

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Avir at Texarkana		STREET ADDRESS, CITY, STATE, ZIP CODE 4925 Elizabeth St Texarkana, TX 75503	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 memory care units and 2 of 9 residents (Resident #1 and Resident #2) reviewed for adequate supervision to prevent accidents. The facility failed to ensure the residents in the Unit 2 Memory Care were adequately supervised while CNA C was in another resident's room getting residents up for breakfast and there was no other staff in the memory unit on 10/09/25, which left residents unsupervised in the dining area resulting in Resident #1 and Resident #2 getting into an altercation. This failure could place residents at an increased risk of injury. Findings included: 1. Record review of Resident #1's face sheet dated 11/05/25 revealed he was [AGE] years old and admitted to the facility initially on 1/22/21 and re-admitted [DATE]. Resident #1 had diagnoses including Alzheimer's disease (progressive neurodegeneration (brain deterioration) that affects memory, thinking, and behavior), dementia (forgetfulness), schizoaffective disorder (a mental health condition that combined symptoms of schizophrenia and a mood disorder, such as depression (persistent sadness) or bipolar (extreme mood swings), muscle weakness, lack of coordination, glaucoma (progressive eye disease that could lead to vision loss), hallucinations (a person perceived something that was not actually present in their environment), anxiety (nervousness), and repeated falls. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated he was understood and understood others. Resident #1 had impaired vision. Resident #1 had a BIMS of 1, which indicated he had severe cognitive impairment. The MDS indicated Resident #1 did not have behaviors. Resident #1 used a wheelchair for mobility. Resident #1 was dependent on staff or required substantial assistance in performing most ADLs. Resident #1 was able to wheel self in his wheelchair. Record review of Resident #1's undated Care Plan Report indicated he was at risk for elopement and resided on the secured unit. Resident #1 was at risk for falls. Resident #1 had impaired physical mobility. Resident #1 had impaired social interaction 10/09/25 as evidenced by resident was noted hitting another resident in the dining room. Resident #1 had impaired visual function. Record review of Resident #1's Progress Notes dated 10/09/25 indicated RN D was notified by CNA (not named in note) that Resident #2 and Resident #1 were in the dining room hitting each other. Resident #1 was sitting in his wheelchair wheeling himself into the dining room, Resident #2 was sitting in the chair at table right at the doorway and Resident #2 started hitting Resident #1. The resident was assessed, and no injuries were noted. 2. Record review of Resident #2's face sheet dated 11/05/25 revealed he was [AGE] years old and admitted to the facility initially on 5/06/25 and re-admitted [DATE]. Resident #2 had diagnoses including cerebral infarction (stroke-disruption of blood flow to the brain, resulting in brain tissue damage or death), schizophrenia (chronic mental health condition characterized by a combination of symptoms that significantly impair a person's thinking, feeling, and behaving), abnormalities of gait and mobility, and lack of coordination. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated he was understood and understood others. Resident #2 had a BIMS of 11, which indicated he had moderate cognitive impairment. The MDS indicated Resident #2 had physical behavioral symptoms directed toward others one to three days. The MDS did not indicate Resident #2 had behaviors. Resident #2 required supervision to moderate assistance for most ADLs but was independent with ambulation. Record review of Resident #2's undated Care Plan Report indicated he used psychotropic medication (medication that affects a person's mental state) for behavioral management and on 8/22/25 he was aggressive with staff, 10/03/25 hit a resident with a toy, and 10/09/25 was seen hitting another resident. Resident #2 was an elopement risk and was placed on the secured unit due to disruptive behaviors and would walk up to resident and start arguments. Record review of Resident #2's Progress Notes dated 10/09/25 indicated RN D was notified by CNA (not named in note) that Resident #2 and Resident #1 were in the dining room hitting each other. Resident #1 was sitting in his wheelchair wheeling himself into the dining room, Resident #2 was sitting in the chair at table right at the doorway and Resident #2 started hitting Resident #1. The resident was assessed, and no injuries were noted. During an interview on 11/06/25 at 9:06 AM, RN D said she had worked at the facility since June 2025 and normally worked the 6 AM - 2 PM shift until the facility changed to twelve-hour shifts. RN D said she usually was the nurse for 100 (Unit 1 Memory Care), 200 (Unit 2 Memory Care), and the left side of 300 hall. RN D said a few residents could be aggressive toward other residents, which included Resident #2. RN D said Resident #2 was pretty quiet and did his own thing. RN D said if they tried to redirect Resident #2 he</p>		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. 1. The facility failed to ensure Dishwasher A wore a facial covering to cover facial hair while serving food in the kitchen on 11/05/25. 2. The facility failed to ensure Dishwasher A wore a hairnet and facial covering to cover his hair and facial hair while in the kitchen area on 11/06/25. 3. The facility failed to ensure [NAME] B wore a facial covering to cover facial hair while preparing food in the kitchen on 11/06/25. These failures could place residents at risk for food contamination. Findings included: During initial tour observations and interview of the kitchen on 11/05/25 beginning at 4:35 PM, revealed [NAME] G was plating food and Dishwasher A was adding drinks and desserts to the meal tray and covered the food with a plate cover. Dishwasher A was noted to have facial hair above his upper lip and on his chin approximately 1/2 inch long and was not wearing facial covering to cover facial hair. [NAME] G said they did not have a Dietary Manager at this time. [NAME] G said they did have an Assistant Dietary Manager, [NAME] E. During an observation and interviews on 11/06/25 beginning at 2:24 PM, revealed [NAME] B was in the kitchen preparing food for the next meal service. [NAME] B was noted to have approximately 1/4 to 1/2 inch facial hair covering his lower face and was not wearing a facial covering to cover his facial hair. [NAME] B said all staff should be wearing hair nets and a facial covering if they had facial hair while in the kitchen, which included anything behind the two doors and he pointed at the kitchen door and dishwashing side door, to prevent hair from getting in the residents' food. There was a plastic bag with hair nets in it hung just outside of the dishwashing side of the kitchen. Dishwasher A was in the dishwashing side of the kitchen washing dishes. Dishwasher A was noted to have facial hair above his upper lip and chin and was not wearing a hairnet or facial covering to cover his hair or facial hair. Dishwasher A said he had been working at the facility for a couple of months. Dishwasher A said he had been educated to wear a hair net and facial covering when serving food, but he did not know he needed to wear them while washing dishes. Dishwasher A said he knew he should have been wearing facial covering yesterday (11/05/25) while serving food and just forgot. Dishwasher A said wearing hair nets and facial coverings were to keep hair out of the resident's food. Dishwasher A said if he was not wearing a hair net or facial covering in the kitchen, anything could happen, like hair could get in the residents' food. Dishwasher A said he did not know how it could affect the residents. On 11/06/25 at 2:49 PM and at 5:15 PM, Interim Dietary Manager H was called. There was no answer and unable to leave a voicemail. During an interview on 11/06/25 at 3:33 PM, the ADM F said he was the Interim ADM and had been at the facility since 10/27/25 this time. ADM F said the facility had gone through a lot of staffing changes and the facility did not have a Dietary Manager at the time, but they had an Interim Dietary Manager. ADM F said Interim Dietary Manager H was currently on leave. ADM F said staff should be wearing hairnets and facial coverings for facial hair when behind the kitchen doors to prevent food contamination. ADM F said he expected staff to follow the policies of the facility. During an interview on 11/10/25 at 9:20 AM, [NAME] E said she had worked at the facility for over 30 years. [NAME] E said everyone that entered the kitchen area, including the dishwashing side, should be wearing a hairnet and if they had facial hair, then they would need facial covering. [NAME] E said kitchen staff should be wearing hairnets/facial covering because hair could fall in anything and get in the resident's food. [NAME] E said hair could contaminate the resident's food. Record review of the facility's policy titled Food Preparation and Service dated revised November 2022, indicated . Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices . food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness . Food Distribution and Service . 8. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food .</p>		