

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER Avir at New Braunfels		STREET ADDRESS, CITY, STATE, ZIP CODE 821 US Hwy 81 W New Braunfels, TX 78130	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, and misappropriation of property for 1 of 6 residents (Resident #1) reviewed for abuse. On [DATE] at 10:25 p.m., CNA A pried Resident # 1's hands off a chair and grabbed the wrists and physically pushed Resident # 1 causing Resident # 1 to fall to the floor and against the wall which required an evaluation at the local ER due to redness to the wrists and back. This failure was identified as past noncompliance IJ as the facility had instituted adequate corrective measure to prevent recurrence of the noncompliance. The noncompliance began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the survey began. This failure could result in residents suffering injury, a diminished quality of life, and/or death. The findings included: Record Review on [DATE] of Resident # 1's face sheet revealed Resident #1 was a -[AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer' disease (a progressive neurogenerative brain disorder), bi-polar (a mental health disorder with mood shifts), anxiety, cognitively impaired, schizophrenia disorder (a mental disorder) with mania depression (symptom of bi-polar), and a lack of coordination. The RP was listed as: a family member. Record review on [DATE] of Resident #1 's quarterly MDS, dated [DATE]., reflected a BIMS score of 3 indicative of severe impairment in cognition. The ADLs (section GG) revealed: the resident was incontinent with bowel and bladder. As for Transfer and Mobility, the resident only required supervision; resident was ambulatory and a wanderer. Record review on [DATE] of Resident #1's Care Plan, undated, revealed, the goals and interventions included: the goal ofADL assistance especially for transfer because the resident had muscle weakness, impaired cognition, lacked coordination and undergoing a disease process [Alzheimer's disease]. For the goal of behaviors/agitation the interventions included: re-direction, structured activities and move to a quiet area. Record review on [DATE] of Resident #1's physician orders, dated [DATE], revealed the resident was prescribed Seroquel 50 mg, 1 tablet at bedtime for schizophrenia disorder. Record review on [DATE] of Resident #1's Nurse Note dated [DATE] authored by LVN B revealed: incident occurred on [DATE] at 10:25 p.m. where CNA A struggled with Resident #1 over a chair. During the struggle CNA A grabbed the resident by his wrists and pushed him to the floor. CNA A also pushed the resident against a wall. CNA A was sent home by LVN B. The note further revealed LVN B called the Administrator immediately after CNA A was sent home. Record review on [DATE] of Resident #1's skin assessment on [DATE] completed by LVN B revealed redness to both wrists and back. Record review on [DATE] of Resident #1's ER report dated [DATE] revealed no injury to Resident # 1 and the x-ray was negative. Record review on [DATE] of LVN B's written statement dated [DATE] repeated the same information as the nurse note dated [DATE]. Namely, incident occurred on [DATE] at 10:25 p.m. where CNA A struggled with Resident #1 over a chair. During the struggle CNA A grabbed the resident by his wrists and pushed him to the floor. CNA A also pushed the resident against a wall. CNA A was sent home by LVN B. The note further revealed LVN B called the Administrator immediately after CNA A was sent home. Record review on [DATE] of CNA C's written (continued on next page)</p>

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>statement undated revealed: she witnessed the tug of war between CNA A and Resident #1 over a chair in the secure men's unit. The written statement also revealed LVN B tried to intervene. During LVN B's intervention, CNA A pushed Resident #1 to the floor and then CNA again pushed the resident into the wall. Record review on [DATE] of CNA A's email dated [DATE], revealed he was defending himself and he tried to de-escalate and the resident lost his balance. The email added CNA A had no intention of harming the resident. Record review on [DATE] Law Enforcement case number card, dated [DATE], revealed law enforcement responded but no arrest was made of CNA A who no longer was in the facility [surveyor made an email request on [DATE] for the law enforcement report] Record review of RN D's written statement undated revealed she responded to the situation and sent CNA A home. Record review of CNA A's employee file revealed: EMR and Criminal History Checks completed [DATE] with no negative information. CNA A completed ANE and dementia training on [DATE]. CNA A's competency checklist revealed he was checked off for ANE and dementia on [DATE]. SB-9 [Senate Bill-9 requiring that providers report abuse] was signed by CNA A on [DATE]. Also, CNA A's last ANE training was on [DATE]. [CNA A was hired on [DATE] and terminated on [DATE]]. During an observation and interview on [DATE] at 1:24 p.m., Resident #1 was wandering the halls in the secure unit. Observation revealed the resident had no skin tears, bruises, or visible injuries. Resident #1 stated he felt safe but could not remember any details involving the incident on [DATE]. The resident did not want to engage in a further interview. During a telephone interview on [DATE] at 3:40 p.m., CNA C stated, she was a witness to the incident on [DATE] at night where Resident #1 was carrying a chair to sit next to the nurse's office. She saw CNA A try to take the chair from the resident and a struggle ensued. She saw CNA A remove the chair from the resident and then pushed the resident down to the floor. She saw when the resident got off the floor and went after the CNA, CNA A again pushed the resident slightly to the wall. CNA C stated CNA A should have de-escalated the situation and never touched a resident and should have called for help. During a telephone interview on [DATE] at 4:09 p.m., LVN B stated she saw Resident #1 pick up a chair to sit next to the nurse station. LVN B stated she heard CNA A tell Resident #1 that he could not sit near the nurse station. LVN B then saw CNA A try to take the chair away from the resident. She then saw that the resident resisted and a struggle ensued. During the struggle, LVN B stated, she saw CNA A peeled the fingers of the resident off the chair. LVN B stated that the resident gave up the chair. LVN B stated she saw when the resident was upset and approached CNA A, and she witnessed CNA A grabbed the resident by the wrist and pushed the resident to floor. LVN B stated she tried to separate the resident and the CNA again. LVN B stated she witnessed when the resident lifted himself off the floor, and CNA A again pushed the resident against the wall. LVN B stated after she removed Resident #1 from the situation and assessed him in his room, she went to get help from other staff in the nearby unit. LVN B stated she also immediately notified the Administrator of the incident. During a telephone interview on [DATE] at 4:53 p.m., CNA A stated the email he sent to the facility was correct and he stood by the statements made in the email. CNA A stated that he took the chair away from the resident to protect the residents in the secure unit and to protect staff. CNA A stated, I held his hands because he (Resident #1) tried to hit me. CNA A stated that he did not push the resident to the floor or wall. CNA A stated he did not willfully abuse the resident but rather was trying to keep safety for the staff and residents and only defended himself. CNA A stated he attended training on ANE, and he learned to report abuse immediately to the Abuse Coordinator. CNA stated he did not remember being trained in dealing with dementia residents and de-escalation for residents in a secure unit. During an interview on [DATE] at 5:00 p.m., the Administrator stated he was notified of the incident on [DATE] around 10:30 p.m. and notified appropriate parties. Verification of PNC prior to the investigation on [DATE], the facility put in place interventions to ensure proper safety for residents to include: Observation on [DATE] at 2:30 p.m., revealed CNA A was not in the facility [suspended [DATE] and terminated]. [Record review on [DATE] of timecard dated [DATE] with clock out date of [DATE] with time of 11:45 p.m. and termination notice dated [DATE]] Assessment of Resident #1 (continued on next page)</p>		

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