STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745021	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lindale	13905 Fm 2710 Lindale, TX 75771

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 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 observation, interview, and record review the facility failed to protect the residents' right to be free from physical abuse and neglect for 2 of 11 residents (Resident #4 and #5) reviewed for abuse, neglect, and exploitation in that: The facility failed to ensure Resident #4 was free from physical abuse on 10/6/25 at approximately 6:00 a.m. when CNA F grabbed her by the arm causing a skin tear. The facility failed to ensure Resident #5 was free from neglect on 5/14/25 when CNA G left her unattended in the shower. Resident #5 did not suffer an injury. These failures could place all residents at risk of loss of dignity, injury, and hospitalization.Findings included: Resident #4 Review of an admission Record dated 12/11/25 for Resident #4 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of history of transient ischemic attack (stroke), cognitive communication deficit (impaired communication), muscle wasting and atrophy, and COPD (chronic obstructive pulmonary disease).Record review of a quarterly MDS dated [DATE] indicated Resident #4 had severely impaired cognition with a BIMS of 7. She required moderate assistance with eating, upper body dressing, and personal hygiene; she required maximal assistance with oral hygiene, toileting hygiene, shower/bath, lower body dressing, and putting on/taking off footwear. She was always incontinent of bowel and bladder.Record review of a comprehensive care plan dated 6/8/25 indicated Resident #4 had an ADL self-care performance deficit related to fatigue, impaired balance, limited mobility, limited range of motion, and musculoskeletal impairment. Appropriate interventions were in place including limited/moderate assistance with dressing. Resident #6Review of an admission Record dated 12/11/25 for Resident #6 indicated she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of mild cognitive impairment of uncertain or unknown etiology (impaired cognition unknown cause), cognitive communication deficit (difficulty communicating), and encephalopathy (altered mental state).Record review of a comprehensive care plan dated 6/26/24 indicated Resident #6 had potential for impaired thought processes related to mild cognitive impairment. Appropriate interventions were in place including maintaining consistent routine, monitoring for changes in cognition, and providing consistent caregivers as much as possible to decrease confusion.Review of Resident #4's nursing progress note by RN J dated 10/6/25 at 9:06 a.m. indicated .At approximately 0520, the staff aid rolled the resident into the dining area to wait for breakfast. The resident sat there for about 10 minutes, and nurse rolled resident back to her room because she was bleeding under her left arm sleeve. Skin tear located on superior side of left forearm. Nurse cleaned with saline water and dressed in strips and bandage. Resident stated that the incident happened by agency aid being too rough with her.Review of an incident report dated 10/6/25 at 5:30 a.m. indicated Resident #4 sustained a skin tear in her room. Resident #4's description of the event indicated I was telling her to stop and she was being too rough. A note in the same incident report indicated Resident was clearly able to state what happened to her.Review of a skin assessment dated [DATE] at 5:55 a.m., completed by RN J indicated Resident #4 had a skin tear on her left antecubital (inner part of elbow). During an interview on 12/9/25 at 10:55 a.m., Resident #4 said she could not recall the incident and did not want to speak to surveyor.Review of a written statement regarding incident involving Resident #4 by RN J dated 10/6/25 indicated .Nurse walked over to help the resident and noticed large circle of blood on the resident's shirt on her left forearm. Nurse asked resident what happened and resident stated that girl was being too rough with me, I told her to stop!.Once in room, nurse provided privacy and resident in B bed was crying about her own experience with aide. Resident B told nurse that aide had been too rough with resident in Bed A. Bed B also said that Bed A told the aide that she was bleeding prior to her shirt being put on. Bed B said that she heard her saying stop, you're being too rough, you're hurting me, you cut me. Resident in Bed B said that aide continued to dress the resident and she didn't heard her say anything.During an interview on 12/10/25 at 11:45 a.m., Resident #6, who was Resident #4's roommate, said she could not recall any incident of alleged abuse. Resident #6 said she had not been abused or mistreated in the facility.Review of a skin assessment dated [DATE] at 11:25 a.m. indicated Resident #6 had edema to bilateral lower extremities but no other alterations in skin integrity and no complaints of pain.Review of a phone interview on 10/6/25 at 8:40 a.m. conducted by ADM with CNA F regarding incident with Resident #4 indicated .When asked about the incident she responded that she went in to assist resident with morning ADL care to get her ready for breakfast. During transfer she reported resident was leaning forward, grabbing at her bed and wheelchair. During this process a skin tear to residents left arm happened. Attempted telephone interviews with CNA F

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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. (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 0677 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 observation, interview, and record review the facility failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 3 of 11 residents (Resident #1, #2 and #3) reviewed for ADL care in that: The facility failed to ensure Resident #1 was provided appropriate incontinent care on 12/9/25 at 2:00 p.m. when she was observed wearing two briefs (double briefed) at the same time.The facility failed to ensure Resident #2 and Resident #3 was provided appropriate incontinent care at an unknown date and time when they said they had been double briefed in the facility.This failure could place all residents at risk of loss of dignity, skin breakdown, infection, and hospitalization.Findings included: Resident #2 Review of an admission Record dated 12/9/25 for Resident #2 indicated she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of chronic respiratory failure, chronic heart failure, type 2 diabetes, abnormal gait and mobility, and generalized weakness. Record review of an annual assessment MDS dated [DATE] indicated Resident #2 had moderately impaired cognition with a BIMS of 8. She required setup/cleanup assistance with eating and oral hygiene; she required maximal assist upper body dressing; she required total assist for toileting hygiene, shower/bath, lower body dressing, and putting on/taking off footwear. Record review of a comprehensive care plan dated 5/25/24 indicated Resident #2 had bowel and bladder incontinence related to diagnosis of immobility and obesity. Appropriate interventions was in place including check resident as required for incontinence and change disposable brief as needed. During an interview on 12/9/25 at 10:15 a.m., Resident #2 said staff had double briefed her as often as they can get away with. Resident #2 said she could not recall any specific dates or staff members involved. During an observation on 12/9/25 at 11:00 a.m., Resident #2 was assisted with incontinent care by CNA C. Resident #2 was not double-briefed and no concerns of skin integrity were noted. Review of a skin assessment dated [DATE] indicated Resident #2 had no alterations in skin integrity noted. Resident #3 Review of an admission Record dated 12/9/25 for Resident #3 indicated she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of functional quadriplegia (inability to move), type 2 diabetes, and morbid obesity.Record review of a quarterly MDS dated [DATE] indicated Resident #3 had intact cognition with a BIMS of 15. She required setup/cleanup assistance with eating; she required supervision for oral hygiene; she required moderate assist for personal hygiene; she required maximal assistance for upper body dressing; she was dependent on staff for toileting hygiene, shower/bath, lower body dressing, and putting on/taking off footwear. She was always incontinent of bowel and bladder.Record review of a comprehensive care plan dated 12/3/25 indicated Resident #3 was at risk for UTIs and skin breakdown related to bladder and bowel incontinence. Appropriate interventions was in place including monitor every 2 hours and change brief promptly for incontinent episodes. During an interview on 12/9/25 at 1:10 p.m., Resident #3 said facility staff had put two briefs on her in the past. Resident #3 said she could not recall specific details of when it happened or what staff members were involved. Resident #3 said she was not double briefed right now. Review of a skin assessment dated [DATE] indicated Resident #3 had rash to her groin with no other alterations in skin integrity.Resident #1Review of an admission Record dated 12/9/25 for Resident #1 indicated she was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of Unspecified Dementia (altered cognition), cognitive communication deficit (impaired ability to communicate), and age-related physical debility. Record review of an annual assessment MDS dated [DATE] indicated Resident #1 had severely impaired cognition with a BIMS of 5. She required setup/cleanup assistance with eating; she required moderate assistance with oral hygiene, upper body dressing, and personal hygiene; she required maximal assistance with toileting hygiene, shower/bath, lower body dressing, and putting on/taking off footwear. She was always incontinent of bowel and bladder.Record review of a comprehensive care plan dated 2/3/25 indicated Resident #1 had bowel and bladder incontinence related to diagnosis of dementia. Appropriate interventions were in place including check resident as required for incontinence and change disposable brief as needed. Record review of a comprehensive care plan dated 7/19/25 indicated Resident #1 had a history of UTIs. Appropriate interventions was in place including check every 2 hours for incontinence, and wash, rinse, and dry soiled areas.During an observation on 12/9/25 at 2:00 p.m., CNA A and CNA B assisted Resident #1 with incontinent care. Resident #1 was observed to be wearing two briefs, both saturated with urine. There was redness noted to her buttocks, barrier cream was applied by CNAs During an interview on 12/9/25 at 2:15 p.m., CNA A said she had seen other residents