

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Town Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 1816 Tile Factory Rd Palestine, TX 75801	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse for 2 of 7 residents (Residents #1 and #2) reviewed for abuse. The facility failed to report abuse on 2/4/26 at approximately 3:38 p.m. when Resident #2 allegedly struck Resident #1 in the face with a closed fist. This failure could place residents at risk of abuse, emotional distress, and loss of dignity. Findings included: 1. Record review of an admission Record, dated 2/18/26, for Resident #1 indicated a [AGE] year-old male, readmitted [DATE], with diagnoses of autistic disorder (impacts how person perceives and socializes with others), muscle wasting and atrophy (weakness from disuse), and diabetes mellitus. Record review of a quarterly MDS, dated [DATE], indicated Resident #1 was rarely or never understood and a BIMS was not conducted. Record review indicated he required partial assistance with toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. Further record review indicated Resident #1 required substantial assistance with eating, oral hygiene, and putting on/taking off footwear. Record review of a comprehensive care plan, dated 2/4/26, indicated Resident #1 had behavioral symptoms related to severe intellectual disability which included biting himself and yelling out when agitated. Further record review indicated interventions included maintaining a calm environment, using calming techniques, and calming words with resident and removing the resident from the area if the behavior interfered with others. 2. Record review of an admission Record, dated 2/18/26, for Resident #2 indicated an [AGE] year-old male, admitted [DATE] with diagnoses of unspecified dementia (altered cognition) and psychotic disorder with delusions due to known physiological condition. Record review of an admission MDS, dated [DATE], indicated Resident #2 had severely impaired cognition with a BIMS of 4. The MDS indicated Resident #2 required supervision with eating, partial assistance with oral hygiene, upper body dressing, lower body dressing, and personal hygiene. Further review of the MDS indicated he required substantial assistance with toileting hygiene, shower/bathing, and putting on/taking off footwear with no noted physical or behavioral symptoms directed toward others. Record review of a comprehensive care plan, dated 2/4/26, indicated Resident #2 was at risk for impaired social interactions related to mood disorder and psychotic disorder. Record review indicated care planned interventions included administer medications as ordered and monitor for side effects and effectiveness. Review of an incident report for physical aggression, dated 2/4/26 at 3:38 p.m., indicated LVN A was assisting a resident in their room when she heard someone call out for the nurse. LVN A exited the room and saw Resident #2 make contact with another resident (Resident #1) on the cheek. LVN A separated the two residents from each other and notified the DON, NP, and RP. No distress or injuries were noted during the assessment. During an interview on 2/18/26 at 10:55 a.m., LVN A said she witnessed the resident-to-resident altercation between Residents #1 and #2. LVN A said she was coming out of a</p> <p>(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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455565	Facility ID: 455565 If continuation sheet Page 1 of 2

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