STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676069	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Texarkana	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the resident's representative and hospice services when there were changes in the resident's physical, mental, or psychosocial status for 1 of 11 residents (Resident #1) reviewed for notification of changes.The facility failed to notify Resident #1's hospice agency and her RP of a falls on [DATE] and [DATE] The facility failed to notify Resident #1's hospice agency and her RP of bruising to her hand and foot on [DATE]. The facility failed to notify Resident #1's RP of behavioral changes or medication changes on [DATE]. The facility failed to notify Resident #1's RP of two falls, behavioral changes, and medication changes on [DATE].The facility failed to notify Resident #1's RP of a fall on [DATE]. These failures could place residents at risk of not receiving adequate and timely intervention and a decline in condition. Findings included:Record review of Resident #1's face sheet dated [DATE] indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #1 had diagnoses which included cerebral infarction (stroke-disruption of blood flow to the brain causing tissue damage), hemiplegia and hemiparesis (paralysis (unable to move) and/or muscle weakness on one side of the body) of right side, mood disorder, anxiety disorder, Alzheimer's (progressive brain disorder that causes gradual memory loss, abnormal thinking, difficulty with daily activities and leads to brain shrinkage and death), weakness lack of coordination, repeated falls, and abnormality of albumin (protein in blood). Resident #1's RP was listed on the face sheet.Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was sometimes understood and sometimes understood others. She was unable to complete the BIMS because she was rarely/never understood. Resident #1 required substantial/maximal assistance from staff for most ADLs. Resident #1 was always incontinent of bowel and bladder. Resident #1 had no falls since prior assessment. Resident #1 was receiving hospice services.Record review of Resident #1's undated Care Plan indicated she was receiving hospice services related to terminal diagnosis of Alzheimer's and decline was expected. Resident #1 used anti-anxiety medications (used to treat anxiety) and on [DATE] resident was noted flailing arms and constantly attempting to roll and scoot out of the bed. Resident #1 was an elopement risk and resided on the secured unit. Resident #1 was at risk for falls related to confusion, deconditioning, and gait/balance problems; on [DATE] she scooted onto the floor, no injuries noted, on [DATE] she slid off the bed onto the fall mat with no injuries noted, on [DATE] resident rolled out of the bed, no injuries noted, on [DATE] resident rolled out of the bed onto the fall mat, no injuries noted, and [DATE] bruises noted to resident's body. Resident #1 had fall interventions including following the facility fall protocol, was noted with terminal restlessness and agitation, flailing in bed, and hospice was notified and medications reviewed dated initiated [DATE].Record review of Resident #1's nurse's note dated [DATE] at 6:42 PM indicated RN A documented she was notified by the CNA (not named) that resident slid off the bed in low position to fall mat before she could get to her. RN A assessed the resident, and she had no signs of pain, redness/bruising to any area and could move all extremities. There was no documentation that RN A notified Resident #1's RP or hospice service of the fall. Record review of Resident #1's nurse's note dated [DATE] at 10:30 AM indicated LVN B documented the resident slid onto the floor with no injury or concerns. There was no documentation that LVN B notified Resident #1's RP or hospice service of the fall.Record review of Resident #1's nurse's note dated [DATE] at 7:42 AM indicated LVN B documented the aide (not named) noticed bruising on resident's right hand pinky and middle finger knuckle and bruising on top of her left foot. LVN B documented she evaluated the rest of Resident #1's body and did not see anything else out of the way. There was no documentation LVN B notified Resident #1's RP or hospice services of the bruising. LVN B documented at 12:34 PM, Resident #1 was hitting her hands on the dining table, upset, trying to hit the CNAs, and acting out with other residents, and LVN B administered her anxiety and pain medication. LVN B documented an order was received from the hospice physician to give Ativan 2 mg (anti-anxiety medication) and hydrocodone 7.5 mg one hour before scheduled time if needed for increased agitation or mood swings. There was no documentation LVN B notified Resident #1's RP of behavior changes or medication changes. Record review of Resident #1's nurse's note dated [DATE] at 7:00 AM indicated LVN B documented resident rolled out of the bed onto the fall mat with pillow under her and there was no injury. LVN B documented there was no new bruising at that time. LVN B notified hospice service and was instructed to monitor resident. There was no documentation LVN B notified Resident #1's RP of fall. LVN B documented at 10:58 AM, Resident #1 was really agitated this morning trying to get out of the bed on her own, aides were having to

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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. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical record maintained for each resident were complete and accurately documented for 1 of 11 residents (Resident #1) reviewed for resident records. The facility failed to ensure LVN C documented the incident/fall on 11/20/2025 reported by the hospice aide (CNA G). This failure could place residents at risk for delayed interventions, appropriate interventions, health complications and decreased quality of life. Findings include:Record review of Resident #1's face sheet dated 12/03/25 indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #1 had diagnoses which included cerebral infarction (stroke-disruption of blood flow to the brain causing tissue damage), hemiplegia and hemiparesis (paralysis (unable to move) and/or muscle weakness on one side of the body) of right side, mood disorder, anxiety disorder, Alzheimer's (progressive brain disorder that causes gradual memory loss, abnormal thinking, difficulty with daily activities and leads to brain shrinkage and death), weakness lack of coordination, repeated falls, and abnormality of albumin (protein in blood).Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was sometimes understood and sometimes understood others. She was unable to complete the BIMS because she was rarely/never understood. Resident #1 required substantial/maximal assistance from staff for most ADLs. Resident #1 was always incontinent of bowel and bladder. Resident #1 had no falls since prior assessment. Resident #1 was receiving hospice services.Record review of Resident #1's undated Care Plan indicated she was receiving hospice services related to terminal diagnoses of Alzheimer's and decline was expected. Resident #1 used anti-anxiety medications (used to treat anxiety) and on 11/17/25 resident was noted flailing arms and constantly attempting to roll and scoot out of the bed. Resident #1 was an elopement risk and resided on the secured unit. Resident #1 was at risk for falls related to confusion, deconditioning, and gait/balance problems. Resident #1 had fall interventions including following the facility fall protocol, was noted with terminal restlessness and agitation, flailing in bed, and hospice was notified and medications reviewed dated initiated 11/19/25.Record review of Resident #1 nurse's notes dated 11/20/25 did not reveal any documentation of resident falling between 4:00 AM-4:30 AM or notification of Resident #1's RP of fall. LVN C was the nurse on duty during that time.During an interview on 12/03/2025 at 12:14 PM, Resident #1's RP said the morning of 11/20/2025 the hospice aide, CNA G came in to bathe Resident #1 and found Resident #1 in the floor thrashing around and CNA G hollered for twenty minutes trying to get help and there was not anyone else in the secured unit. Resident #1's RP said CNA G ended up moving Resident #1 to where she felt safe to leave her because there was a television on a bedside table that she was afraid would fall on Resident #1 and had to go outside the secured unit to get the nurse. Resident #1's RP said the night shift nurse (LVN C) did not document anything about the incident in Resident #1's chart. Resident #1's RP said she had reviewed Resident #1's chart on 11/20/2025 with the day shift nurse (LVN B) and there was no documentation from the night shift nurse (LVN C) of the incident or the fall.During an interview on 12/03/2025 beginning at 3:01 PM, Hospice Representative H said apparently the hospice aide, CNA G, had gone in early the morning of 11/20/2025 and found Resident #1 on the floor and CNA G called her after getting the facility nurse because CNA G thought the facility was mad at her for not getting the nurse sooner. Hospice Representative H said CNA G told her Resident #1 was thrashing and rolling around on the floor and CNA G did not think she could leave Resident #1 right then and moved the television away that was on a bedside table, so it did not fall on Resident #1. Hospice Representative H said CNA G told her she opened Resident #1's door and kind of hollered out for help but not too loud because she did not want to wake everyone up. Hospice Representative H said CNA G decided to get Resident #1's bed changed so it would be ready for her to get put back in as she waited for someone in the secured memory unit. Hospice Representative H said CNA G told her when she still did not find anyone, CNA G went outside the secured unit to get the nurse. Hospice Representative H said after CNA G told her what had gone on, she reported off to Hospice Representative J who reported off to Resident #1's RP and their hospice RN made a visit to assess Resident #1. Hospice Representative H brought Hospice Representative J into the call. Hospice Representative H and Hospice Representative J said they never suspected Resident #1 had been abused. Hospice Representative J said Resident #1 had behaviors they were trying to manage with medications, and they had multiple fall mats and a mat against the wall because she was very active and would flail her arms and legs and fall off the bed