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	06/10/2026

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide personal privacy when providing care for 1 of 9 (Resident #3) residents reviewed for privacy. The facility did not ensure CNA D and CNA E pulled the privacy curtain while providing incontinent care for Resident #3 on [DATE]. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth.Findings included: Record review of the face sheet dated [DATE] indicated Resident #3 was a [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses including Myasthenia Gravis (a condition that causes weakness in the voluntary muscles), lack of coordination, cognitive communication deficit (an impairment in communication), and weakness. Record review of the MDS dated [DATE] indicated Resident #3 sometimes understood others and was usually understood by others. The MDS indicated Resident #3 did not have a BIMS score. The MDS indicated Resident #3 was dependent on staff for toileting. Record review of the care plan revised [DATE] indicated Resident #3 had an ADL self-care performance deficit related to confusion, fatigue, impaired balance, and limited mobility. Record review of a progress note dated [DATE] indicated Resident #3 expired in the facility. Record review of video footage from electronic monitoring indicated on [DATE] at 5:59 pm 2 CNAs performed incontinent care on Resident #3. The video footage indicated the CNAs did not pull the privacy curtain during incontinent care. The video footage indicated Resident #3's roommate was sitting up in bed while incontinent care was being provided on Resident #3. The video footage indicated the CNAs spoke with Resident #3's roommate while providing care. During an interview on [DATE] at 12:52 p.m. CNA E said she had worked the night shift on [DATE]. CNA E said Resident #3 was already in bed when she started her shift on [DATE]. During an interview on [DATE] at 1:33. CNA D said she had worked the night shift on [DATE]. CNA E said Resident #3 was already in bed when she started her shift on [DATE]. During an interview on [DATE] at 3:13 p.m. the DON identified CNA D and CNA E as the CNAs in the video dated [DATE]. The DON said the CNAs should have pulled the privacy curtain while providing incontinent care and their attention should have been on Resident #3 and not speaking with his roommate during incontinent care. The DON said the importance of providing privacy and giving their attention to the residents during incontinent care was for dignity and respect. During an interview on [DATE] at 9:52 a.m. CNA E said she was unable to come to the facility to review the video dated [DATE]. During an interview on [DATE] at 10:05 a.m. CNA D said she was one of the CNAs in the video dated [DATE]. CNA D said she did not know why the privacy curtain was not pulled during incontinent care in the video that she must have forgotten to pull the privacy curtain. CNA D said they were not engaging with Resident #3 during care and talking to his roommate because Resident #3 did not talk and his roommate was talking to them. CNA E said the importance of engaging with the resident during care was in case the resident needed something or wanted something. CNA E said the importance in ensuring the privacy curtain was pulled when providing care was for dignity. Record review of the facility's Resident Rights policy revised 2/2021 indicated, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity.t. privacy and confidentiality. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Dignity policy revised 2/2021 indicated, 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. Resident are treated with dignity and respect at all times. 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 grooming and personal hygiene were provided for 1 of 4 (Resident #1) residents reviewed for ADLs. The facility failed to ensure Resident #1's mouth, chin, and neck were cleaned on 6/9/26. The failure could place residents at risk of not receiving services/care and decreased quality of life.Findings Include: Record review of the face sheet dated 6/9/26 indicated Resident #1 was an [AGE] year-old female that was re-admitted to the facility on [DATE] with diagnoses including encephalopathy (any disease damage, or malfunction of the brain that alters its structure or function), cognitive communication deficit (an impairment in communication), dementia, intellectual disabilities, and anxiety. Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS score of 04 and was severely cognitively impaired. The MDS indicated Resident #1 required partial/moderate assistance with personal hygiene. Record review of the care plan last revised on 2/10/26 indicated Resident #1 had potential for an ADL self-care performance deficit. During an observation and interview attempt on 6/8/26 at 1:44 p.m. Resident #1 had a red substance streaked around her mouth and down her chin and neck. Resident #1 kept mumbling and asking for help while being interviewed and observed. A staff member was informed that Resident #1 needed assistance and observed staff enter Resident #1's room to help her. During an observation on 6/8/26 at 2:42 p.m. Resident #1 was lying in bed, sleeping, and covered with blanket. Resident #1 had a red colored substance around her mouth and streaked down her chin and neck. During an interview on 6/9/26 at 1:33 p.m. CNA A said she was working the 100 Hall on 6/8/26 and she and CNA B had laid Resident #1 down yesterday after they were told Resident #1 was asking for help. CNA A said Resident #1 did not have anything on her mouth, face, or neck when they laid her down. CNA A said she remembered them wiping down Resident #1. CNA A said the importance of ensuring residents were cleaned up after spilling something on themselves or down their chin and neck was for personal hygiene. During an interview on 6/10/26 at 2:14 p.m. the ADON said she expected staff to clean a resident's mouth, chin, and neck when needed. The ADON said a resident should be cleaned up prior to being laid down. The ADON ensuring a resident's mouth, neck, and chin were clean was so they did not feel dirty. Record review of the facility's Activities of Daily Living (ADL), Supporting policy revised 2/2025 indicated, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care).

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 9 (Resident #3) residents reviewed for accident hazards. The facility failed to ensure CNA D and CNA E used a gait belt (an assistive device used by caregivers and physical therapists to help patients safely stand, walk, or transfer between chairs and beds) when transferring Resident #3 from the wheelchair to the bed on [DATE]. The failure could place dependent residents at risk for falls, significant injuries and decreased quality of life.Findings Include: Record review of the face sheet dated [DATE] indicated Resident #3 was a [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses including Myasthenia Gravis (a condition that causes weakness in the voluntary muscles), lack of coordination, cognitive communication deficit (an impairment in communication), and weakness. Record review of the MDS dated [DATE] indicated Resident #3 sometimes understood others and was usually understood by others. The MDS indicated Resident #3 did not have a BIMS score. The MDS indicated Resident #3 was dependent on staff for transfers. Record review of the care plan revised [DATE] indicated Resident #3 had an ADL self-care performance deficit related to confusion, fatigue, impaired balance, and limited mobility. Record review of a progress note dated [DATE] indicated Resident #3 expired in the facility. Record review of video footage from electronic monitoring indicated on [DATE] at 5:59 pm 2 CNAs transferred Resident #3 from the wheelchair to the bed without a gait belt. The video footage indicated the CNAs lifted Resident #3 out of the wheelchair from under both arms and by the back of his pants and put him in bed. During an interview on [DATE] at 12:52 p.m. CNA E said she had worked the night shift on [DATE]. CNA E said Resident #3 was already in bed when she started her shift on [DATE]. During an interview on [DATE] at 1:33. CNA D said she had worked the night shift on [DATE]. CNA E said Resident #3 was already in bed when she started her shift on [DATE]. During an interview on [DATE] at 3:13 p.m. the DON identified CNA D and CNA E as the CNAs in the video dated [DATE]. During an interview on [DATE] at 9:52 a.m. CNA E said she was unable to come to the facility to review the video dated [DATE]. During an interview on [DATE] at 10:05 a.m. CNA D said she was one of the CNAs in the video dated [DATE]. CNA E said they did not properly transfer Resident #3 on the video dated [DATE]. CNA E said they did not use a gait belt or mechanical lift and instead lifted Resident #3 from under the arms and by the back of his pants. CNA E said the importance of not transferring a resident by lifting them from underneath their arms was because they might have a pacemaker in place and that using a gait belt was the proper way to transfer a resident. During an interview on [DATE] at 10:25 a.m. PTA F reviewed the video dated [DATE] regarding transfer of Resident #3. PTA F said the CNAs improperly transferred Resident #3 by not using a gait belt, lifting under his arms, and pulling up on the back of his pants. PTA F said the importance of proper transfers was to prevent injuring the residents. PTA F said lifting a resident from under the arms when transferring could cause damage to the nerves, tendons, and/or ligaments in the shoulder. PTA F said pulling up on the back of a resident's pants was unstable as the pants could slip or tear causing the resident to trip and possibly injuring themselves. During an interview on [DATE] at 2:14 p.m. the ADON said she expected staff to use a gait belt when transferring a resident from the wheelchair to the bed. The AODN said it was not acceptable for a resident to be transferred by lifting them up from under their arms and by the back of their pants. The ADON said the importance of proper transfers was to prevent injuring the residents. Record review of the facility's Safe Lifting and Movement of Residents policy revised 7/2017 indicated, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 1. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving residents. 2. Manual lifting (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of residents shall be eliminated when feasible.4. Staff responsible for direct care will be trained in the use of manual (gait/transfer belts, lateral board (an assistive device designed to help caregivers smoothly move immobile patients between to horizontal surfaces)) and mechanical lifting devices.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review the facility failed to have food available to meet the nutritional needs in accordance with established guidelines for 1 of 1 lunch meals reviewed. The facility failed to follow the posted menu on 6/10/26. The facility failed to ensure the kitchen staff properly portioned the spaghetti served during lunch on 6/10/26. The facility failed to ensure kitchen staff provided all residents with the same portion of mixed vegetables on 6/10/26. The facility failed to ensure the facility did not run out of garlic bread during lunch on 6/10/26. These failures could place residents at risk of decreased quality of life, poor intake, and/or weight loss. Findings included: During an observation on 6/10/26 at 11:28 a.m. the board in the resident dining room indicated the following meal was to be served for lunch: spaghetti, roasted cauliflower, garlic toast, and fresh fruit cup. During an observation on 6/10/26 at 11:30 a.m. lunch trays were being prepared. Lunch was spaghetti (sauce and noodles mixed together), mixed vegetables, garlic bread, and a fruit cup. During lunch service the spaghetti portions were not measured, the cook used tongs and put 2-3 tongs full of spaghetti on the trays. The kitchen ran out of garlic bread during lunch service and part of the 200 hall, and all of the 300 and 400 halls did not receive any garlic bread. The 300 hall trays were the last prepared and while preparing the 300 hall trays kitchen staff started giving some residents only a half scoop of mixed vegetables and less spaghetti. [NAME] G began heating up carrots on the stove. Record review of the Dining Manager's recipes for Spaghetti with Ground Meatballs and Sauce indicated the portion size for a regular portion was a #12 scoop of ground meatballs and sauce and 4oz of pasta. During an interview with the Administrator on 6/10/26 at 12:35 p.m. the Administrator said he expected there to be enough garlic bread for all the residents in the facility. The Administrator said the spaghetti should have been measured for the correct portion size. The Administrator said all food on the trays should be the same portions for all residents unless indicated otherwise by the residents' orders. The Administrator said the importance of ensuring every resident got the same meal and what was offered on the menu was a resident right. The Administrator said the importance of the food being properly portioned was to ensure residents' nutritional needs were being met. During an interview on 6/10/26 at 1:48 p.m. [NAME] G said he had worked at the facility for approximately a year and 3 months. [NAME] G said he was trained at the facility by a previous cook. [NAME] G said he did not know why but it was probably a mix up that they used mixed vegetables for the lunch service instead of the roasted cauliflower that was on the menu. [NAME] G said when serving spaghetti, they could use a scoop or tongs. [NAME] G verified the spaghetti recipe did not indicate the use of tongs for serving. [NAME] G said he used tongs to serve the spaghetti because when he used the scoop some of the food would fall out and the residents were not getting a proper portion. [NAME] G said using the tongs he knew the residents were getting plenty of spaghetti and probably more than a regular portion. [NAME] G said they were running out of mixed vegetables during lunch service and that some residents were not receiving a full scoop of mixed vegetables. [NAME] G said they had used 4 cans of mixed vegetables which was usually plenty, but the facility had got several new residents, and 4 cans was not enough this time. [NAME] G said they did run out of garlic bread during lunch service and that was because the miss counted. [NAME] G said he did not have an answer as to the importance of proper portion size and not running out of something on the menu. [NAME] G said the importance of following the posted menu was to stay on task and for the food order. Record review of the facility's Standarized Recipes policy dated 2023 indicated, Standarized recipes will be used when preparing menu items. 1. Standarized recipes (in appropriate portion sizes) for planned menu items will be maintained in the facility .3. Cooks/chefs are expected to use and follow the recipes provided. Record review of the facility's Portion Control policy dated 2023 indicated, Individuals will receive the appropriate portions of food as outlined on the menu. Control at the point of service is necessary to assure that accurate portion sizes are served.3. Food should be (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	served with ladles scoops, spoodles (a hybrid kitchen utensil that combines the features of a traditional spoon and a ladle), and spoons of standard sizes. Scales should be used as needed to weigh meat portions. Scoops should be leveled off (not overflowing) for the most accurate portion sizes. a. Portions that are too small result in the individual not receiving the nutrients needed. b. Portions that are too large increase food costs as well as providing the individual with more food than needed.Serving Utensils #12 scoop=1/3 cup=2.67 ounces.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 staff (ADON) and 1 of 5 (Resident #2) residents viewed for infection control. The facility failed to ensure the ADON performed hand hygiene between glove changes while providing wound care to Resident #2 on 6/9/26. This failure could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building.Findings Include: During an observation and interview on 6/9/26 at 10:18 a.m. revealed the ADON performed wound care on Resident #2 with assistance from CNA C. The ADON gathered supplies from the treatment cart including bottle of Dakins solution (a mild, diluted bleach antiseptic used to clean acute and chronic wounds, prevent infections, and reduce odor) from bottom drawer of cart and placed on bedside table covered with wax paper. The ADON entered the room, performed hand hygiene and put on a gown and gloves. CNA C assisted in turning Resident #2 onto her side and holding Resident #2 in place. The ADON removed the dressing dated 6/9/26 and gauze that was in the wound bed. The ADON said wound care had been performed on the night shift due to Resident #2 having a bowel movement and the dressing getting dirty. The ADON removed her gloves, did not perform hand hygiene, and put on sterile gloves. The ADON picked up the non-sterile bottle of Dakins solution and wet gauze. The ADON cleansed the wound and packed the wound with Dakins soaked gauze. The ADON applied silicone faced foam and a border dressing (an advanced, multi-layer bandage that featured soft, atraumatic silicone contact layer that adheres to only the surrounding skin and a highly absorbent foam pad) to the wound. The ADON removed her gloves, did not perform hand hygiene, and began digging in her pockets for a marker. The ADON washed her hands, obtained a marker from her pocket, picked up trash from the floor, washed her hands, put on gloves, and dated and initialed the dressing. The ADON gathered supplies and exited the room. During an interview on 6/9/26 at 12:42 p.m. the ADON said hand hygiene should be performed before starting wound care and between glove changes. The ADON said she chose to use sterile gloves when performing wound care and going from wet to dry, but that the sterile gloves were not required. The ADON said she did not perform hand hygiene when she took off her gloves after cleaning Resident #2's wound because she had accidentally thrown away her hand sanitizer. The ADON said the importance of proper hand hygiene was to prevent infections. During an interview on 6/9/26 at 3:13 p.m. the DON said she expected staff to perform hand hygiene before and after entering a resident room or providing care and between glove changes. The DON said the importance of proper hand hygiene was infection control. Record review of the facility's Handwashing/Hand Hygiene policy revised 1/2025 indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident.c. after contact with blood, body fluids, or contaminated surfaces.g. immediately after glove removal.