STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455001	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Beaumont	4195 Milam St Beaumont, TX 77707

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 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 all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events caused the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 2 of 4 residents (Resident #3 and #4) reviewed for reporting allegations of abuse. The facility failed to report physical abuse and verbal abuse to the State Agency within 2 hours when it was reported to DON/delegated abuse coordinator Resident #3 threw a TV remote at Resident #4 causing a laceration to Resident #4's nose on 07/26/2025 at 7:48 p.m. and Resident #3 made a statement regarding needing a gun, so he could shoot up some people in this place on 07/30/2025 at 4:52 p.m. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included: 1. Record review of Resident #3's face sheet dated 08/07/2025 indicated he was a [AGE] year-old male, admitted on [DATE], and his diagnoses included chronic kidney disease (gradual loss of kidney function), anxiety disorder (persistent and excessive worry that interferes with daily activities), and dementia (loss of cognitive functioning). Record review of Resident #3's admission MDS assessment dated [DATE] indicated he can make himself understood and understands others. He had a BIMS score of 12 which indicated moderate cognitive impairment. He had verbal behavioral symptoms directed towards other occurring 1 to 3 days during the 7 days look back window and no physical behavioral symptoms identified. Record review of Resident #3's care plan dated 07/26/2025 indicated he was involved in a resident-to-resident altercation involving a TV remote. Interventions included residents were separated, room change performed, placed on 1:1 monitoring, MD and Psych services notified. Care plan dated 08/06/2025 indicated resident has potential to be verbally aggressive related to dementia, ineffective coping skills, mental/emotional illness, and poor impulse control with interventions analyze key times, places, circumstances, triggers and what de-escalates behavior and document, assess and anticipate resident's needs; administer medications as ordered and give the resident as many choices as possible about care and activities. Record review of Resident #3's nurse progress note authored by RN D indicated on 7/26/2025 at 11:30 p.m., Resident approached nurses' station and informed nurse my roommate was cursing and yelling at me and then threw the remote and hit me in the stomach, so I threw it back and busted his face. Resident #3 and Resident #4 were separated. RN D assessed Resident #3 with no new injuries noted at the time of the assessment. RN D notified DON, ADON, and the administrator of the incident. RN D inquired about local police department notification and the corporate nurse informed him this incident was not reportable to the local police department. Corporate Nurse spoke with the Resident #3 over the phone. Resident #3 was moved to another room and 1:1 monitoring was initiated. Resident #3 was his own responsible party, and MD was notified of the resident altercation. Record review of Resident #3's nurse progress note authored by RN D indicated on 7/30/2025 at 5:00 p.m., Resident #3 was watching TV show featuring guns and made the comment at 4:45 p.m. that I need a gun, so I can shoot up some people in this place. RN D notified DON at 4:52 p.m. of the incident. Resident #3 was placed on q 15-minute behavioral monitoring. Psych services was notified of incident. 2. Record review of Resident #4's face sheet dated 08/07/2025 indicated he was a [AGE] year-old male, initially admitted on [DATE] and readmitted on [DATE], and his diagnoses included metabolic encephalopathy (brain dysfunction caused by underlying metabolic disturbances, leading to symptoms like confusion, memory loss, and altered consciousness), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), delusional disorders (mental health condition in which a person can't tell what's real from what's imagined), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #4's quarterly MDS assessment dated [DATE] indicated he usually made himself-understood and usually understands others. His BIMS was a 99 indicating that he was unable to successfully complete the interview to obtain a BIMS score. No behaviors of verbal or physical abuse were noted. Record review of Resident #4's care plan dated 07/26/2025 indicated verbal aggression of cursing at roommate and interventions included analyze key times, places, circumstances, triggers and what de-escalates behavior and document, assess and anticipate resident's needs; administer