the charge nurse was responsible for ensuring the CNAs handled trash properly. The Administrator said putting bags with trash on the floor was unsanitary and it could result in the spread of infection. The Administrator said he expected for the staff to wear the appropriate attire, such as gown and gloves, when performing procedures. The Administrator said the DON was responsible for ensure the staff were doing this. The Administrator said not wearing the appropriate attire could cause infections to be spread. Record review of an Inservice Form dated 03/04/2025 presented by the DON for all staff with subject Enhanced Barrier Precautions indicated LVN L's signature. Record review of the facility's Enhanced Barrier Precautions policy revised February 2025, indicated, Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include. device care or use (feeding tube). During an interview with the Regional Nurse Consultant on 09/24/2025 at 7:09 PM, the policy regarding proper disposal of trash was requested and not received upon exit of the facility.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interviews and record reviews, the facility failed to develop and implement an infection prevention and control program to include antibiotic use protocols and a system to monitor antibiotic use for 1 of 1 facility reviewed for antibiotic stewardship. The facility failed to utilize an antibiotic tracking log for the months of August 2025 through September 2025. This failure could place residents at risk for inappropriate antibiotic use. Findings included: Record review of the facility's antibiotic tracking log, the last month the tracking and trending on antibiotic usage was completed in July 2025. The tracking logs for August 2025 and September 2025 were not completed. During an interview on 09/23/25 at 9:15 a.m., the DON stated infection control for August 2025 and September 2025 were not completed yet. The DON stated she was responsible for completing August 2025 and September 2025 infection control log but due to transition of changing companies/EHR system, and the ADON leaving two months ago the log had not been completed within a timely manner. The DON stated usually the ADON was responsible for ensuring the log was completed and she monitored it by reviewing the logs weekly via email. The DON stated it was important to keep up with the antibiotic stewardship program and tracking/trending of infections to identify and intervene for any negative patterns. During an interview on 09/24/25 at 3:21 p.m., the Regional Nurse Consultant stated that the ICP, which was the DON now, was responsible for completing the infection control log with the applicable tracking and trending. The Regional Nurse Consultant stated the infection control log should be completed monthly. The Regional Nurse Consultant stated typically it was ADON's duty however, the facility was between ADONs so the DON and Regional Nurse Consultant should be ensuring it was completed. The Regional Nurse Consultant stated she did require the log be sent to her monthly for review but with the changes of the EHR system transition, no ADON in place, and transcribing physician orders to ensure accuracy took precedence. The Regional Nurse Consultant stated it was important for tracking and trending to be completed timely so the facility can identify and intervene as needed for any negative trends. During an interview on 09/24/25 at 4:51 p.m., the Administrator stated he expected tracking and trending logs to be completed timely to ensure negative trends were addressed. The Administrator stated that due to the transition of changing companies, EHR system and a vacant ADON position made this a challenge. The Administrator stated the ADON was responsible for completing the log and the DON was responsible for monitoring and overseeing. The Administrator stated it was important for tracking and trending to be completed timely to manage and correct any negative trends. Record review of the facility's policy Antibiotic Stewardship, revised on 12/2016, reflected. Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. 1. The purpose of our antibiotic's stewardship program is to monitor the use of antibiotics in our residents.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 2 of 8 residents (Resident #30, Resident #2, and Resident #31) reviewed for resident rights. 1.The facility failed to ensure Resident #30 was treated with respect and dignity when Resident #30 asked an unknown staff member to take him to the restroom before he ate his lunch and the staff member failed to comply with Resident #30's request during lunch on 09/22/25.2. The facility did not ensure RN A provided privacy when administering Resident #2 and #31's insulin. These failures could place residents at risk for diminished quality of life, loss of dignity, and self-worth. Findings included: 1.Record review of Resident #30's face sheet dated 09/15/25 indicated he was a [AGE] year-old-male who admitted to the facility on [DATE] with the diagnoses chronic systolic congestive heart failure (disease in which the heart muscle cannot pump blood effectively), sleep apnea (sleep disorder in which breathing stops and starts repeatedly), atrial fibrillation (an irregular often rapid heart rate that causes poor blood flow), and high blood pressure. Record review of Resident #30's admission MDS assessment dated [DATE] indicated he was understood by others and made himself understood. The MDS also indicated he had a BIMS score of 7 which meant he had severe cognitive impairment. The MDS also indicated he required moderate assistance with transfers and bed mobility, maximal assistance with toileting and bathing, and setup for eating. Record review of Resident #30's care plan dated 09/23/25 did not indicate his ADL care. During an observation and interview on 09/22/25 at 12:20 PM Resident #30 was laying in his bed with his lunch tray untouched on top of his bedside table. He said an unknown facility staff member brought him his tray and told him they would be back to take him to the restroom. He said he tried to wait but had already had an accident and did not want to eat while he was covered in urine. he said he felt unclean. During an interview on 09/22/25 at 12:35 PM CNA B said that she was unaware of Resident #30 needed to go to the restroom because the department heads passed the trays on the hall daily. She said no one notified her that he needed to use the restroom. She said if she had known she would have taken him because it was his right. CNA B grabbed her cart and immediately went to his room and changed him and set him up for his lunch. During an interview on 09/24/25 at 6:25 PM the DON said the department heads passed trays on the hall, but she expected the unknown staff to notify nursing when Resident #30 expressed the need to use the restroom to ensure he made it to the restroom and prevented him from urinating on himself. The DON said the failure placed a risk for Resident #30 having skin breakdown as well as Resident #30 being upset that he is wet and not be able to eat his food in a timely manner. During an interview on 09/24/25 at 7:08 PM The administrator said he expected the staff to ensure to meet the resident care needs timely regardless of meal service. He said he expected the unknown (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to notify the correct staff member to ensure Resident #30 was taken to the restroom. He said the failure placed a risk for Resident #30's health, safety, and dignity being compromised. 2. Resident #31 Record review of Resident #31's face sheet, dated 09/23/25, reflected Resident #31 was an [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses which included diabetes mellitus ((lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) due to underlying condition with diabetic chronic kidney disease (a complication of diabetes that damages the kidneys). Record review of Resident #31's quarterly MDS assessment, dated 09/01/25, reflected Resident #31 made himself understood, and understood others. Resident #31's BIMS score was 9, which reflected her cognition was moderately impaired. Record review of Resident #31's comprehensive care plan dated 06/03/25 reflected Resident #31 had a diagnosis of diabetes mellitus. The care plan interventions included administer medications/insulin as ordered and monitor/document for side effects and effectiveness. Record review of the physician order summary report, dated 09/23/25, reflected Resident #31 had an order for Novolog Injection Solution 100 unit/ml, inject as per sliding scale, 4 units. subcutaneous before meals and at bedtime related to diabetes mellitus with a start date 09/11/25. During an observation on 09/22/25 at 11:35 a.m., revealed Resident #31 was sitting at the dining table when RN A walked over and told him she was about to give him insulin. RN A raised Resident #31 shirt up and administered 4 units to Resident #31's RLQ. There were 13 residents sitting in the dining room ready for lunch to be served. Resident #2 Record review of Resident #2's face sheet, dated 09/23/25, reflected Resident #2 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) with diabetic nephropathy (complication of diabetes mellitus that affects the kidneys) and legal blindness. Record review of Resident #2 quarterly MDS assessment, dated 07/14/25, reflected Resident #2 made herself understood, and understood others. Resident #2's BIMS score was 12, which reflected her cognition was moderately impaired. Record review of Resident #2's comprehensive care plan, dated 07/16/25, reflected Resident #2 had Diabetes Mellitus. The care plan interventions included diabetes medication as ordered by the doctor, monitor/document for side effects/effectiveness and fasting serum blood sugar as ordered by the doctor. Record review of the physician order summary report, dated 09/23/25, reflected Resident #2 had an order for Humalog KwikPen, inject as per sliding scale, 14 units. subcutaneous before meals and at bedtime related to diabetes mellitus with a start date 09/23/25. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/22/25 at 11:42 a.m., revealed Resident #2 was sitting at the dining table when RN A walked over and told her she was about to give her insulin. RN A raised Resident #2 shirt up and administered 14 units to Resident #2's RLQ. There were 12 residents sitting in the dining room ready for lunch to be served. During an interview on 09/24/25 at 2:30 p.m., Resident #2 stated she was not aware RN A raised her shirt up and administered insulin in the dining room. Resident #2 stated she would have said something to her. During an interview on 09/22/25 at 11:32 a.m., RN A stated it was standard practice to administer insulin in the abdomen in an open area. RN A stated she always did that and was never told not to. During an interview on 09/24/25 at 3:21 p.m., the Nurse Consultant stated her expectation was insulin to be administered in a private area. The Nurse Consultant stated the DON was responsible for ensuring privacy was given through random observations and education as needed. The Nurse Consultant stated it was important to provide privacy to protect the residents' dignity. During an interview on 09/24/25 at 4:16 p.m., the DON stated insulin administration should be given in the resident room or in a private area. The DON stated she monitored by random spot checks and check offs. The DON stated she has never noticed RN A administering insulin in the dining room. The DON stated it was important to provide privacy to protect the residents' dignity and privacy. During an interview on 09/24/25 at 4:51 p.m., the Administrator stated insulin administration should be given in a private location out of view of other residents or non-clinical staff. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated it was important to provide privacy when administering insulin to protect the residents' dignity. Record review of the facility's Dignity policy, revised 02/2021, reflected . each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents are treated with dignity and respect at all times.		

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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 observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 4 of 20 residents (Resident #3, Resident #5, Resident #17, and Resident #30) reviewed for care plans. 1. The facility failed to develop a care plan to address Resident #3's wounds and the use of enhanced barrier precautions. 2. The facility failed to develop a care plan to address Resident #17's g-tube. 3. The facility failed to ensure a care plan was developed to address Resident #30's smoking. 4. The facility failed to ensure a comprehensive care plan was developed for Resident #5. These failures could place residents at risk of not having their individual needs met and a decreased quality of life. Findings included: 1. Record review of Resident #3's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and gastrostomy status (creation of an external opening into the stomach to provide nutrition). Record review of Resident #3's Comprehensive MDS assessment dated [DATE] indicated she was rarely/never understood and sometimes understood others. The MDS assessment indicated Resident #3 had a short-term and long-term memory problem. The MDS assessment indicated Resident #3 was dependent on staff for all ADLs, and she had a feeding tube. The MDS assessment indicated Resident #3 had one or more unhealed pressure ulcers/injuries and received pressure ulcer/injury care. Record review of Resident #3's care plan reviewed 07/24/2025, did not address Resident #3's wounds, wound care, and enhanced barrier precautions. Record review of Resident #3's Order Summary Report dated 09/23/2025, indicated the following orders enhanced barrier precautions with high contact resident care due to gastrostomy tube (tube inserted directly into the stomach through the abdominal wall to provide nutrition, hydration, and medications) with a start date of 09/08/2025. Cleanse abrasion on right buttock with normal saline and apply anasept gel (gel applied to wounds to help prevent/treat infections) and collagen sheet or powder (powder or sheet applied to wounds to help tissue regeneration). Cover with border gauze island one time a day with a start date of 09/11/2025. Cleanse Stage I pressure wound on right buttock with normal saline apply triad paste (a paste that sticks to wet skin, absorbs fluid, moisture, protects, and promotes wound healing) and cover with border gauze island one time a day with a start date of 09/11/2025. Unstageable deep tissue injury to coccyx clean with normal saline or wound cleanser apply anasept and collagen sheet or powder to wound. Cover with border gauze island one time a day may change if dressing becomes soiled or saturated with a start date of 09/11/2025. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/24/2025 starting at 9:06 AM, LVN L did not follow enhanced barrier precautions when disconnecting Resident #3's g-tube from her feeding. The Treatment Nurse entered the room, put on a gown and gloves to follow enhanced barrier precautions, and prompted LVN L to put on a gown. The Treatment Nurse provided wound care to Resident #3's right buttock and coccyx as ordered with the assistance of LVN L. 2. Record review of a face sheet dated 09/15/2025 indicated Resident #17 was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and gastrostomy (creation of an external opening into the stomach to provide nutrition). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #17 was usually understood and understood others. The MDS assessment indicated Resident #17 had a BIMS score of 5, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #17 required partial/moderate assistance with toileting and personal hygiene, showering/bathing self and set-up or cleanup assistance for eating. The MDS assessment did not indicate Resident #17 had a feeding tube. Record review of Resident #17's care plan reviewed 07/31/2025 did not address Resident #17's g-tube. Record review of Resident #17's Order Summary Report dated 09/23/2025 indicated: As needed complete tube site care every shift and as needed start date 09/11/2025. Verify enteral tube placement by checking for residual gastric volume (check the stomach contents) prior to medication administration and feedings every shift with a start date of 09/11/2025. Isosource 1.5 (liquid nutrition tube-feeding formula) at 50 ml/hr via g-tube with a start date of 09/11/2025 May use Diabetisource 1.2 (tube feeding formula designed for individuals with diabetes) at 50 ml/hr until Isosource 1.5 arrives with an order date of 09/22/2025. During an observation on 09/24/2025 at 10:32 AM, Resident #17 had Diabetisource 1.2, feeding, connected to her g-tube at 50 ml/hr. During an interview on 09/24/2025 at 6:02 PM, the MDS Coordinator said she was responsible for completing the care plans. The MDS Coordinator said Resident #3's plan of care for her wounds and the use of enhanced barrier precautions and Resident #17's g-tube were not included in the residents' care plans because she had not had time to put them in. The MDS Coordinator said due to the change in companies for the facility she did not have access to put in the residents' care plans. The MDS Coordinator said it was important to put these things in the care plan because they needed to follow the plan of care. During an interview on 09/24/2025 at 6:28 PM, the Administrator said care plans should be completed timely, and they should include care of the g-tube, any wounds, and the use of enhanced barrier precautions. The Administrator said the MDS Coordinator was responsible for completing the care plans. The Administrator said it was important for the care plans to be completed to ensure the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents received the best quality of care. 3. Record review of Resident #30's face sheet dated 09/15/25 indicated he was a [AGE] year-old-male who admitted to the facility on [DATE] with the diagnoses chronic systolic congestive heart failure (disease in which the heart muscle cannot pump blood effectively), sleep apnea (sleep disorder in which breathing stops and starts repeatedly), atrial fibrillation (an irregular often rapid heart rate that causes poor blood flow), and high blood pressure. Record review of Resident #30's admission MDS assessment dated [DATE] indicated he was understood by others and made himself understood. The MDS also indicated he had a BIMS score of 7 which meant he had severe cognitive impairment. The MDS also indicated he required moderate assistance with transfers and bed mobility, maximal assistance with toileting and bathing, and setup for eating. Record review of Resident #30's care plan dated 09/23/25 did not indicate him being a smoker. During an interview on 09/24/25 at 5:27 PM the MDS Nurse said Resident #30 should have had a care plan for smoking, but she guessed she forgot to add the care plan for smoking. The MDS Nurse said the failure placed a risk for the nursing staff not being able to care for the Resident #30 correctly while smoking. During an interview on 09/24/25 at 6:11 PM the DON said Resident #30 should have had a care plan when he admitted and the MDS nurse was responsible for completing those care plans. The DON said the failure placed a risk for the staff not knowing what measures were needed for care for Resident #30 while smoking. 4. Record review of Resident #5's face sheet, dated 06/23/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #5 had diagnoses which included vascular dementia (disease in which there is a decline in memory and thinking related to blocked blood flow to the brain), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), high blood pressure, and aphasia (language disorder that affects the ability to communicate). Record review of Resident #5's admission MDS assessment, dated 08/21/25, indicated she sometimes made herself understood and she sometimes understood others. Resident #5 had a BIMS score of 1, which indicated she was severely cognitively impaired. Resident #5 required moderate assistance with toileting, baths, and dressing. Resident #5 was independent with transfers and bed mobility and required supervision with eating. Record review of Resident #5's EMR, on 09/23/25, indicated she did not have a care plan implemented. Resident #5 had a care plan for a previous stay, dated 07/10/23. During an interview on 09/24/25 at 4:50 PM, LVN C said she was not sure who was responsible for completing care plans but Resident #5 should have had a care plan for the charge nurses to know how to provide care and interventions. During an interview on 09/24/25 at 5:22 PM, the MDS Nurse said she was responsible for all residents' comprehensive care plans and the DON and ADON were responsible for the acute care plans. The MDS Nurse said Resident #5 should have a care plan, but she did not have access to the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	systems the facility used, and she was just now completing the care plans. She said she looked at the admission assessment and all assessments. She said without the care plan the staff could have been missing the risks she added and diagnoses for Resident #5. During an interview on 09/24/25 at 6:11 AM, the DON said she expected the care plan for Resident #5 to be in place. She said the care plan should have been completed within 14 days after the admission MDS was completed. The DON said the MDS Nurse was responsible for Resident #5's care plan. The DON said the failure placed a risk for staff not knowing the care provided to Resident #5. During an interview on 09/24/25 at 6:59 PM, the Administrator said his expectation was for all residents to have care plans to meet their needs. He said the failure placed a risk for patient care being compromised. Record review of the facility's policy titled, Care Planning- Interdisciplinary Team, revised 2024, indicated The interdisciplinary team is responsible for the development of resident care plans Resident care plans are developed according to the timeframes and criteria established by 483.21.Comprehensive, person-centered care plans are based on resident assessments.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 4 of 6 residents (Resident #2, Resident #22, Resident #29, and Resident #51) reviewed for accidents and supervision. 1. The facility failed to ensure 2-person assistance was used when Resident #2 was transferred from her bed to the wheelchair by CNA K with the use of a mechanical lift on 09/24/2025. 2. The facility failed to ensure Resident #22 did not have fingernail clippers on her dresser and hand sanitizer and hair spray on her bedside table. 3. The facility failed to ensure Resident #29 did not have a can of hairspray on her dresser, nail polish remover in her caddy, another can of hairspray on her table by the window, and nail polish remover on her dresser by the television in a caddy. 4. The facility failed to ensure Resident #53 did not have a blue razor in the trash can in her room. 5. The facility failed to ensure RN A disposed of the lancet properly. 6. The facility failed to ensure the razor in wing B medication cart had a cover on it. These failures could place residents at an increased risk for falls and injuries. Findings included: 1. Record review of Resident #2's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder depressive type (mood disorder with symptoms such as feelings of sadness, worthlessness, and depression), legal blindness, muscle weakness, and muscle wasting and atrophy (thinning or wasting of muscle tissue). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated she was understood and understood others. The MDS assessment indicated Resident #2's vision was severely impaired, and she had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #2 required substantial/maximal assistance with toileting, showering/bathing, lower body dressing and partial/moderate assistance with personal hygiene and upper body dressing. The MDS assessment indicated Resident #2 was dependent on staff for transfers. Record review of Resident #2's care plan reviewed 07/16/2025 indicated, she had a potential for injury related to previous falls, unsteady gait, visual deficits, attempted to stand unassisted and lost balance easily. Interventions included 2 staff to assist resident during transfers. Resident #2's care plan indicated she had an ADL self-care performance deficit and limited physical mobility. Resident #2's care plan did not address the use of the mechanical lift. Record review of Resident #2's Order Summary Report dated 09/23/2025 did not indicate the use of the mechanical lift. During an observation and interview on 09/24/2025 at 9:01 AM, CNA K was observed coming out of Resident #2's room with the mechanical lift. There were no other staff members observed in Resident #2's room. Resident #2 said CNA K transferred her from her bed to the wheelchair, and she was not comfortable in her wheelchair. CNA K said she transferred Resident #2 with the use of the mechanical lift by herself. During an interview on 09/24/2025 at 9:49 AM, CNA K said the use of the mechanical lift probably (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required 2 staff, but she was not sure because at some facilities only one staff was required. CNA K said she thought they may have trained her on the use of the mechanical, but it had been a while. CNA K said she transferred Resident #2 on her own because the nurse had to step out of the room, and she did not wait for her to come back to help her. CNA K said it was important for the adequate number of staff to be used for transfers for safety. During an interview on 09/24/2025 at 10:28 AM, LVN L said Resident #2 should be transferred with 2 staff with the mechanical lift. LVN L said the CNAs should not use one staff to transfer residents with the mechanical that CNA K should have waited for her to come assist her or for other staff to help her. LVN L said one person should not perform the transfer for the residents' safety. During an interview on 09/24/2025 at 5:23 PM, the DON said transferring with the mechanical lift required 2 staff. The DON said CNA K should have asked another staff member for assistance with Residents #2's transfer. The DON said CNA K could have been injured or the resident could have been injured. During an interview on 09/24/2025 at 6:05 PM, the Administrator said he expected for 2 staff to use the mechanical lift to transfer the residents. The Administrator said the DON was responsible for ensuring the staff were transferring the residents properly. The Administrator said not using 2 staff when required could result in the resident being harmed. 2. Record review of Resident #22's face sheet, dated 09/24/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #22 had diagnoses which included Alzheimer's disease (progressive disease that destroys memory and important mental functions), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), and high blood pressure. Record review of Resident #22's quarterly MDS assessment, dated 07/09/25, indicated she was able to make herself understood and understood others. Resident #22 had a BIMS score of 3, which indicated she had severe cognitive impairment. Resident #22 required maximal assistance with bathing and dressing, supervision with toileting, bed mobility, and transfers, and setup with eating. Record review of Resident #22's care plan did not address items she could not keep in her room. During an observation on 09/22/2025 at 11:07 AM revealed Resident #22 had fingernail clippers on her dresser and hand sanitizer and hair spray on her bedside table. 3. Record review of Resident #29's face sheet, dated 09/15/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #29 had diagnoses which included dementia (cognitive function severe enough to interfere with daily life), anxiety (intense, excessive, and persistent worry and fear about everyday situations), high blood pressure, and depression (lowering of a person's mood). Record review of Resident #29's admission MDS assessment, dated 06/14/25, indicated she was able to make herself understood and she was able to understand others. Resident #29 had a BIMS score of 6, which indicated she had severe cognitive impairment. Resident #29 required moderate assistance with toileting, bathing, and transfers, and she required for bed mobility, and setup for eating. Record review of Resident #29's care plan, dated 06/23/25, indicated she had impaired visual (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	functioning, ADL self -care deficits, and cognitive impairment with interventions in place to reorient her as needed and provide simple instructions with care. During an observation on 09/22/2025 at 3:43 PM revealed Resident #29 was out in the hallway in her wheelchair but had a can of hairspray on her dresser, nail polish remover in her caddy, another can of hairspray on her table by the window, and nail polish remover on her dresser by the television in a caddy. During an observation on 09/23/2025 at 10:35 AM revealed Resident #29 was out of the room and the door was opened, there continued to be a can of hairspray on her dresser, nail polish remover in her caddy, another can of hairspray on her table by the window, and nail polish remover on her dresser by the television in a caddy. During an interview on 09/24/25 at 4:30 PM CNA E she said the hairspray, fingernail polish remover, or the nail clippers were not supposed to be left out. She said she had completed a round and removed the items when she began her shift. CNA E said the failure placed a risk for injury for all residents in the unit. During an interview on 09/24/25 at 4:39 PM, LVN C said hairspray, fingernail polish remover, and nail clippers probably were not supposed to be out. She said the failure placed a risk for any of the residents harming themselves. LVN C said all staff were responsible for ensuring the items were not in the residents' rooms. LVN C said the items were always out so she figured it was ok. During an interview on 09/24/25 at 6:01 PM, the DON said hairspray, nail clippers, and nail polish remover were not supposed to be out in the locked unit. The DON said the nursing staff were all responsible for ensuring those items were not out in the unit. She said the failure placed a risk for residents ingesting, placing in their eyes, and using the items inappropriately. During an interview on 09/24/25 at 6:53 PM, the Administrator said the hairspray, nail clippers, and nail polish remover should be kept in the medication room or the carts and used by a nurse, CNA, or med aide. The Administrator said nurse aides and the charge nurse were responsible for ensuring items were not in the room. He said the failure placed a risk for residents ingesting or using inappropriately. 4. Record review of Resident #51's face sheet, dated 09/15/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #51 had diagnoses which included senile degeneration of the brain (progressive decline in cognition), impulse disorder (mental health disorder that makes it difficult to resist urges and behaviors), depressive disorder (group of conditions that lower a person's mood), and chronic pain. Record review of Resident #51's quarterly MDS assessment, dated 02/25/25, indicated she sometimes made herself understood and usually understood others. Resident #51 had a BIMS score of 0, which indicated she had severe cognitive impairment. Resident #51 was dependent on staff for all her ADLs. Record review of Resident #51's care plan, dated 07/09/25, indicated she had cognitive loss related to senile degeneration of the brain with interventions to provide the residents with a homelike environment. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/22/2025 at 10:55 AM revealed Resident #51 was lying in bed, but she had a blue razor in the trash can in her room. During an interview on 09/24/25 at 5:15 PM, LVN R said her expectation was for the aides to place used razors in the sharp's container. LVN R said the failure placed a risk of someone getting cut. During an interview on 09/24/25 at 6:05 PM, the DON said the razors should not be in the room. They should be locked in an area to where no other residents would have access to them. The risk was injury. The nurse's staff should ensure the items were not in the rooms. The razors should be placed in sharps containers after use. During an interview on 09/24/25 at 6:56 PM, the Administrator said he expected personal care items to be stored out of resident reach except when in use. The nurse and CNAs were responsible for ensuring the items should not be in the rooms. The risk was patient health and safety risk. 5. During an observation on 09/22/25 at 11:42 a.m., RN A performed hand hygiene, applied a set of gloves and prepared to obtain a fingerstick blood sugar for Resident #2. RN A gathered a glucometer (measures the amount of sugar in the bloodstream at a specific time), lancet (device used to prick the skin for a small blood sample), 1 test strip, and alcohol wipe and placed them on the dining table where Resident #2 was sitting. RN A pricked Resident #2's index finger with a lancet needle but was unable to get blood. RN A doffed (off) and don (on) new gloves without cleansing her hands or using hand sanitizer. RN A gathered another lancet, test strip and alcohol wipe and placed it on the dining table again. RN A pricked Resident #2's middle finger with a lancet needle then wiped off the blood from the finger using a small alcohol wipe. RN A squeezed the pricked finger to collect blood for the glucose testing. Once RN A picked up the supplies which included the lancet needle and disposed of the used lancet in the trash can on her medication cart. During an interview on 09/22/25 at 11:50 a.m., RN A stated lancets and test strips should be disposed of in the sharp container. When asked why she did not dispose the lancet and test strip properly, RN A stated, I wasn't thinking properly. RN A stated disposing of the lancet and test strip could possibly cause an injury or transmission of blood borne pathogens. 6. During an observation and interview on 09/23/25 at 10:58 a.m., a razor was in the bottom drawer uncovered in wing B nurse's cart. LVN D stated the razor should have a protective cover. LVN D stated it was important for the razor to have a protective cover to prevent an injury. During an interview on 09/24/25 at 3:21 p.m., the Regional Nurse Consultant stated she expected lancets were disposed of in the sharp container and razors were stored properly by ensuring the safety cover was in place. The [NAME] Nurse Consultant stated the DON was responsible for monitoring by random observations and education as needed. The Regional Nurse Consultant stated it was important to dispose of sharps properly to residence the risk of a needle stick or transmission of blood borne pathogens. The Regional Nurse Consultant stated it was important to properly store razors to reduce the risk of injury. During an interview on 09/24/25 at 4:16 p.m., the DON stated the lancets should be discarded in the sharp container after every use and razors should not be stored without the cover on the blade. The DON stated she monitored by random spot checks. The DON stated there had not been any issues in the past. The DON stated it was important to dispose of lancets and store razors properly to prevent an injury and transmission of blood borne pathogens. (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/24/25 at 4:51 p.m., the Administrator stated he expected lancets to be discarded in the sharp container and razors covers should remain on razors unless they are in use. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated it was important to dispose of lancets and store razors properly to prevent an injury/accidents and transmission of blood borne pathogens. Record review of the Obtaining a Fingerstick Glucose Level policy, revised 10/2011, reflected .the purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Steps in the Procedure. 6. Discard lancet into the sharp's container. Record review of the facility's undated, Sharps Disposal policy, reflected .this facility shall discard contaminated sharps into designated containers. 2. Contaminated sharps will be discarded into containers that are: b. puncture resistant. Record review of the facility's policy revised, July 2017, titled, Lifting Machine, using a Mechanical, indicated, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 3 of 3 residents (Resident #1, Resident #8, and Resident #58) reviewed for dialysis. 1. The facility failed to keep ongoing communication with the dialysis facility for Resident #58. 2. The facility failed to obtain a dialysis contract for Resident #58's dialysis clinic. 3. The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #1 and Resident #8. These failures could place residents at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: 1. Record review of Resident #58's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included end stage renal disease (final stage of chronic kidney disease, the kidneys no longer function adequately to maintain the body's needs and dialysis or a kidney transplant required for survival). Record review of Resident #58's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #58 had a BIMS score of 13, which indicated her cognition was intact. The MDS assessment indicated Resident #58 required dialysis while a resident of the facility. Record review of Resident #58's Order Summary Report dated 09/24/2025 indicated dialysis check shunt (provides access to the bloodstream for dialysis) for signs and symptoms of infection or bleeding every shift with a start date of 09/11/2025. Record review of Resident #58's care plan revised 09/23/2025 indicated she required hemodialysis (a type of dialysis that filters the blood since the kidneys cannot) related to renal failure. Interventions included to encourage resident to go for the scheduled dialysis appointments and to check and change dressing daily at access site. During an interview on 09/22/2025 at 12:21 PM, Resident #58's family member said Resident #58 went for dialysis every Tuesday, Thursday, and Saturday. During an interview on 09/23/2025 at 1:49 PM, the Administrator said the facility did not have a dialysis contract for Resident #58's dialysis clinic. During an interview on 09/24/2025 at 10:18 AM, LVN L said Resident #58 went to the dialysis clinic on Tuesday, Thursday, and Saturday. LVN L said she was sending dialysis communication forms to Resident #58's dialysis clinic, but she had not received any back from the dialysis clinic. LVN L said she had not attempted to contact the clinic to communicate with them regarding the dialysis communication forms or obtaining treatment information. LVN L said it was important for them to have ongoing communication with the dialysis clinic to know if Resident #58 was declining, any changes were made, and she was tolerating her dialysis treatments and to have ongoing collaboration with the clinic. During an interview on 09/24/2025 at 11:48 AM, the charge nurse at the dialysis clinic said the facility had not been sending communication forms for the dialysis clinic to fill out for Resident #58. The charge nurse at the dialysis clinic said the communication form was for the facility and the dialysis clinic to communicate, and it was important for them to have ongoing communication and for the facility to know if the resident had any adverse effects during her treatment. During an interview on 09/24/2025 at 5:31 PM, the DON said the nurses should be completing the top portion of the dialysis communication form and sending it with the resident to the dialysis clinic, and then when the resident returned to the facility the communication form should be returned with the bottom portion completed by the dialysis clinic. The DON said there was currently no monitoring in place to ensure communication with the dialysis clinic was completed. The DON said it was important for communication and so if there were any changes at the facility, the dialysis clinic was aware, and if there were any changes at the dialysis clinic, the facility was aware. During an interview on 09/24/2025 at 6:12 PM, the Administrator said the facility's communication system between the dialysis clinic and the facility should be adhered to. The Administrator said the charge nurses were responsible for maintaining ongoing communication with the dialysis clinic. The (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator said not maintaining ongoing communication with the dialysis clinic could result in the residents' health being compromised. The Administrator said they did not have the dialysis contract for the dialysis clinic Resident #58 went to because it was his first survey at the facility. The Administrator said he was responsible for obtaining the dialysis contracts, and it had been an oversight. The Administrator said it was important to have dialysis contracts to be clear on expectations from both parties and to establish protocols to protect the resident.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 6 medication carts (A-Wing nurse's medication cart) and 4 of 8 residents (Resident #24, Resident #27, Resident #28, Resident #50) observed for medication storage. 1. The facility failed to ensure Resident #24 did not have remedy cream on her room table. 2. The facility failed to ensure Resident #27 did not have triple antibiotic ointment at her bedside. 3. The facility failed to ensure Resident #28 did not have Preparation H cream (a cream used for hemorrhoids) and lantiseptic (a barrier cream used for skin breakdown) on plastic drawers next to her chair. 4. The facility failed to ensure Resident #50 did not have and unknown white cream in a specimen cup on his bedroom shelf. 5. The facility failed to ensure RN E secured the A-Wing Nurse Medication Cart when it was not in use and unattended on 09/22/2025. These failures could place residents at risk for not receiving drugs and biologicals as needed and a drug diversion. Findings included: 1. Record review of Resident #24's face sheet, dated 09/23/25, indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses diabetes mellitus (disease causing too much sugar in the blood), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), dementia (cognitive function severe enough to interfere with daily life), tremors, and high blood pressure. Record review of Resident #24's admission MDS, dated [DATE], indicated she was able to make herself understood and she was able to understand others. The MDS also indicated she had a BIMS score of 3 which meant she had severe cognitive impairment. The MDS also indicated she required maximal assistance with bathing, dressing, and personal hygiene and she required setup for bed mobility, transfer, and eating. Record review of Resident #24's care plan, dated 07/09/25, indicated she had impaired cognitive function with interventions to administer medications as ordered. Record review of Resident #24's order summary report, dated 09/23/25, indicated she had an order: May apply barrier cream as needed with a start date of 08/24/2025 and no end date. During an observation on 09/22/2025 at 11:14 AM, Resident #24 was out of the room but had a tube of Remedy Prevent ointment on her dresser table. During an observation on 09/23/2025 at 10:23 AM, Resident #24 was lying in her bed and had a tube of Remedy Prevent ointment on her dresser table and she was not interviewable. 2. Record review of Resident #27's face sheet, dated 09/24/25, indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses Alzheimer's disease (progressive disease that destroys memory and important mental functions), psychotic disorder (mental disorder characterized by disconnection from reality), depression (lowering of a person's mood), heart failure (disease in which the heart does not pump blood as it should), and high blood pressure. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's quarterly MDS assessment, dated 07/25/25, indicated she usually understood others and was usually able to make herself understood. The MDS also indicated she had a BIMS score of 7 which indicated she had severe cognitive impairment. The MDS also indicated she required supervision for transfers, and bathing, moderate assistance for toileting, setup for eating and independent with bed mobility. Record review of Resident #27's care plan, dated 06/05/25, indicated she had impaired cognitive function with interventions to administer medications as ordered. Record review of Resident #27's order summary report, dated 09/24/25, did not indicate she had an order for triple antibiotic ointment. During an observation on 09/23/2025 at 10:33 AM, Resident #27 had a tube of triple antibiotic ointment in her caddy sitting on her bedside table and she was not interviewable. 3. Record review of Resident #28's face sheet, dated 09/23/25, indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses dementia (cognitive function severe enough to interfere with daily life), heart failure (disease causing the heart difficulty pumping enough blood), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and major depression (excessive lowering of a person's mood). Record review of Resident #28's annual MDS, dated [DATE], indicated she could make herself understood and she understood others. The MDS also indicated she had a BIMS score of 6 which indicated she had severe cognitive impairment. The MDS also indicated she required supervision for bathing, toileting, and dressing and she was independent with eating, transfers, and bed mobility. Record review of Resident #28's care plan, dated 05/07/25, indicated she had impaired cognitive function and impaired visual functioning with interventions to administer medications as ordered. Record review of Resident #28's order summary report, dated 09/23/25, indicated she had an order for: Preparation H Rectal Ointment 0.25-14-74.9% (Phenylephrine-mineral oil-petroleum) insert 1 application rectally every 6 hours as needed for hemorrhoids with a start date of 09/16/25 and no end date. During an observation on 09/22/2025 at 12:10 PM, Resident #28 had a tube of Preparation H rectal ointment and a 1-ounce packet of Iantiseptic cream lying on top of her plastic drawers next to the chair in her room. During an observation and interview on 09/23/2025 at 10:37 AM, Resident #28 was sitting on her bed and had a tube of Preparation H rectal ointment and a 1-ounce packet of Iantiseptic cream lying on top of her plastic drawers next to the chair in her room. Resident #28 said she used it when she needed to. She said rubbed a little bit of the Preparation H rectal ointment on her butt at a time when it hurt. 4. Record review of Resident #50's face sheet, dated 09/30/25, indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), dementia (cognitive function severe enough to interfere with daily life), hearing loss, and high blood pressure. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/22/2025 at 11:24 AM, Resident #50 was sitting in his chair watching wrestling and had an unknown white cream in a specimen cup on his shelf. During an observation and interview on 09/24/25 at 4:30 PM, CNA E said the medications that were out were not supposed to be left out on the unit. She said the family brought the white cream that was located in Resident #50's room. She said the family did not specify what the cream was supposed to be but told her to use it for his mouth. CNA E said the staff should not have left the creams out because its harmful for the residents on the unit. CNA E said the failure could place a risk for any of the residents potentially drinking or eating the creams. CNA E said the medications were out but she made rounds upon her coming in to work and ensured it was all put away as it was supposed to be. During an interview on 09/24/25 at 4:39 PM, LVN C said the medication and creams should not have been out. She said the failure placed a risk for all the residents harming themselves. LVN C said all staff were responsible for ensuring the medications and creams were not in the residents' rooms. LVN C said the charge nurses normally completed rounds in the rooms, but she had been working at the facility for a month and thought it was okay for the creams and medications to be out because the creams and medications had always been out in the residents' rooms. During an interview on 09/24/25 at 6:01 PM, the DON said the lantiseptic, hemorrhoid cream, or barrier creams were not supposed to be out in the locked unit. The DON said all the nursing staff were responsible for ensuring medication and creams were not out in the locked unit. The DON said the failure placed a risk for residents ingesting, placing in their eyes, and using the cream or medications inappropriately. The DON said it all should have been stored on the nurse's carts or medication rooms. During an interview on 09/24/25 at 6:53 PM, the Administrator said the medications should have been kept in the medication room or the nurse's carts and administered by a nurse or medication aide. The Administrator said the nurse aides and the charge nurse were responsible for ensuring medications and creams were not in the residents' room. He said the failure placed risks for residents ingesting or using inappropriately. 5. During an observation and interview on 09/22/2025 starting at 12:30 AM, there was an unlocked, unattended medication cart on A-Wing. RN E said it was the A-Wing Nurse Medication Cart, and she was responsible for it. RN E said she did not realize she left it unlocked. RN E said the medication carts should be locked at all times because somebody could get into it. During an interview on 09/24/2025 at 5:39 PM, the DON said the medication cart should be locked when it was not in use. The DON said the nurse or medication aide whomever was using the medication cart was responsible for ensuring it was locked. The DON said she monitored to ensure the medication carts were locked when unattended by conducting random spot checks. The DON said an unlocked medication cart could result in a resident, visitor, or unauthorized personnel getting into the medication cart. During an interview on 09/24/2025 at 6:26 PM, the Administrator said he expected for the medication cart to be locked when out of the nurses' sight. The Administrator said the DON was responsible for ensuring the this happened. The Administrator said the medication cart being unlocked could compromise the residents' safety. Record review of the facility's policy titled, Medication Labeling and Storage, revised February 2023, (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.		

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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. Based on observations, and interviews, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 16 of 16 confidential residents reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 09/23/25. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During an interview on 09/22/2025 at 12:21 PM, Resident #58's family member said the food was served cold. During an interview on 09/23/2025 at 9:29 AM, Resident #2 said the food tasted bad. During an observation and interview on 09/23/25 at 12:30 p.m., lunch tray was sampled by the Dietary Manager and five surveyors. The sample tray consisted of a smothered pork chop, green beans, black eyed peas, peach pie and a roll. The Dietary Manager stated the smothered pork chop was lukewarm, green beans were lukewarm/bland, black-eyed peas were lukewarm/bland, and the pie was tart. The surveyors agreed. During an interview on 09/24/25 at 12:05 p.m., CNA U stated no residents complained to her about food being cold or bland but if so, she would offer the resident an alternative. CNA U stated all food complaints would be reported to the nurse and dietary staff. CNA U stated residents not eating their food could potentially cause weight loss. During an interview on 09/24/25 at 12:07 p.m., LVN O stated she had not had any residents complained about food being cold or bland. LVN O stated she would offer an alternative and report to the Dietary Manager. LVN O stated residents not eating their food could potentially cause weight loss and skin breakdown. During an interview on 09/24/25 at 2:31 p.m., the Dietary Manager stated she had not had any complaints regarding food being cold or bland. The Dietary Manager stated she told the residents before if there were any issues to come directly to her and she would try her best to fix it. The Dietary Manager stated she monitored meal service including food quality daily by interviewing residents and tray sampling. The Dietary Manager included there were no issues found with food quality during her tray sampling. The Dietary Manager stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss. During an interview on 09/24/25 at 4:51 p.m., the Administrator stated he expected food to be the appropriate temperature and seasoned for palatability. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing. The Administrator stated he has not experienced a test tray that was not palatable. The Administrator stated he has not had any complaints when serving residents in the dining room regarding temperature and palatability. The Administrator stated that typically he assisted in delivering trays but not collecting them to observe any concerns. The Administrator stated it was important to ensure food was palatable and had an appetizing temperature for managing weight and quality of life. Record review of the facility's policy titled, Food and Nutrition Services revised 10/2017 reflected. each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional. needs.		

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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 each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 2 residents (Resident #2 and Resident #51) reviewed for reasonable accommodations. 1. The facility failed to ensure Resident #2's call light was within reach on 09/23/2025. 2. The facility failed to ensure Resident #51's call light was in reach for her to use when assistance was needed on 09/22/25 and 09/23/25. These failures could place residents at risk for a delay in assistance and a decreased quality of life. Findings include: 1. Record review of Resident #2's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder depressive type (mood disorder with symptoms such as feelings of sadness, worthlessness, and depression), legal blindness, muscle weakness, and muscle wasting and atrophy (thinning or wasting of muscle tissue). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated she was understood and understood others. The MDS assessment indicated Resident #2's vision was severely impaired, and she had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #2 required substantial/maximal assistance with toileting, showering/bathing, lower body dressing and partial/moderate assistance with personal hygiene and upper body dressing. The MDS assessment indicated Resident #2 was dependent on staff for transfers. Record review of Resident #2's care plan reviewed 07/16/2025 indicated, she was at risk for falls, was very impatient and impulsive when she asked for care to encourage resident to use call light to gain assistance. Resident #2's care plan indicated she had a potential for injury related to previous falls, unsteady gait, visual deficits, attempted to stand unassisted and loses balance easily. Interventions included to place frequently needed articles within reach, and to place call light within reach. During an observation and interview on 09/23/2025 starting at 9:29 AM, Resident #2 was in her wheelchair by the end of the foot of her bed. Resident #2 said she was blind and asked for her call light. Resident #2 said the staff had issues with giving her, her call light. She said sometimes she had to yell, Hey, I need my call light. Resident #2's call light was on her bed by the head of the bed. During an interview on 09/23/2025 at 9:55 AM, CNA G said she rushed out of Resident #2's room and forgot to give her, the call light. CNA G said everybody should ensure the call light was within reach of the resident, and if they noticed it was not, they should put it within reach. CNA G said it was important for the call light to be within the residents reach because they could fall and need help. During an interview on 09/24/2025 at 5:41 PM, the DON said the call lights should be in reach for all residents. The DON said all staff should ensure the call lights were within reach, and if they noticed it was not, they should give it to them. The DON said if the call light was not within reach the residents could need assistance and not be able to get the assistance they required. During an interview on 09/24/2025 at 6:27 PM, the Administrator said the call lights should be kept (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within the residents' reach. The Administrator said the DON was responsible for ensuring this happened. The Administrator said the call light not being within the residents' reach could compromise their safety. 2. Record review of Resident #51's face sheet dated 09/15/25 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses senile degeneration of the brain (progressive decline in cognition), impulse disorder (mental health disorder that makes it difficult to resist urges and behaviors), depressive disorder (group of conditions that lower a person's mood), and chronic pain. Record review of Resident #51's quarterly MDS assessment dated [DATE] indicated she sometimes made herself understood and usually understood others. The MDS also indicated she had a BIMS score of 0 which indicated she had severe cognitive impairment. The MDS also indicated she was dependent on staff for all of her ADLs. Record review of Resident #51's care plan dated 07/09/25 indicated she had cognitive loss related to senile degeneration of the brain with interventions to provide resident with a homelike environment. During an observation on 09/22/2025 at 10:55 AM Resident #51 was lying in bed and her call light was in the dresser drawer next to her bed. During an observation on 09/23/2025 at 9:41 AM Resident #51 was lying in her bed yelling loudly and her call light was on the floor under the bed. During an interview on 09/24/25 at 6:27PM the DON said Resident #51's call light should have always been in reach. The DON said all staff were responsible for ensuring the call light remained in resident's reach, and the failure placed a risk for Resident #51 not getting the help she needed. During an interview on 09/24/25 at 7:05 PM the Administrator said he expected the call lights to always be in reach for all residents. He said the failure placed a risk of timely care being compromised. Record review of the facility's policy titled, Call System, Residents, revised January 2025, indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. Call system communication may be audible or visual. The system may be wired or wireless. 3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. 4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment for 2 of 8 residents (Resident #51 and Resident #2) reviewed for a homelike environment. 1. The facility failed to ensure Resident #51's pillow had a pillowcase on it on 09/22/25 and 09/24/25. 2. The facility failed to ensure Resident #2's fitted sheet did not have reddish-brownish particles and multiple brown stains on it on 09/23/2025 and 09/24/2025. These failures could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: 1. Record review of Resident #51's face sheet, dated 09/15/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #51 had diagnoses which included senile degeneration of the brain (progressive decline in cognition), impulse disorder (mental health disorder that makes it difficult to resist urges and behaviors), depressive disorder (group of conditions that lower a persons mood), and chronic pain. Record review of Resident #51's quarterly MDS assessment, dated 02/25/25, indicated she sometimes made herself understood and usually understood others. Resident #51 had a BIMS score of 0, which indicated she had severe cognitive impairment. Resident #51 was dependent on staff for all of her ADLs. Record review of Resident #51's care plan, dated 07/09/25, indicated she had cognitive loss related to senile degeneration of the brain with interventions to provide the resident with a homelike environment. During an observation on 09/22/2025 at 10:55 AM revealed Resident #51 was lying in bed and did not have a pillowcase on her pillow. During an observation and interview on 09/24/25 at 5:15 PM, LVN R said she was unsure of why Resident #51 did not have a pillowcase on her pillow, but she said she should have had a pillowcase. She said the CNAs were responsible for ensuring Resident #51 had a pillowcase. LVN R said Resident #51 not having a pillowcase placed a risk for being uncomfortable. LVN R said she would not want to lay on a pillow without a pillowcase covering it. During an interview on 09/24/25 at 5:30 PM LVN R said she spoke with the CNAs that worked with Resident #51 and the CNAs said Resident #51 had a habit of fidgeting and taking her pillowcase off, so they left it off. During an interview on 09/24/25 at 6:29 PM, the DON said she expected the CNAs to put the pillowcase on for Resident #51 and if the resident removed the pillowcase the CNAs should place it back on. The DON said the failure placed a risk for discomfort for Resident #51. During an interview on 09/24/25 at 7:08 PM with the Administrator revealed he expected the CNAs to put the pillowcases on and if removed he expected staff to replace it. The Administrator said the failure placed a risk for improper sanitation and decreased dignity for Resident #51. 2. Record review of Resident #2's face sheet dated 09/15/2025 indicated she was a [AGE] year-old (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	female admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder depressive type (mood disorder with symptoms such as feelings of sadness, worthlessness, and depression), legal blindness, muscle weakness, and muscle wasting and atrophy (thinning or wasting of muscle tissue). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated she was understood and understood others. The MDS assessment indicated Resident #2's vision was severely impaired, and she had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #2 required substantial/maximal assistance with toileting, showering/bathing, lower body dressing and partial/moderate assistance with personal hygiene and upper body dressing. Record review of Resident #2's care plan reviewed 07/16/2025 indicated, she had an ADL self-care performance deficit and limited physical mobility. During an observation and interview on 09/23/2025 at 9:29 AM, Resident #2 said she was blind. Resident #2 said the CNAs did not change her sheets yesterday, she was not able to provide the names of the CNAs. Resident #2 said she did not remember when the last time her sheets were changed. Resident #2's fitted sheet had multiple brown stains on it and there were reddish-brownish particles in the bed. Resident #2's bed pad had a dried light tan stain on it. During an observation and interview on 09/23/2025 at 4:28 PM, Resident #2 said she did not know if her sheets were changed. Observed Resident #2's sheets and the top sheet and bed pad were clean, but the fitted sheet had multiple brown stains on it. During an observation and interview on 09/24/2025 at 9:53 AM, CNA K said she made Resident #2's bed and changed the sheets. CNA K removed the blanket and top sheet, and the fitted sheet still had multiple brown stains on it and there were reddish-brownish particles in the bed. CNA K said she changed the top sheet, but did not change the fitted sheet. She said she did not change it because she did not notice it was stained. CNA K said the residents' sheets were changed every other day on their shower days and if they were dirty, they should be changed. CNA K said it was the responsibility of the CNAs to ensure the residents had clean linens. She said it was important for them to have clean linens so they would feel clean. During an interview on 09/24/2025 at 9:57 AM, LVN L said the nurses were supposed to check to ensure the CNAs were changing the residents' sheets. LVN L said the residents' sheets should be changed when they were up and out of their room. LVN L said it was important for the residents' sheets to be clean for infection control and to prevent bed bugs. During an interview on 09/24/2025 at 5:22 PM, the DON said the residents' sheets should be changed every day when they were assisted out of their bed and as needed. The DON said the CNAs should be ensuring the sheets were changed and clean. The DON said it was important for the residents' sheets to be changed because it could cause the resident discomfort and it could be an infection control issue. During an interview on 09/24/2025 at 6:31 PM, the Administrator said he expected for the residents to have clean linen, and the CNAs were responsible for ensuring they had clean linens. The Administrator said it was important for sanitation and for the residents' dignity. (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Homelike Environment, revised February 2021, indicated, Residents are provided with a safe, clean, comfortable and homelike environment. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment. e. clean bed and bath linens that are in good condition.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the transfer or discharge of a resident was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider for 2 of 4 residents (Resident #8, Resident #54) reviewed for discharge. The facility failed to provide transfer and discharge documentation in the EMR for Resident #8 and Resident #54 to include a physician's orders, reason for discharge or a discharge summary. This failure could place residents at risk of an unsafe discharge. The findings include: 1. Record review of Resident #8's electronic face sheet, dated 09/23/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE] with hospitalizations on 07/28/2025, 08/05/2025, 08/26/2025, and 09/18/25 and re-admissions on 07/30/2025, 08/06/2025, 08/29/2025, and 09/20/2025. Resident #8 had diagnoses which included: End stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), Vitamin B12 deficiency anemia (a condition that occurs when the body does not have enough vitamin B12), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), heart failure, atrial fibrillation (an irregular, often rapid heart rate that commonly caused poor blood flow), major depressive disorder, seizures, and personal history of pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest) and acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). Record review of Resident #8's comprehensive MDS assessment, dated 06/14/2025, revealed a BIMS score of 15, which indicated she was cognitively intact. Record review of Resident #8's care planning notes, dated 09/23/2025, did not identify reasons for multiple hospitalizations. Record review of Resident #8's EMR, on 09/23/2025, revealed there were no discharge orders, discharge assessments, progress notes reflecting change of condition, MD or family notification or discharge summary for 07/28/2025, 08/05/2025, 08/26/2025 or 09/18/2025. Record review of Resident #8's hospital paperwork after readmission on [DATE] revealed the resident was admitted due to complaints of nausea and vomiting and was treated for gallstones which resulted in a cholecystectomy (surgical removal of gallbladder). Record review of Resident #8's hospital paperwork after readmission on [DATE] revealed the resident admitted to the hospital due to complaints of nausea and vomiting, received a new order for Ondansetron and returned to the facility. Record review of hospitalization on 08/26/2025 was attempted however, the facility was unable to provide hospital paperwork. Record review of Resident #8's hospital paperwork after readmission on [DATE] revealed the resident was admitted to the hospital due to complaints of nausea and coffee ground emesis although hospital paperwork was minimal, and treatment provided was not indicated. 2. Record review of Resident #54's electronic face sheet, dated 09/24/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on 07/31/2025 to an acute care hospital. Resident #54 had diagnoses which included: peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), discitis (a condition that involves inflammation and infection of the spine) of cervical region, urine retention, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of the bones wears down), hypertension (high blood pressure), anemia (a condition in which the blood does not have enough healthy red blood cells and protein to carry oxygen all through the body), dementia (a group of thinking and social symptoms that interferes with daily functioning), right leg atherosclerosis (a condition characterized by hardening of the arteries and restriction of blood flow). Record review of Resident #54's discharge MDS assessment, dated 07/31/2025, revealed intact short-term memory and cognitive skills for daily decision making. Record review of SLUMS (St. Louis University Mental Status Examination for detecting mild cognitive impairment and dementia) test (continued on next page)		

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results (assessment date unknown) indicated score of 12 which indicated dementia. Record review of Resident #54's care planning notes, dated 09/24/25, did not identify reasons for hospitalization. Record review of Resident #54's EMR on 09/24/25 revealed there were not discharge orders, discharge assessments, progress notes reflecting change of condition or need for hospitalizations, MD or family notification or discharge summary for 07/31/2025. Record review of NP progress noted, dated 07/25/25, revealed a vascular consult (date not identified) was pending for on-going management of chronic disease. During an interview on 09/23/2025 at 3:23 p.m., Resident #8 stated she recalled going to the hospital multiple times due to nausea and vomiting and one time, I had a surgery. Resident #8 did not recall what paperwork was sent with her to the hospital. An interview as attempted but not completed on 9/24/25 at 11:45 a.m. with Resident #54. The resident did not return to the facility after his hospitalization. During an interview on 09/23/25 at 10:29 a.m., RN A stated for resident's transferred to the hospital, she would document vital signs, reason for transfer and what hospital the resident was sent to. The RN could not recall if she documented this information consistently for all resident transfers. During an interview on 09/23/2025 at 10:50 a.m., with Medical Records Staff Employee T stated she did not have any Discharge Summaries for Resident #38 or Resident #54. During an interview on 09/24/2025 at 3:56 p.m., the DON stated she expected nursing staff to complete a physical assessment of residents prior to discharge and indicate findings in a progress note to include reason for discharge, notification of responsible party, physician and DON, indication of vital signs and complete a progress note with SBAR data. The DON stated she would provide in-services to nursing staff regarding expected documentation for discharges. During an interview on 09/24/2025 at 4:51 p.m., the Administrator stated he expected nursing staff to complete full nursing assessments, notify appropriate personnel which included the DON, provide on-site interventions and document these tasks. The Administrator stated he was not aware the nursing staff were not completing full documentation for discharges. The Administrator acknowledged that failure to complete full documentation could place residents at risk for improper discharges. Record review of the facility's Nursing Policy and Procedure, titled Transfer or discharge, Facility-Initiated, dated October 2022, revealed Facility-initiated transfers and discharges must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy, and Documentation of Facility-Initiated Transfer or Discharge, 1.the following information is documented in the medical record: a. The basis for the transfers or discharge; c. the date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the services provided, as outlined by the comprehensive care plan, met professional standards of quality, for 1 of 7 residents (Resident #2) reviewed for services provided to meet professional standards. The facility failed to ensure RN A administered Resident #2's Humalog KwikPen (insulin medication) according to the manufacturer's instructions. This failure could place residents at risk of inaccurate drug administration and not receiving the care and services to meet their individual needs. Findings included: Record review of Resident #2's face sheet, dated 09/23/25, reflected Resident #2 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) with diabetic nephropathy (complication of diabetes mellitus that affects the kidneys). Record review of Resident #2 quarterly MDS assessment, dated 07/14/25, reflected Resident #2 made herself understood, and understood others. Resident #2's BIMS score was 12, which reflected her cognition was moderately impaired. Record review of Resident #2's comprehensive care plan, dated 07/16/25, reflected Resident #2 had a diagnosis which included Diabetes Mellitus. The care plan interventions included diabetes medication as ordered by the doctor, monitor/document for side effects/effectiveness and fasting serum blood sugar as ordered by the doctor. Record review of Resident #2's physician order summary report, dated 09/23/25, reflected Resident #2 had an order for Humalog KwikPen, inject as per sliding scale, 14 units. subcutaneous before meals and at bedtime related to diabetes mellitus with a start date 09/23/25. During an observation and interview on 09/22/25 at 11:42 a.m., revealed RN A prepared Resident #2's Humalog KwikPen by removing the pen cap, placed a needle onto the pen, and turned the dose knob to 14 units. RN A administered the medication to Resident #2's RLQ. RN A did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob into 2 units before turning the dose knob to 14 units. RN A stated priming the insulin was not required before administering Resident #2's insulin. RN A stated it was important to ensure insulin was administered per the manufacturer's instructions because the resident may not get the correct dosage of insulin which could have led to uncontrolled diabetes. During a telephone interview on 09/23/25 at 9:49 a.m., the Pharmacy Consultant stated the insulin pen should be primed 2 units prior to each dose to ensure the resident was getting the correct dose. The Pharmacy Consultant stated she did a random medication pass which included insulin administration and she did not notice any issues. The Pharmacy Consultant stated it was important to prime the insulin pen to bring the insulin to the tip of the needle so the resident could receive the correct dose of insulin. During an interview on 09/24/25 at 3:21 p.m., the Regional Nurse Consultant stated her expectation was for an insulin pen to have the needle primed with 2 units prior to drawing up the dose before administration. The Regional Nurse Consultant stated the DON was responsible for ensuring insulin was properly administered through random observation and education as needed. The Regional Nurse Consultant stated it was important to properly prime the needle, so the resident got the complete dose. During an interview on 09/24/25 at 4:16 p.m., the DON stated insulin pens were to be primed with 2 units prior to administration to ensure the residents received the accurate dose. The DON stated she monitored insulin administration during check offs. The DON stated RN A insulin administration check-off should have been completed April 2025. When the DON was asked why RN A had not been checked off for her annual, she stated, I don't have an answer. The DON stated she had not noticed any issues with insulin administration in the past. The DON stated it was important to properly prime the needle to prevent hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). During an interview on 09/24/25 at 4:51 p.m., the Administrator stated insulin pens should be primed per manufacturer instructions before administration. The Administrator stated the DON was responsible for monitoring and overseeing insulin administration. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator stated it was important to properly prime the needle to ensure the accurate dose was given. Record review of the manufacture's guidelines titled Humalog KwikPen, revised 05/2025, reflected . Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Record review of the Insulin Administration policy, revised 09/2014, reflected .to provide guidelines for the safe administration of insulin to residents with diabetes. 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system (s) prior to their use.		

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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 a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 2 residents (Resident #4) reviewed for ADLs. The facility failed to ensure Resident #4's facial hair was removed. This failure could place residents at risk of not receiving services and care, and a decreased quality of life. Findings included: Record review of Resident #4's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included multiple fractures of the pelvis and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #4's Comprehensive MDS assessment dated [DATE] indicated she understood others and was understood. The MDS assessment indicated Resident #4 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #4 required partial/moderate assistance with dressing, personal hygiene, and setup or clean-up assistance with eating. Record review of Resident #4's task record indicated bathing every shift, with no signatures to indicate bathing was completed on 9/11/2025, 09/18/2025, and 09/23/2025 for the month of September 2025. Record review of Resident #4's care plan reviewed 07/31/2025 indicated she had an ADL self-care performance deficit related to limited physical mobility, and she required assistance of 1 staff for bathing. During an observation and interview on 09/22/2025 at 2:17 PM, Resident #4 was in her bed, she had multiple hairs on her chin and upper lip approximately 1-2 cm long. Resident #4 said she had not removed her facial hair, but she needed to. Resident #4 said she did not know if she was getting her baths and started talking about a different topic. During an observation on 09/24/2025 at 9:38 AM, Resident #4 was in her bed, she had multiple hairs on her chin and upper lip approximately 1-2 cm long. During an interview on 09/24/2025 at 10:13 AM, LVN L said the CNAs were responsible for removing facial hair usually this was done on the residents' shower days. LVN L said Resident #4 sometimes refused her showers because of her dementia, but the CNAs should be offering for her facial hair to be removed because she did allow them to remove it. LVN L said she had noticed Resident #4 had facial hair but had not had time to address it with the CNAs. LVN L said she was not aware of any missed showers for Resident #4. LVN L said it was important for facial hair to be removed for the resident's self-esteem and dignity. During an interview on 09/24/2025 at 4:30 PM, CNA P said she noticed Resident #4 had facial hair. CNA P said Resident #4 allowed them to shave her, and she had no excuse for not doing it. CNA P said it was important for facial hair to be removed for her to be well-groomed and because she was a woman. During an interview on 09/24/2025 at 5:48 PM, the DON said she was not aware of Resident #4 refusing for her facial hair to be removed. The DON said the CNAs were responsible for making sure facial hair was removed. The DON said it was important for the resident's dignity. During an interview with the Regional Nurse Consultant on 09/24/2025 at 7:09 PM, the policy regarding ADLs/shaving was requested and not received upon exit of the facility.		

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NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure based on the comprehensive assessment of a resident, the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 2 (Resident #41) residents reviewed for quality of care. The facility failed to ensure the Treatment Nurse conducted a skin assessment on 09/22/2025, after she was notified that Resident #41 had newly identified redness under both breasts. This failure could place residents at risk for not receiving appropriate care and treatment, a decreased quality of life, and pressure ulcers. Findings included: Record review of Resident #41's face sheet dated 09/15/2025 indicated she was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination), legal blindness, and excoriation skin-picking disorder (compulsive picking of one's skin). Record review of Resident #41's Comprehensive MDS assessment dated [DATE] indicated she was understood and understood others. The MDS assessment indicated Resident #41's vision was highly impaired, and her BIMS score was 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #41 required partial/moderate assistance with personal hygiene, showering/bathing, and toileting. The MDS assessment indicated Resident #41 did not have any ulcers, wounds, or skin problems. Record review of Resident #41's Order Summary Report dated 09/23/2025 did not indicate any orders to be applied to her skin or any wound treatments. Record review of Resident #41's Skin Assessments indicated the following: 09/17/2025 no alterations in skin integrity noted. completed by the Treatment Nurse. 09/24/2025 (conducted after surveyor intervention) moisture associated skin damage under both breast, NP notified, new order for area to be cleaned with wound cleanser or normal saline antifungal powder to be applied daily and as needed. Completed by the Treatment Nurse. - Record review of Resident #41's care plan indicated she required limited to extensive assistance of 1-2 staff with personal hygiene. Resident #41's care plan indicated she was at risk for pressure ulcers due to moisture, impaired mobility, and scratching self. Interventions included to assess for moisture problem areas such as under the breasts. During an observation and interview on 09/22/2025 at 10:45 AM, Resident #41 was in her room, and she said she had an open area on her breast that bothered her. Resident #41 tried to lift her breast to show the state surveyor but was unable to. CNA B walked into the room, and the state surveyor asked CNA B to assist Resident #41 with lifting her breast for an observation to be made. Resident #41 had redness and irritation under both breasts. The left breast had increased irritation and redness. CNA B applied powder and said she would notify the Treatment Nurse. During an interview on 09/24/2025 at 12:01 PM, CNA B said when a resident had redness, or a new skin condition identified they charted it in the electronic record and notified the treatment nurse. CNA B said she charted Resident #41's redness under her breasts in the electronic record and verbally notified the Treatment Nurse on 09/22/2025. CNA B said it was important for the nurse to be notified of newly identified skin conditions and a skin assessment be completed for it to be monitored, and because it could worsen and turn into a sore. During an interview on 09/24/2025 at 12:31 PM, the Treatment Nurse said CNA B reported to her on Monday, 09/22/2025, that Resident #41 had redness under her breasts. The Treatment Nurse said she had not completed a skin assessment to assess Resident #41. She said she had not done the skin assessment because it slipped my mind. The Treatment Nurse said when she completed the skin assessment on Resident #41 last week, she did not notice any redness underneath Resident #41's breasts. The Treatment Nurse said when she was notified by the staff of a skin issue, she should complete a skin assessment. The Treatment Nurse said it was important to complete a skin (continued on next page)		

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment to monitor the skin issue and see if it was healing or if it was worsening and so they could report it to the doctor. During an interview on 09/24/2025 at 5:27 PM, the DON said the Treatment Nurse was responsible for conducting skin assessments and treatments. The DON said if the Treatment Nurse was not available the charge nurses were responsible. The DON said the Treatment Nurse should have assessed Resident #41's skin, after she was notified by CNA B of an abnormal skin finding and notified the doctor to get orders for treatment. The DON said it was important for a skin assessment to be completed to maintain skin integrity. The DON said not completing a skin assessment after an abnormal skin finding was reported could have ill effects and the skin issue could worsen. During an interview on 09/24/2025 at 6:08 PM, the Administrator said he expected for any redness or abnormal skin finding to be assessed, treated appropriately, and for the doctor to be notified. The Administrator said if the Treatment Nurse was in the facility, it was her responsibility, if not, the charge nurses were responsible. The Administrator said unaddressed skin issues could worsen or cause more serious problems. Record review of the facility's policy titled, Prevention of Pressure Injuries, revised April 2020, indicated, .Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. Evaluate, report and document potential changes in the skin.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this was not possible or resident preferences indicate otherwise for 2 of 14 residents (Resident #4 and Resident #57) reviewed for nutrition and hydration. 1. The facility failed to provide fluids for Resident #57 to ensure adequate nutrition. 2. The facility failed to ensure Resident #4's RD recommendation for Boost VHC (nutritional supplement) four times a day was implemented, after it was recommended due to weight loss on 08/22/2025. These failures could place residents at risk for compromised hydration, malnourishment, illness, skin breakdown, and decreased quality of life. Findings include: 1. Record review of Resident #57's electronic face sheet, dated 09/24/25, revealed an [AGE] year-old male originally admitted to the facility on [DATE]. Resident #57's diagnoses included Alzheimer's dementia (most common form of dementia (most common form of dementia characterized by progressive cognitive decline), atherosclerotic heart disease (a condition characterized by build-up of plaque in the arteries), hypertension (high blood pressure), hyperlipidemia (a condition where there are high levels of fat particles in the blood), SIADH (Syndrome of Inappropriate antidiuretic Hormone Secretion, a condition when the body produces excess amounts of antidiuretic hormone leading to water retention and low sodium levels in the blood), and diabetes mellitus (a metabolic disorder characterized by high blood sugar levels over a prolonged period). Record review of the admissions BIMS assessment, dated 09/16/25, revealed Score 99 which indicated severe cognitive impairment. Record review of Resident #57's physician's orders dated 09/10/25 revealed an order for a regular texture diet and regular consistency liquids. Record review of physician's diet order, dated 09/24/25, revealed a new order for pureed texture diet, nectar consistency liquids. Record review of care plan, dated 09/10/25, revealed resident was totally dependent in all areas of ADL concern including eating and drinking. Observation of Resident #57 on 09/22/2025 at 10:02 a.m. and 2:15 p.m. revealed resident noted with dry oral cavity and cracked, dry lips. No fluids or mouth swabs were present at bedside. Observation of Resident #57 on 09/23/25 at 8:45 a.m. revealed the resident with dry mucous membranes and lips appeared chapped, cracked. Noted water pitcher with approximately 18 ounces of clear, thin liquid on bedside table. The pitcher was full to the lid with clear, thin liquid. Observation of Resident #57 on 09/24/25 at 9:35 a.m. revealed an opened packet of lemon oral swabs located on nightstand. Observed resident's oral cavity to be less dry, lips remained cracked with no emollient cream observed to have been utilized. Observed 18 ounces of clear, thin liquid in water pitcher with a straw in the same location as was observed on 09/23/25 and 4.23 ounces of thin apple juice which was unopened. During an interview on 09/24/25 at 9:00 a.m. with CNA U, CNA U stated she checked Resident #57 this morning but did not notice fluids at the bedside. CNA U stated she was told the resident was now on thickened liquids, but she was unable to identify what type of thickened liquids. During an interview on 09/24/2025 at 9:05 a.m. with LVN L, LVN L stated she was off for two days, and prior to her days off, she notified hospice that Resident #57 was not eating well and noted an overall decline in care. LVN L stated she was not aware of any changes in the diet order for this resident. During an interview on 09/24/2025 at 3:56 p.m. with the DON, the DON stated she expected staff to identify residents who were non-verbal or physically unable to provide his/her own hydration and assist with fluid intake routinely throughout each shift. The DON stated water-based emollient was available as a nursing measure for any resident with chapped / cracked lips. The DON stated she expected oral care to be provided as a nursing measure as indicated. The DON stated adverse effects of not providing adequate hydration could result in complications related to dehydration. During an interview on 09/24/2025 at 4:51 p.m. with the Administrator, the Administrator stated he expected nursing management to monitor residents at risk for hydration and ensure needs of residents were (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being met. 2. Record review of Resident #4's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included multiple fractures of the pelvis and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #4's Comprehensive MDS assessment dated [DATE] indicated she understood others and was understood. The MDS assessment indicated Resident #4 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #4 required partial/moderate assistance with dressing, personal hygiene, and setup or clean-up assistance with eating. The MDS assessment did not indicate Resident #4 had weight loss. Record review of Resident #4's Order Summary Report dated 09/23/2025 indicated an order for Boost VHC (nutritional supplement) give 60 ml by mouth two times a day with a start date of 09/12/2025. Record review of Resident #4's Medication Flowsheet dated 09/01/2025-09/30/2025 indicated, Boost VHC 60 ml twice a day with a start date of 06/12/2025. The Medication Flowsheet indicated she was receiving the Boost VHC twice a day. Record review of a progress note for Resident #4 dated 08/22/2025 indicated: RD consult for resident with a significant weight loss. Resident returned from hospital stay with weight loss.weight loss -7.32% x30d (30 days) . will recommend increasing Boost VHC to further support nutrition adequacy and promote replenishing weight lost.Increase Boost VHC 60 ml QID (four times a day) . signed by the RD. Record review of Resident #4's care plan reviewed 07/31/2025 did not address the use of nutritional supplements or her weight loss. During an interview on 09/23/2025 at 4:52 PM, RN A said Resident #4 was receiving her Boost twice a day. RN A said she was not aware of an order for Resident #4 to receive Boost four times a day. RN A said the ADON was responsible for monitoring weight loss and the RD's recommendations, but the ADON left last month, and she was not sure who took over the role. RN A said the DON monitored the residents' weights. RN A said since Resident #4 was not receiving the Boost four times a day as recommended by the RD, she was not receiving the proper nutrients, and she could lose more weight. During an interview on 09/24/2025 at 5:30 PM, the DON said she was responsible for making the changes the RD recommended. The DON said she was not aware of the RD's recommendation to increase Resident #4's Boost VHC to four times a day. The DON said she may have missed that one. The DON said since the Boost VHC was not increased, Resident #4's nutrition could be affected. During an interview on 09/24/2025 at 6:11 PM, the Administrator said the RD's recommendations should be followed and addressed appropriately. The Administrator said the DON and Dietary Manager were responsible for following up on the RD's recommendations. The Administrator said if the RD's recommendations were not followed the resident's body weight or health could be compromised. Record review of the Nutrition Recommendation Form completed by the RD on 08/22/2025, indicated, Resident #4 Dietician Recommendations Boost VHC 60 ml four times a day. Record review of the facility's Dietitian Consultants undated policy, indicated, .Significant Weight Changes a. RD to assess resident with significant weight changes on a monthly basis.e. It is recommended to have a weight meeting with RD and nursing staff during the second week of the month, subsequent to RD's weight report review and analysis. Fortified [additional calories and protein for weight loss, underweight, increased nutrient needs] . Record review of the facility's policy titled, Resident Hydration and Prevention of Dehydration, revised October 2017, revealed the following: 6. Nurses' aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. 7. If potential inadequate intake and/or signs .dehydration are observed .monitoring will be initiated and incorporated into the care plan.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, based on a resident's comprehensive assessment, a resident was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 2 residents (Resident #17) reviewed for enteral nutrition. The facility failed to ensure Resident #17 received Isosource 1.5 (liquid nutrition tube-feeding formula) as ordered by the physician on 09/22/2025. This failure could place residents at risk of weight loss, nutritional imbalances, and health complications. Findings included: Record review of a face sheet dated 09/15/2025 indicated Resident #17 was a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) and gastrostomy (creation of an external opening into the stomach to provide nutrition). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #17 was usually understood and understood others. The MDS assessment indicated Resident #17 had a BIMS score of 5, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #17 required partial/moderate assistance with toileting and personal hygiene, showering/bathing self and set-up or cleanup assistance for eating. The MDS assessment did not indicate Resident #17 had a feeding tube. Record review of Resident #17's Order Summary Report dated 09/23/2025 indicated: Isosource 1.5 (liquid nutrition tube-feeding formula) at 50 ml/hr via g-tube with a start date of 09/11/2025 May use Diabetisource 1.2 (tube feeding formula designed for individuals with diabetes) at 50 ml/hr until Isosource 1.5 arrives with an order date of 09/22/2025. Record review of Resident #17's undated Medication Administration Record indicated, may use diabetisource 1.2 50 ml/hr until Isosource 1.5 arrives dated 09/22/2025 signed completed for the 6 PM-6 AM shift. There was no signature for the 6 AM-6 PM shift. Resident #17's MAR did not indicate the order for Isosource 1.5 (liquid nutrition tube-feeding formula) at 50 ml/hr via g-tube with a start date of 09/11/2025. Record review of Resident #17's care plan reviewed 07/31/2025 indicated she had a cerebral vascular accident (stroke) if resident was unable to swallow, give enteral feeding (nutrition delivered into the gut through a tube inserted through the abdominal wall) as ordered by the physician. During an observation on 09/24/2025 at 10:32 AM, Resident #17 had Diabetisource 1.2, feeding, connected to her g-tube at 50 ml/hr dated 09/22/2025. During an interview on 09/23/2025 at 3:41 PM, RN H said when she arrived to her shift (6 PM-6AM) yesterday (09/22/2025) she went to Resident #17's room and noticed Diabetisource was running. RN H said there was not any Isosource, so she called the doctor, and he said they could use the Diabetisource until the Isosource was available. RN H said prior to yesterday (09/22/2025) her last shift worked was Thursday (09/18/2025), and on Thursday (09/18/2025) Resident #17 had Isosource. RN H said it was important for Resident #17 to have the correct feeding because she may not get the correct minerals and vitamins that she needed, and she could get sick and start losing weight. During an interview on 09/24/2025 at 3:36 PM, LVN D said the Diabetisource for Resident #17 was changed by the night nurse, LVN N, prior to the start of her shift at 6 AM on 09/22/2025. LVN D said LVN N reported to her there was no more Isosource. LVN D said she had not notified the doctor of the incorrect feeding being administered because she did not catch it until RN H arrived for her shift at 6 PM. LVN D said if they ran out of a feeding formula, they should notify the doctor and get the order to use a different formula. LVN D said Resident #17 having the incorrect formula could result in her having an allergic or negative reaction, and she may not receive the right amount of calories she needed. During an interview on 09/24/2025 at 4:24 PM, LVN N said she did not know why the Diabetisource was administered. She said she worked Sunday night (6 (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM-6 AM), and Resident #17's feeding should have been Isosource. LVN N said she thought she administered the correct feeding. LVN N said it was important for the correct feeding to be administered so the resident could get the correct nutrients. During an interview on 09/24/2025 at 5:43 PM, the DON said she was notified there was no more Isosource by the nurses over the weekend. The DON said because of the transition of companies they had issues ordering the Isosource. The DON said it was between Sunday, 09/21/2025, and Monday, 09/22/2025, Resident #17 was switched to the Diabetisource. The DON said if they did not have the Isosource available the nurses should have called the doctor to obtain an order for the Diabetisource until the Isosource was available. The DON said Resident #17 not having the correct feeding formula could result in nutritional deficiencies. During an interview on 09/24/2025 at 6:29 PM, the Administrator said he expected the feeding formulas to be followed per the doctor's orders, and the DON was responsible for ensuring this happened. The Administrator said Resident #17 having the incorrect feeding could compromise her nutritional requirements. Record review of the facility's policy titled, Enteral Nutrition, revised November 2018, indicated, Adequate nutritional support through enteral nutrition is provided to residents as ordered.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents (Residents #30) reviewed for respiratory care. 1. The facility failed to ensure Resident #30's oxygen filter was clean in the back of the concentrator on 09/22/25-09/24/25. 2. The facility failed to ensure Resident #30's oxygen tubing and water was dated, on 09/22/25. 3. The facility failed to ensure Resident #30 had an order in place to ensure oxygen tubing and water were changed and dated, and the filter was cleaned weekly on Sundays. These failures could place residents at risk for respiratory infections and exacerbation of respiratory disease. Findings included:1. Record review of Resident #30's face sheet, dated 09/15/25, indicated a [AGE] year-old-male who was admitted to the facility on [DATE]. Resident #30 had diagnoses which included chronic systolic congestive heart failure (disease in which the heart muscle cannot pump blood effectively), sleep apnea (sleep disorder in which breathing stops and starts repeatedly), atrial fibrillation (an irregular often rapid heart rate that causes poor blood flow), and high blood pressure. Record review of Resident #30's admission MDS assessment, dated 08/25/25, indicated he was understood by others and made himself understood. Resident #30 had a BIMS score of 7, which meant he had severe cognitive impairment. Resident #30 required moderate assistance with transfers and bed mobility, maximal assistance with toileting and bathing, and setup for eating. Record review of Resident #30's care plan, dated 09/23/25, did not indicate his oxygen use. Record review of Resident #30's order summary report did not indicate an order for changing and cleaning the oxygen tubing, water and filter. During an observation and interview on 09/22/25 at 10:32 AM revealed Resident #30 was lying in the bed with oxygen on set at 2L/M. The oxygen filter was dirty with thick gray fuzzy matter and no dates on oxygen water or tubing. During an observation and interview on 09/23/2025 at 9:37 AM Resident was lying in bed asleep with oxygen on set at 2L/M. He said he was feeling better today. Resident #30's oxygen water and tubing was dated 9/22/25 but the oxygen filter continued to be dirty with thick gray fuzzy matter. During an observation and interview on 09/24/25 at 5:05 PM, LVN R and the state surveyor looked at the oxygen filter and LVN R said the filter was dirty and the charge nurses were supposed to change the oxygen filters and tubing out on Sundays and clean the filters as well. She said the failure placed a risk for Resident #30 not getting accurate air supply and risk for him breathing in bacteria. During an interview on 09/24/25 at 6:08 PM, the DON said the nurses were responsible for cleaning and changing the filters and the water weekly. She said Resident #30 should have had an order in place when the oxygen order was placed to ensure those things were being completed. The DON said the failures placed a risk for Resident #30 not getting the accurate percentage of the oxygen and not breathing in clean air which could have caused upper respiratory infections. During an interview on 09/24/25 at 7:12 PM, the Administrator said the concentrators should have been maintained appropriately. He said the charge nurses should have been cleaning and changing the filters as ordered. The Administrator said the failures placed a risk for health and safety concerns. He said he would think Resident #30 would not be getting the accurate amount of oxygen with the filter being that dirty. Record review of the facility's policy Oxygen Administration, revised October 2010, indicated: PurposeThe purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation1. Verify that there is a physician's order for this procedure. Review the physician's orders, facility protocol for oxygen administration.2. Review the resident's care plan to assess any special needs of the resident.3. Assemble the equipment and supplies as needed.General Guidelines1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter.Weekly Documentation1. Oxygen/nebulizer tubing/masks to be changed by nursing department, weekly, and documented in the electronic health record.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 6 residents (Resident #57) reviewed for pain management. The facility failed to monitor and record pain levels per physician's order for Resident #57. This deficient practice could place residents at risk of experiencing pain, undue pain and mental distress. The findings were: Record review of Resident #57's electronic face sheet, dated 09/24/25, revealed an [AGE] year-old male originally admitted to the facility on [DATE]. Resident #57 had diagnoses which included Alzheimer's dementia (most common form of dementia characterized by progressive cognitive decline), atherosclerotic heart disease (a condition characterized by build-up of plaque in the arteries), hypertension (high blood pressure), hyperlipidemia (a condition where there are high levels of fat particles in the blood), SIADH (Syndrome of Inappropriate Antidiuretic Hormone Secretion, a condition when the body produces excess amounts of antidiuretic hormone leading to water retention and low sodium levels in the blood), and diabetes mellitus (a metabolic disorder characterized by high blood sugar levels over a prolonged period). Record review of Resident #57's admissions BIMS assessment, dated 09/16/2025, revealed a score of 99, which indicated severe cognitive impairment. Record review of Resident #57's physician's orders, dated 9/10/25, revealed an order for a Pain Assessment to be completed every shift. Record review of Resident #57's September MAR revealed a pain level of 0, assessed and recorded on 09/15/25 on the night shift. No other pain assessment levels were indicated. Record review of Resident #57's nursing progress notes, dated 8/1/25-9/10/25, completed on paper charting did not reveal any documentation which indicated a pain assessment was completed every shift. Record review of Resident #57's care plan revealed the resident was assessed as receiving hospice services with the goal that the resident would be comfortable with no signs or symptoms of pain or distress. Observation of Resident #57 on 09/22/25 at 10:02 a.m. revealed non-verbal communications with strained facial expression and non-sensical calling out. Observation of Resident #57 on 09/23/25 at 8:45 a.m. revealed the resident lying in bed, responsive with groans only to verbal stimuli. Observation of Resident #57 on 09/24/25 at 9:35 a.m. revealed the resident lying in bed, eyes closed, unlabored breathing and moaning in response to verbal stimuli. Observation of Resident #57 on 09/24/25 at 4:45 p.m. with family member [] at bedside, resident observed with facial grimacing. During an interview on 9/22/25 at 1:36 p.m., the family member of Resident #57 revealed she felt the resident was not getting enough to drink and she wished staff would check on him more often. During an interview on 9/24/25 at 9:05 a.m. with LVN L, LVN L revealed she noticed Resident #57 had an overall decline in health. LVN stated she was not aware there was an order on the MAR that required staff to assess resident's pain level. During an interview on 09/24/25 at 3:56 p.m. with the DON, the DON stated if a resident had orders for every shift pain assessment, she expected nursing staff to complete assessments, record pain level in the MAR or utilize Wong-Baker Assessment Scale for non-verbal residents. The DON stated a blank MAR would indicate the assessment was not completed and adverse effects of not assessing for pain could result in the resident experiencing pain unnecessarily. During an interview on 09/24/25 at 4:51 p.m. with the Administrator, the Administrator stated he expected nursing staff to follow physician's orders and notify the physician of any concerns. The Administrator stated the failure to follow orders could mean a resident experienced unnecessary pain. During an interview on 09/24/25 at 4:51 p.m. with the Administrator, the Administrator stated he expected nursing staff to follow physician's orders and notify the physician of any concerns. The Administrator stated the failure to follow orders could mean a resident experienced unnecessary pain.		

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NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that licensed staff were able to demonstrate the specific competencies, and skill sets necessary to care for resident's needs for 1 of 1 resident (Resident #2) and 2 of 2 nursing staff (RN A and CNA K) reviewed for competencies. 1. The facility did not perform RN A's annual skill checkoffs on obtaining a fingerstick glucose level and insulin administration. 2. The facility failed to conduct CNA K's competency assessment to ensure she demonstrated competency in the use of the mechanical lift. These failures could place the residents at risk of receiving care from staff who do not have the training and competency needed for providing care. Findings included: 1. During an observation and interview on 09/22/25 at 11:42 a.m., RN A performed hand hygiene, applied a set of gloves and prepared to obtain fingerstick blood sugar for Resident #2. RN A gathered a glucometer (measures the amount of sugar in the bloodstream at a specific time), lancet (device used to prick the skin for a small blood sample), 1 test strip, and alcohol wipe and placed them on the dining table where Resident #2 was seating. RN A pricked Resident #2's index finger with a lancet needle but was unable to get blood. RN A doffed (off) and don (on) new gloves without cleansing her hands or using hand sanitizer. RN A gathered another lancet, test strip and alcohol wipe and placed it on the dining table again. RN A pricked Resident #2's middle finger with a lancet needle then wiped off the blood from the finger using a small alcohol wipe. RN A squeezed the pricked finger to collect blood for glucose testing. RN A picked up the supplies which included lancet needle and disposed of the used lancet in the trash can on her medication cart. RN A then prepared Resident #2's Humalog KwikPen by removing the pen cap, placing a needle onto the pen, and turning the dose knob to 14 units. RN A administered the medication to Resident #2's RLQ. RN A did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob into 2 units before turning the dose knob to 14 units. RN A stated priming the insulin was not required before administering Resident #2's insulin. RN A stated it was ok to place the glucometer, lancet, alcohol wipe and test strip on the resident's dining table without having a barrier between it. RN A stated it was important to ensure insulin was administered per the manufacturer's instructions because the resident may not get the correct dosage of insulin which could lead to uncontrolled diabetes. During an interview on 09/22/25 at 11:50 a.m., RN A stated she should have performed hand hygiene between gloves changes and cleaned the glucometer between each resident. RN A stated it was ok to place the glucometer, lancet, alcohol wipe and test strip on the resident's dining table without having a barrier between it. During an interview on 09/24/25 at 4:16 p.m., the DON stated insulin check offs should be completed upon hire, annually, and as needed. The DON stated RN A's check-off should have been completed April 2025. When asked why she had not been checked off for her annual, the DON stated, I don't have an answer. The DON stated she was responsible for making sure the competencies were completed in a timely manner. The DON stated she had a log where she kept their annual proficiency dates that she reviewed monthly. The DON stated it was important to ensure staff carry out their task appropriately and according to the policies. During an interview on 09/24/25 at 4:51 p.m., the Administrator stated insulin administration competency should be checked annually for compliance. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated it was important that RN A was (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked off for insulin administration and blood sugar check off to ensure care was appropriately given. 2. Record review of Resident #2's face sheet dated 09/15/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder depressive type (mood disorder with symptoms such as feelings of sadness, worthlessness, and depression), legal blindness, muscle weakness, and muscle wasting and atrophy (thinning or wasting of muscle tissue). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated she was understood and understood others. The MDS assessment indicated Resident #2's vision was severely impaired, and she had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #2 required substantial/maximal assistance with toileting, showering/bathing, lower body dressing and partial/moderate assistance with personal hygiene and upper body dressing. The MDS assessment indicated Resident #2 was dependent on staff for transfers. Record review of Resident #2's Order Summary Report dated 09/23/2025 did not indicate the use of the mechanical lift (mechanical lift). Record review of Resident #2's care plan reviewed 07/16/2025 indicated, she had a potential for injury related to previous falls, unsteady gait, visual deficits, attempted to stand unassisted and lost balance easily. Interventions included 2 staff to assist resident during transfers. During an observation and interview on 09/24/2025 at 9:01 AM, CNA K was observed coming out of Resident #2's room with the mechanical lift. There were no other staff members observed in Resident #2's room. Resident #2 said CNA K transferred her from her bed to the wheelchair, and she was not comfortable in her wheelchair. CNA K said she transferred Resident #2 with the use of the mechanical lift by herself. During an interview on 09/24/2025 at 9:49 AM, CNA K said the use of the mechanical lift probably required 2 staff, but she was not sure because at some facilities only one staff was required. CNA K said she thought they may have trained her on the use of the mechanical, but it had been a while. During an interview on 09/24/2025 at 11:26 AM, the DON said she did not have a competency check for the mechanical for CNA K. The DON said the competency checks should be completed upon hire. During an interview on 09/24/2025 at 5:23 PM, the DON said transferring with the mechanical lift required 2 staff. The DON said the charge nurse, the therapy director, or herself were responsible for completing the competency checks for the mechanical lift. The DON said completing CNA K's competency check for the mechanical was missed. The DON said it was important for the staff's competency to be assessed to ensure the staff were doing the transfers correctly. During an interview on 09/24/2025 at 6:05 PM, the Administrator said he expected for all training to be completed to ensure compliance. The Administrator said the DON was responsible for ensuring trainings were completed. The Administrator said it was important to ensure the staff had thorough training so they could provide the appropriate care. Record review of the facility's policy revised, July 2017, titled, Lifting Machine, Using a Mechanical, (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. Record review of the facility's policy titled, Staffing Sufficient and Competent Nursing, indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident and determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 3 of 20 residents (Resident #2, Resident #33, and Resident #62) reviewed for pharmacy services. 1. The facility failed to ensure there was not a delay in administering Resident #33's Lasix (diuretic removed fluid) and Potassium when they were ordered on 09/15/2025 and not administered until 09/19/2025. 2. The facility failed to ensure Resident #62's daptomycin (antibiotic) was administered on 04/02/2025. 3. The facility did not ensure RN A administered Resident #2's Humalog KwikPen (insulin medication) according to the manufacturer's instructions. These failures could place the residents at risk of not having medications available for use, medications errors, and inaccurate records. Findings included: 1. Record review of Resident #33's face sheet dated 09/15/2025 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included chronic embolism and thrombosis of unspecified veins of the bilateral lower extremities (condition of chronic blood clots in the veins of the lower legs or feet) and hypertension (high blood pressure). Record review of Resident #33's Comprehensive MDS assessment dated [DATE] indicated Resident #33 was understood by others and understood others. The MDS assessment indicated Resident #33 had a BIMS score of 10, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #33 required partial/moderate assistance with toileting, dressing, and personal hygiene. Resident #33's MDS assessment did not indicate he received a diuretic. Record review of a Telephone Order for Resident #33 dated 09/15/2025 indicated: Lasix 20 mg take 1 tablet daily by mouth at 7:00 AM for edema Potassium 20 meq take 1 tablet daily by mouth at 7:00 AM as a supplement to Lasix for 5 days. Record review of Resident #33's Order Summary Report dated 09/24/2025 indicated Lasix (furosemide) 20 mg give 1 tablet by mouth in the morning with a start date of 09/19/2025. There was no order for potassium. Record review of Resident #33's MAR for September 2025 indicated: Furosemide (Lasix) 20 mg take 1 tab daily for edema administered 09/19/2025-09/23/2025. Potassium 20 meq take 1 tablet daily for supplementation administered 09/19/2025-09/23/2025. Record review of Resident #33's care plan revised 09/23/2025 indicated he was unable to self-administer medications related to cognitive impairment. Interventions included medications would be administered at the preferred time as ordered and by licensed or certified team members. During an interview on 09/23/2025 at 5:01 PM, RN A said she was not sure if Resident #33 was (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to receive Lasix or Potassium. RN A said it had not been reported to her from the other nurses that he had orders for these medications. During an interview on 09/24/2025 at 10:24 AM, LVN L said she contacted the NP due to Resident #33's swelling to his lower extremities, and she received an order for Lasix 20 mg daily and Potassium 20 meq daily, both for 5 days, from the NP on 09/15/2025. LVN L said she did not administer the Lasix and Potassium on 09/15/2025 because Resident #33 did not want it that late in the day. LVN L said on 09/15/2025 she ordered Resident #33's Lasix and Potassium from the pharmacy. LVN L said after this she was off for 2 days, and when she returned, she learned the medication was still not in the facility. LVN L said on 09/15/2025, when she left, she gave report to LVN M and reported the new orders for Resident #33. LVN L said when she returned on 09/19/2025, and realized Resident #33's medications were not in the facility she contacted the pharmacy, the medications were delivered, and they were administered. LVN L said she had not contacted the doctor to let him know Resident #33's medications were not administered. LVN L said it was important for Resident #33 to receive the ordered medications to get the fluid off of him, and not administering them when ordered could result in him having shortness of breath and increased swelling. 2. Record review of Resident #62's face sheet dated 09/23/2025 indicated Resident #62 was a [AGE] year-old female admitted to the facility on [DATE] and discharged on 04/04/2025 with diagnoses which included fracture of the lower end of the right femur (fracture of the right bone between the knee and the hip). Record review of Resident #62's MDS assessment dated [DATE] indicated she understood others and was understood by others. The MDS assessment indicated she had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #62 required partial/moderate assistance with toileting, showering, and dressing. The MDS assessment indicated Resident #62 received IV medications while a resident at the facility. Record review of Resident #62's Baseline Care Plan dated 04/02/2025 indicated she required IV medications/fluids. Record review of Resident #62's Physician Order report dated 04/01/2025 indicated: 04/02/2025-04/06/2025 daptomycin in 0.9% sodium chloride 500 mg/ml 500 mg intravenous once a day. Record review of Resident #62's Medication Administration Record dated 04/01/2025-04/16/2025 indicated daptomycin in 0.9% sodium chloride 500 mg/ml 500 mg intravenous once a day 04/02/2025 not administered reason indicated drug/item unavailable signed by RN A. 04/03/2025 administered. Record review of Resident #62's progress notes dated 04/01/2025-04/04/2025 did not indicate her daptomycin was not administered. During an interview on 09/23/2025 at 5:13 PM, RN A said she did not know why Resident #62 missed a dose of her daptomycin. RN A said Resident #62's medications were ordered when she admitted and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Avir at Citizens Trail		STREET ADDRESS, CITY, STATE, ZIP CODE 1008 Citizens Trail Texarkana, TX 75501	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have arrived the following day. RN A said if a medication did not arrive the nurse should call the pharmacy. RN A said she did not remember if she notified the pharmacy or the NP that Resident #62 missed a dose of her daptomycin, but since it was the protocol she thought she probably did. RN A said Resident #62's missed dose of her medication could postpone getting rid of the infection. During an interview on 09/24/2025 at 5:33 PM, the DON said when the nurses received a telephone order they should write the order, put it on the MAR, document in the nurses' notes, and send a copy of the telephone order or call the pharmacy for them to send the medication. The DON said if the medication did not arrive to the facility the nurse should call the pharmacy, notify the doctor to let him know the medication was not administered, and get new medication orders. The DON said she did not remember Resident #62 missing a dose of her daptomycin. The DON said prior to today she was not aware there was a delay in administering Resident #33's Lasix and Potassium. The DON said the residents not receiving medications as ordered could result in a delay in their treatment and have an ill effect on the residents. During an interview on 09/24/2025 at 6:17 PM, the Administrator said he expected medication orders to be followed through appropriately, and when missed it should be addressed with the patient's physician for any change in the orders. The Administrator said the DON was responsible for this. The Administrator said not administering medications as ordered could compromise the patient's health. During an interview on 09/24/2025 at 7:04 PM, the Pharmacy Technician said Resident #62's daptomycin was ordered 04/01/2025, and it was delivered 04/02/2025 between 3 PM and 5 PM. The Pharmacy Technician said Resident #33's Lasix and Potassium were ordered the morning of 09/19/2025, and they were delivered the same day around 5 PM. 3. Record review of Resident #2's face sheet, dated 09/23/25, reflected Resident #2 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) with diabetic nephropathy (complication of diabetes mellitus that affects the kidneys). Record review of Resident #2 quarterly MDS assessment, dated 07/14/25, reflected Resident #2 made herself understood, and understood others. Resident #2's BIMS score was 12, which reflected her cognition was moderately impaired. Record review of Resident #2's comprehensive care plan, dated 07/16/25, reflected Resident #2 had diabetes mellitus. The care plan interventions included diabetes medication as ordered by the doctor, monitor/document for side effects/effectiveness and fasting serum blood sugar as ordered by the doctor. Record review of the physician order summary report, dated 09/23/25, reflected Resident #2 had an order for Humalog KwikPen, inject as per sliding scale . 14 units. subcutaneous before meals and at bedtime related to diabetes mellitus with a start date 09/23/25. During an observation and interview on 09/22/25 at 11:42 a.m., RN A prepared Resident #2's Humalog KwikPen by removing the pen cap, placing a needle onto the pen, and turning the dose knob to 14 units. RN A administered the medication to Resident #2's RLQ. RN A did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob into 2 units before turning the dose knob to 14 units. RN A stated priming the insulin was not required before administering Resident #2's insulin. RN A stated it was important to ensure insulin was administered per the manufacturer's (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructions because the resident may not get the correct dosage of insulin which could have led to uncontrolled diabetes. During a telephone interview on 09/23/25 at 9:49 a.m., the Pharmacy Consultant stated the insulin pen should be primed 2 units prior to each dose to ensure the resident was getting the correct dose. The Pharmacy Consultant stated she did a random medication pass which included insulin administration, and she did not notice any issues. The Pharmacy Consultant stated it was important to prime the insulin pen to bring the insulin to the tip of the needle, so the resident received the correct dose. During an interview on 09/24/25 at 3:21 p.m., the Regional Nurse Consultant stated her expectation was for an insulin pen to have the needle primed with 2 units prior to drawing up the dose. The Regional Nurse Consultant stated the DON was responsible for ensuring insulin was properly administered through random observation and education as needed. The Regional Nurse Consultant stated it was important to properly prime the needle so that the resident received the complete dose. During an interview on 09/24/25 at 4:16 p.m., the DON stated insulin pens were to be primed with 2 units prior to administration to ensure the residents received the accurate dose. The DON stated she monitored insulin administration during check offs. The DON stated RN A insulin administration check-off should have been completed April 2025. RN A stated she had not been checked off this year. When asked why she had not been checked off for her annual, she stated I don't have an answer. The DON stated she had not noticed any issues with insulin administration in the past. The DON stated it was important to properly prime the needle to prevent hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). During an interview on 09/24/25 at 4:51 p.m., the Administrator stated insulin pens should be primed per manufacturer instructions before administration. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated it was important to properly prime the needle to ensure the accurate dose was given. Record review of the manufacture's guidelines titled Humalog KwikPen, revised 05/2025 reflected. Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Record review of the Insulin Administration policy, revised 09/2014, reflected. to provide guidelines for the safe administration of insulin to residents with diabetes. 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system (s) prior to their use. Record review of the facility's policy titled, Physician's Orders, revised February 2025, indicated, The purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services. A current list of orders must be maintained in the electronic record of each resident.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675958	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure that residents were free of significant medication errors for 1 of 1 resident (Resident #2) reviewed for insulin administration. The facility did not ensure RN A administered Resident #2's Humalog KwikPen (insulin medication) according to the manufacturer's instructions. This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of Resident #2's face sheet, dated 09/23/25, reflected Resident #2 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included Type 2 diabetes mellitus (lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) with diabetic nephropathy (complication of diabetes mellitus that affects the kidneys). Record review of Resident #2 quarterly MDS assessment, dated 07/14/25, reflected Resident #2 made herself understood, and understood others. Resident #2's BIMS score was 12, which reflected her cognition was moderately impaired. Record review of Resident #2's comprehensive care plan dated 07/16/25 reflected Resident #2 had Diabetes Mellitus. The care plan interventions included diabetes medication as ordered by the doctor, monitor/document for side effects/effectiveness and fasting serum blood sugar as ordered by the doctor. Record review of the physician order summary report, dated 09/23/25, reflected Resident #2 had an order for Humalog KwikPen, inject as per sliding scale . 14 units. subcutaneous before meals and at bedtime related to diabetes mellitus with a start date 09/23/25. During an observation and interview on 09/22/25 at 11:42 a.m., RN A prepared Resident #2's Humalog KwikPen by removing the pen cap, placing a needle onto the pen, and turning the dose knob to 14 units. RN A administered the medication to Resident #2's RLQ. RN A did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob into 2 units before turning the dose knob to 14 units. RN A stated priming the insulin was not required before administering Resident #2's insulin. RN A stated it was important to ensure insulin was administered per the manufacturer's instructions because the resident may not get the correct dosage of insulin which could have led to uncontrolled diabetes. During a telephone interview on 09/23/25 at 9:49 a.m., the Pharmacy Consultant stated the insulin pen should be prime 2 units prior to each dose to ensure the resident was getting the correct dose. The Pharmacy Consultant stated she did a random medication pass which included insulin administration, and she did not notice any issues. The Pharmacy Consultant stated it was important to prime the insulin pen to bring the insulin to the tip of the needle so the resident can receive the correct dose. During an interview on 09/24/25 at 3:21 p.m., the Regional Nurse Consultant stated her expectation was for an insulin pen to have the needle prime with 2 units prior to drawing up the dose. The Regional Nurse Consultant stated the DON was responsible for ensuring insulin was properly administered through random observation and education as needed. The Regional Nurse Consultant stated it was important to properly prime the needle so that the resident gets the complete dose. During an interview on 09/24/25 at 4:16 p.m., the DON stated insulin pens were to be primed with 2 units prior to administration to ensure the residents received the accurate dose. The DON stated she monitored insulin administration during check offs. The DON stated RN A insulin administration check-off should have been completed April 2025. RN A stated she had not been checked off this year. When asked why she had not been checked off for her annual, stated I don't have an answer. The DON stated she had not noticed any issues with insulin administration in the past. The DON stated it was important to properly prime the needle to prevent hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). During an interview on 09/24/25 at 4:51 p.m., the Administrator stated insulin pens should be primed per manufacturer instructions before administration. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated it was important to properly prime the needle to ensure the accurate dose was given. Record review of the manufacture's guidelines titled Humalog KwikPen (continued on next page)		

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

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 05/2025 reflected. Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Record review of the Insulin Administration policy, revised 09/2014, reflected. to provide guidelines for the safe administration of insulin to residents with diabetes. 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system (s) prior to their use. Record review of the facility's policy titled, Physician's Orders, dated February 2025, indicated, The purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services. A current list of orders must be maintained in the electronic record of each resident.		

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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 accommodate residents' food preferences for 1 of 3 residents (Resident #21) reviewed for preferences. The facility failed to honor Resident #21's preference for double meat for the lunch meals on 09/22/2025 and 09/23/2025. This failure could place residents at risk for a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: Record review of Resident #21's face sheet dated 09/15/2025 indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included schizoaffective disorder, bipolar type (mood disorder with symptoms such as hallucinations, delusions, depression) and profound intellectual disabilities (significant limitations in cognitive function and limits abilities to live independently). Record review of Resident #21's Comprehensive MDS assessment dated [DATE] indicated he was able to make himself understood and understood others. The MDS assessment indicated Resident #21 had a BIMS score of 10, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #21 was independent for eating. The MDS assessment indicated Resident #21 required a therapeutic diet. Record review of Resident #21's Order Summary Report dated 09/24/2025 did not indicate any diet related orders. Record review of Resident #21's care plan reviewed 06/17/2025 indicated he required a therapeutic diet as evidenced by no added salt and regular texture with thin liquids to serve diet as ordered. Resident #21's care plan did not further address giving him double meat for all meals. Record review of Resident #21's lunch meal tickets dated 09/22/2025 and 09/23/2025 indicated double meat all meals. During an observation on 09/22/2025 at 11:54 AM, Resident #21 was in the dining room, his lunch meal had one beef pepper steak. During an interview on 09/22/2025 at 2:32 PM, Resident #21 said he did not know he was supposed to get double meat portions, but it may be, so he did not stay hungry. During an observation and interview on 09/23/2025 at 12:04 PM, Resident #21 did not receive double meat portions. The MDS Coordinator said she did not check the trays today. She said RN A checked them, but she did check them yesterday (09/22/2025). The MDS Coordinator said Resident #21 was not served double portions because they did not serve the second portion until the resident finished the first portion of the meat. The MDS Coordinator said Resident #21 needed the double meat portions to keep him from having weight loss. During an interview on 09/23/2025 at 12:35 PM, the Dietary Manager said Resident #21 received double meats because he requested it. The Dietary Manager said the cook missed serving the double meats to Resident #21. The Dietary Manager said when the cook served the meals they were supposed to put the double portions on the tray, and then the nurses checked the trays to ensure they were correct. The Dietary Manager said since Resident #21 had not received the double portions he could still be hungry and could start losing weight. During an interview on 09/23/2025 at 12:41 PM, RN A said she was responsible for checking the trays in the dining room today (09/23/2025). RN A said she did not catch that Resident #21 was not served double portions of meat. RN A said he received double meat portions because he did not eat anything else on his tray. RN A said since Resident #21 did not receive the double meat portions he may not stay as full as he wanted, and it could lead to weight loss. During an interview on 09/24/2025 at 5:26 PM, the DON said the nurses were responsible for checking the meal trays. The DON said the Dietary Manager was responsible, as well, for ensuring the kitchen staff followed the meal tickets. The DON said Resident #21 not receiving double meat portions could cause him to be upset and feel like they did not consider his wants and needs. During an interview on 09/24/2025 at 6:01 PM, the Administrator said he expected for the staff to follow the meal tickets and the residents' preferences. The Administrator said the Dietary Manager was responsible for ensuring the meal tickets and the residents' preferences were followed. The Administrator said this was important for the residents' nutrition and for them to have an enjoyable (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meal. Record review of the facility's policy titled, Food and Nutrition Services, revised October 2017, indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Reasonable efforts will be made to accommodate resident choices and preferences. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided.		

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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 ensure safe and sanitary storage of resident's food items for 1 of 2 residents reviewed for personal food safety. (Residents #30) The facility did not develop or implement the personal food policy related to personal refrigerators for Residents #30. This failure could place residents at risk for food borne illnesses. Findings included: 1. Record review of Resident #30's face sheet, dated 09/15/25, indicated he was a [AGE] year-old-male who admitted to the facility on [DATE] with the diagnoses chronic systolic congestive heart failure (disease in which the heart muscle cannot pump blood effectively), sleep apnea (sleep disorder in which breathing stops and starts repeatedly), atrial fibrillation (an irregular often rapid heart rate that causes poor blood flow), and high blood pressure. Record review of Resident #30's admission MDS assessment, dated 08/25/25, indicated he was understood by others and made himself understood. The MDS also indicated he had a BIMS score of 7 which meant he had severe cognitive impairment. The MDS also indicated he required moderate assistance with transfers and bed mobility, maximal assistance with toileting and bathing, and setup for eating. Record review of Resident #30's care plan, dated 09/23/25, did not indicate his ADL care. During an observation and interview on 09/23/25 at 9:37 AM, Resident #30's refrigerator had no thermometer in it. The refrigerator did not have a paper with dates and temperatures. The refrigerator had 2 cokes, 2 packages of sandwich meat and one capri sun drink in it. Resident #30 said he did not know about the thermometer, but he ate his food when he did not like what the facility had for meals. During an interview on 09/24/25 at 12:50 PM, the Administrator said the facility did not have a policy for personal refrigerators. During an interview on 09/24/25 at 5:13 PM, the Treatment Nurse said every resident should have had a thermometer in their refrigerators and a log of temperatures on the refrigerators to ensure they are on the correct temperatures for the foods not to spoil. During an interview on 09/24/25 at 6:30 PM, the DON said she expected a thermometer to be in the room, and she said she would normally provide one, but she was not aware Resident #30 had a personal refrigerator. She said the Housekeeping Supervisor should have monitored the temperatures on all residents' personal refrigerators. The DON said the Housekeeping Supervisor had a book that she kept the resident personal refrigerator temperatures in. The DON said the failure placed a risk is for food not being at correct temperatures or safe for eating. During an interview on 09/24/25 at 6:40 PM, the Housekeeping Supervisor said she kept a log of residents' refrigerator temperatures. She said Resident #30 had just received his refrigerator about a week ago and she had not taken a temperature of his refrigerator since he had it. The Housekeeping Supervisor said the Maintenance Supervisor usually placed the thermometers in the residents' refrigerators and she kept a log of the temperatures. The Housekeeping Supervisor said she was aware Resident #30 did not have a thermometer, but she would put a thermometer in Resident #30's refrigerator on 09/24/25. During an interview on 09/24/25 at 7:10 PM, Administrator said all residents with personal refrigerators should have been monitored by staff for correct temperatures for sanitation and safety concerns. The Administrator the staff should have been checking the temperatures timely. He said the failure placed a risk for health and safety for the residents.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 2 of 5 residents (Resident #6 and Resident #5) review for accuracy of records. The facility failed to ensure Resident #6's diet order was updated to reflect resident signed waivers and matched the dietary meal ticket. The facility failed to complete admission assessments for Residents #5 within 24 hours following their admission to the facility on [DATE] and 08/15/25. This failure could place residents at risk of improper care due to inaccurate records and identifying information. Findings included: 1. Record review of Resident #6's face sheet, dated 09/15/25, revealed a [AGE] year-old male admitted [DATE] with no hospitalizations. Review of diagnoses revealed dysphagia (difficulty swallowing), dementia (a group of conditions that cause a decline in cognitive abilities), bipolar disorder (a mental health condition that causes extreme mood swings), atrial fibrillation (a heart rhythm disorder), chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways), hypertension (high blood pressure). Record review of Resident #6's comprehensive MDS, dated [DATE], revealed BIMS Score of 4 indicating severe cognitive impairment. Record review of Resident #6's MDS revealed resident was independent in self-feeding, required supervision in bed mobility, maximum assistance in transfers and was dependent in toileting, bathing, and dressing. Record review of Resident #6's Care Plan, dated 07/09/25, revealed the resident signed a diet waiver refusing nectar thickened liquids and preferred thin liquids and received a pureed textured diet. Record review of Resident #6's physician's orders revealed an order dated 03/11/25 (d/c'd 04/11/25) for mechanical soft texture with nectar thickened liquids; and order dated 04/11/25 (d/c'd 04/22/25) for mechanical soft texture; and order dated 04/22/25 (d/c'd 05/06/25) for pureed texture; and an order for 05/06/25 (d/c'd 05/07/25) for pureed texture, thin liquids. Record review of current diet order revealed resident received a pureed textured diet. Record review of Refusal of Care or Treatment form, dated 04/11/25, revealed Resident #6 signed a form to discontinue nectar thickened liquids. Record review of Refusal of Care or Treatment form dated 04/11/25 revealed resident signed a second form to discontinue puree diet. Record review of physician's orders revealed that diet order dated 08/26/25 for pureed texture was d/c'd on 09/24/25 and new order reflects regular texture and consistency. [KA5] During an interview with the Dietary Manager on 09/24/25 at 11:00 a.m., the Dietary Manager stated that discrepancy was corrected in the Care Plan Meeting held today after surveyor identified discrepancy in diet card and physician's order. During an observation on 04/22/25 at 10:41 a.m., Resident 36 was observed with regular textured snack items on the nightstand. During an interview on 09/23/25 at 4:49 p.m., LVN D stated resident #6 received a regular diet and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she believed he signed a waiver. During an interview on 09/23/25 at 4:54 p.m. the DON stated she was not aware there was a discrepancy with current diet order, diet care (meal ticket) and the signed waivers. During an interview on 9/24/25 at 11:06 a.m., CNA U stated he was not aware or did not recall if resident signed a diet waiver. During an interview on 09/24/25 at 3:56 p.m. the DON stated that she expected the nursing staff to input diet changes accurately to the electronic medical record system as indicated. The DON stated that failure to accurately record orders to include diet order changes could result in harm or injury to resident. During an interview on 09/24/25 at 4:51 p.m. the Administrator stated that he expected monitoring of nursing documentation for all new orders to ensure accuracy of records and that nothing was missed for the residents that could cause harm. 2.Record review of Resident #5's face sheet, dated 09/23/25, indicated she was a [AGE] year-old female who admitted to the facility on [DATE] and re-admitted on [DATE] with the diagnoses vascular dementia (disease in which there is a decline in memory and thinking related to blocked blood flow to the brain), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), high blood pressure, and aphasia (language disorder that affects the ability to communicate). Record review of Resident #5's admission MDS assessment, dated 08/21/25, indicated she sometimes made herself understood and she sometimes understood others. The MDS indicated she had a BIMS score of 1 which indicated she was severely cognitively impaired. The MDS indicated Resident #5 required moderate assistance with toileting, baths, and dressing, and she was independent with transfers and bed mobility, and required supervision with eating. Record review of Resident #5's EMR on 09/23/25 indicated she did not have a care plan implemented. Resident #5 had a care plan for a previous stay dated 07/10/23. Record review of Resident #5's EMR on 09/24/25 at 12:20 PM indicated she did not have an admission assessment completed for her admission on [DATE] nor did she have re-admission assessment completed on 08/15/25 when she returned from a 4-day hospital visit. Record review of Resident #5's paper chart on 09/24/25 at 12:24 PM indicated she had an undated incomplete admission assessment for her admission on [DATE] created by LVN S. Record review of Resident #5's paper chart on 09/24/25 at 12:24 PM indicated she did not have a re-admission assessment completed on 8/15/25. During a telephone interview on 09/24/25 at 4:11 PM, LVN S said she worked at the facility on the 6:00 pm to 6:00 AM shift and said she did recall working on the date Resident #5 admitted to the facility. LVN S said she thought she completed the admission assessment. She said she was not sure, but she thought the admission assessments had to be completed within 24 hours of the admission. She said on 08/09/24 the day shift nurse should have completed the admission assessment. LVN S said she really did not know the risk of the failure of not completing the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission assessment for Resident #5, but she would have thought the staff would have to find out how to care for Resident #5 without the admission assessment being completed. During an interview on 09/24/25 at 4:40 PM, LVN C said she started a day or two after Resident #5 admitted to the facility. She said she did not know how long they had to complete an admission assessment when a resident admitted. She said it should have been a re-admit assessment completed when she returned from the hospital on [DATE] but she was unsure if she had to complete it or not. LVN C said the failure placed a risk for decreased care related to not knowing what went on with resident after hospital visit or what care was needed to be provided. During an interview on 09/24/25 at 5:25PM, the MDS Nurse said she never worked the floor and did not know what or when each admission or readmit assessment should have been completed. She said she used the admission assessment as part of her information for MDS assessments but could not remember Resident #5's admission assessments not being completed. During an interview on 09/24/25 at 6:15PM, the DON said LVN S was responsible for ensuring the admission assessment for Resident #5 was completed. The DON said the admission assessment should have been completed in 24 hours. She said the charge nurse LVN C should have completed a re-admit admission assessment on 8/15/25 when Resident #5 returned from a hospital visit since her discharge was more than 3 days. The DON said the failure placed a risk for Resident #5 not having all the information from the hospital for care, and no care plan. During an interview on 09/24/25 at 7:00PM, the Administrator said the nurse had to complete the admission assessments within 24 hours of admission. He said a re-admission assessment should have been completed for Resident #5 after being discharged more than 72 hours. The Administrator said he expected the admission assessments to be completed timely as related to guidelines. He said the charge nurses were responsible for completing the admission assessments, but he expected the DON to follow up to ensure the assessments were completed. The Administrator said the failure placed risk for Resident #5's health and safety being compromised. Record review of facility policy and procedure titled, Physician's Orders, dated February 2025, revealed 3. A current list of orders must be maintained in the electronic record of each resident and 5. Physician's orders are essential for the comprehensive care of the residents. These orders encompass dietary plans. Review of facility policy and procedures titled, Food and Nutrition Services, dated October 2017, revealed 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. a. If an incorrect meal is provided, nursing staff will report to FSS so that a new food tray can be obtained. During an interview on 09/24/25 at 12:50 PM the Administrator said the facility did not have a policy for assessments.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observations, interviews, and record review, the facility failed to follow established policy regarding smoking areas, and smoking safety for 1 of 1 facility. The facility did not ensure staff kept their smoking material stored properly on 09/22/25. This failure could place residents and staff at risk of unsafe smoking and injury. Findings included: During an observation and interview on 09/22/25 at 9:49 a.m., a 1/2 smoked cigarette was observed next to the toaster in the kitchen. [NAME] Q stated the cigarette belonged to her and it should not be at the workstation next to the toaster. [NAME] Q stated her personal belonging should be stored in her bag. [NAME] Q stated it was important that cigarettes were stored in her bag to prevent a fire. During an observation and interview on 09/22/25 at 10:59 a.m., a cigarette was observed in a filing cabinet in the laundry room. The Housekeeping Supervisor stated the cigarette belonged to a PRN staff that will no longer come back. The Housekeeping Supervisor stated cigarettes should be stored in a cigarette cart in their personal bag. The Housekeeping Supervisor stated she monitored staff by conducting compliance spot checks. The Housekeeping Supervisor stated it was important to store cigarettes properly to prevent a fire in a non-smoking area. During an interview on 09/24/25 at 2:31 p.m., the Dietary Manager stated cigarettes should be stored in their personal bag until the staff went to the smoking area of the facility. The Dietary Manager stated she monitored staff compliance by daily rounds. The Dietary Manager stated it was important to store cigarettes away from where food was to prevent cross-contamination and a fire. During an interview on 09/24/25 at 4:51 p.m., the Administrator stated cigarettes should remain in the cigarette cart while in the building and stored in an area inaccessible to residents. The Administrator stated department managers were responsible for monitoring their assigned area for staff compliance. The Administrator stated cigarettes should be stored properly due to their flammable nature. Record review of an undated facility floor plan reflected the designated smoking area outside the main dining room. Record review of the Employee Handbook, dated 04/2025 did not address where smoking materials should be kept while not in the designated smoking area.		