STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455574	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Weatherford	521 W 7th St Weatherford, TX 76086

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from abuse and neglect for one of seven (Resident #1) residents reviewed for abuse. On 10 /11/25 CNA A dragged Resident # 1 by her ankles approximately 40 feet down the hallway in the memory care unit when Resident # 1 refused to allow CNA A to perform incontinent care. The noncompliance was identified as PNC. The IJ began on 10/11/25 and ended on 10/16/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of serious physical injuries, fear and emotional trauma, decline in health and a decreased quality of life.Findings included:Record review of Resident #1's face sheet, dated 12/30/25, revealed she was a [AGE] year-old female admitted on [DATE]. She resided on the memory care unit and had the following diagnoses: vascular dementia (occurs when damaged blood vessels reduce oxygen and nutrient flow to the brain, impairing memory, thinking, and behavior), anxiety disorder, peripheral vascular disease (peripheral vascular disease is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in blood vessels), osteoarthritis of bilateral knees (degeneration of joint cartilage and the underlying bone which causes pain and stiffness especially in the hip, knee, and thumb joint), and lipodermatosclerosis (chronic inflammatory condition of the skin where the lower legs harden and thicken due to poor blood flow). Record review of Resident # 1's admission MDS, dated [DATE], reflected that she was incontinent of bowel and bladder and had a BIMS of four, (severe cognitive impairment), displayed wandering behaviors, inattention, disorganized thinking, and did not resist care or display behavioral symptoms or aggression toward others. Record review of the Care Plan, problem which was initiated and revised on 11/16/25, reflected Resident #1 had a problem of mixed bladder incontinence and an intervention was initiated on 11/16/25 to check the resident for incontinence every two hours. It also reflected that she had the problem of ADL self-performance deficit, initiated 10/16/25, with interventions that were also initiated on 10/16/25. Resident #1 required assistance of one staff to use the toilet and required total assistance with transfers but did not specify how many CNAs were required to assist with transfers. The care plans were updated on 10/15/25 after the incident on 10/11/25 to reflect that the resident resisted care and had the potential to be physically aggressive with staff. The care plan was revised on 10/16/25 to include: allow the resident to make decision about treatment regime to provide a sense of control, give clear explanation to all care activities, if resident resists with adl's leave and return in five to ten minutes and try again Record review of CNA A's timecard reports reflected CNA A worked:10/11/25: 6:00 a.m.- 2:21 p.m.10/12/25: 6:36 a.m. - 2:10 p.m.Record review of daily staffing schedule, dated 10/11/25, reflected CNA A was the only CNA assigned to the memory care unit from 6:00 a.m. - 2:00 p.m. on 10/11/25. Record review of the daily staffing schedule, dated 10/12/25, reflected CNA A worked 6:00 a.m. to 2:00 p.m. on the north side (the opposite side) of the building. It is unknown if CNA had contact with or was in the same (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	space as, Resident #`1 at any point during this shift. Record review of CNA A's employe file reflected CNA A was not suspended until 10/12/25 after completing her shift and was terminated on 10/16/25. The record reflected The Investigation proved she did not follow policy and procedure. Record review of the facility's policy titled Abuse, Neglect, and Misappropriation Prevention Program dated revised April 2021, reflected the following: Residents have the right to be free from abuse and neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and chemical restraint not required to treat the resident's symptoms. The program consists of a facility wide commitment and resource allocation to support the following objectives.1.Protect residents from abuse, neglect exploitation, or misappropriation of property by anyone including facility staff, other residents, family members, staff from other agencies, friends, visitors.5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems. During an observation and an attempted interview on 12/30/25 at 2:00 PM Resident # 1 was sitting in the sitting area of the memory care unit. Resident #1 made eye contact but would not answer direct questions or engage in conversation. She was well groomed, and well dressed, and had no odors. There was no visible bruising. During an interview on 12/30/25 at 3:00 p.m., LVN D stated on 10/11/25 around 6:00 a.m., CNA A reported that Resident #1 was acting up, was dirty and refused to be changed. She stated she went to the memory care unit and saw Resident #1 sitting in a chair and Resident #1 smelled of feces. She stated CNA A was standing in front of her talking loudly to Resident #1. She stated CNA A tried to get Resident #1 to get up and stop yelling. Resident #1 refused to get up and continued to yell. LVN D stated CNA A then reached underneath Resident #1's arms and attempted to pick her up from the chair and Resident #1 grabbed the chair to resist. Resident # 1 slid down to the ground. She stated CNA A, then grabbed Resident #1's ankles and dragged her on the floor down the hall to her room. She stated Resident #1 was screaming, yelling, and resisting CNA A as she dragged her down the hallway. LVN D stated she did not intervene because she was shocked to see the incident and also stated CNA A was so agitated that she was afraid she would aggravate the situation further if she intervened before they got to Resident #1's room. She stated CNA C arrived at that time and she told CNA C to take over Resident #1's care from CNA A. She stated she told CNA A to go off the hall and take a break, and she left the memory care unit. LVN D stated she was the night shift charge nurse when this incident happened, and she was getting ready to go off duty. LVN D stated again she did not intervene because CNA A was a large woman and was terribly upset which made her hesitant to approach her for fear she would increase CNA A's agitation. LVN D stated she the abuse coordinator/administrator of the incident. She stated she also notified the physician and the responsible party. During an interview with Resident #1's responsible party, he stated he was notified of the incident of alleged abuse, but he did not remember who notified him or the date he was notified. During an interview on 12/30/25 at 3:40 p.m., CNA B stated she went outside the memory care unit a little after 5 :00 a.m. to ask CNA A for assistance. CNA A came into the unit and started screaming at Resident #1 to get up, and told her she had until the count of three to get up. CNA B stated Resident #1 was sitting in a gray chair by the television. CNA B stated she saw CNA A grab Resident #1 and pick her up out of her chair and lower her onto the floor. She stated CNA A then grabbed Resident #1 by the ankles and dragged her, while she laid on the floor, from the gray chair in the lobby to her room down the hallway. She stated when they got to the room CNA C and herself intervened at that time and took over Resident #1's care, as they were told to do by LVN D. She stated she did not immediately intervene on the behalf of Resident #1 as she had been trained to do by the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility. She also stated she did not notify the abuse coordinator/administrator because she thought LVN D notified the administrator/abuse coordinator. During an interview on 12/31/25 at 10:00 a.m., CNA A stated she no longer worked at the facility and did work her entire shift on the memory care unit on 10/11/25. CNA A stated when she arrived at the facility on 10/11/25, it was a little after 5:00 a.m She stated CNA B came to her and told her Resident #1 was out of control. She stated CNA B told her Resident #1 needed to be changed but refused. She stated Resident #1 was yelling and screaming. CNA A stated she told Resident #1 she needed to get up from the chair and let CNA B change her brief. She stated Resident #1 would not get up from the chair, and she tried to assist her to stand and at that time Resident #1 threw herself out of the chair and kicked at her wrapped her arms around CNA A's legs. She stated she took Resident #1's arms off her legs and Resident #1 continued to kick at her . CNA A stated there were a lot of residents around and she was afraid for those residents' safety, so she grabbed Resident #1's legs and pulled her to her room. She stated CNA B, CNA C, and LVN D were there, but did not try to help her. She stated LVN D was the nurse, and she just stood there and watched the whole thing . She stated she worked the full shift on the memory care unit on 10/11/25 and worked again on 10/12/25 for eight hours before she was suspended . She stated she was terminated on 10/16/25 as a result of this allegation of abuse. and was currently employed as a CNA at another nursing facility. In an interview on 12/31/25 at 3:00 p.m., the Administrator stated on 10/14/25 she viewed a video of the incident that occurred on 10/11/2025 that was recorded by the facility's electronic monitoring system. She stated the facility had recently undergone a change of ownership, and she was hired in August as the Administrator, but had worked as a marketer in the facility since 2016. She stated she viewed the video with the former DON and the ADON, and after she saw the film, she reported the incident to the police and the state and federal authorities. She stated she did not report the allegation before she saw the video because she was not sure it actually happened until she viewed the video. In an interview on 12/31/25 at 4:00 p.m., the Police Detective that responded to the facility's report on 10/15/25 stated another officer recorded the facility's video recording of the incident that occurred on 10/11/25 as he watched the video by using his work phone on 10/15/25. The Detective stated while watching the video, he observed CNA A drag Resident #1 down the hallway by her ankles. During an observation on 1/9/25 at 2:00 PM of a video dated 10/11/25 at 5:19 a.m., which was in the possession of the police department it was revealed Resident # 1 was sitting in a chair in the lobby area of the memory care unit. The observation revealed there were six other unidentified residents visible in the area. LVN D was standing behind Resident #1, and did not intervene, while CNA A was standing over Resident #1 pointing and shaking her finger in the face of Resident #1. The observation further revealed Resident #1 was looking up at CNA A and did not resist or strike out at CNA A. Further observation revealed CNA A grabbed Resident #1 under her arms and lifted her up while Resident #1 held on to the arms of the chair. The observation revealed CNA A jerked Resident #1 up and Resident #1 fell to the floor and CNA A immediately grabbed Resident #1 by the right leg and began dragging her. The observation also revealed CNA A then grabbed Resident #1's other ankle and dragged Resident #1 on her back down the hallway to her room and then halfway inside the door, at which point, the video ended. CNA A, CNA B, CNA C, and LVN D were observed standing calmly in the video and no one intervened to protect Resident #1. The facility was evaluated to be in past noncompliance based on the corrections implemented prior to entrance. Review of the plan reflected:1. Resident # 1 received a skin assessment on 10/11/25 which reflected no open areas or bruising. Responsible party, Ombudsman, and Medical Director notified. Police were notified on 10/15/25. CNA A reassigned on 10/12/25 and suspended pending investigation for the allegation of abuse on 10/12/25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. All residents in the secured unit were given a skin assessment on 10/15/25. Interviewable residents were given a safe survey and residents unable to answer safe survey questions were given a skin assessment 10/15/25. There were no findings related to suspected abuse. 3. Education provided by the [NAME] President of Clinical Operations to the designated educators (managers) on the following for all staff members to include the Administrator, Assistant Director of Nursing, Social Services, Activity director, and the Wound Care Nurse, over the following Abuse and neglect, De-escalation, Aggressive Behavior, and Mental Health Management, Resident Rights, and dignity. A competency test was given to all staff after the in-service. Completed 10/15/25. 4. Education provided to all staff by the designated educators (managers)on the following for all staff members to include the Administrator, Assistant Director of Nursing, Social Services, Activity director, and the Wound Care Nurse, over the following by the [NAME] President of Clinical Operations. Abuse and neglect, De-escalation, Aggressive Behavior, and Mental Health Management, Resident Rights, and dignity. A competency test was given to all staff after the in-service. Completed 10/15/25. 5. Five staff and five residents interviewed weekly for four weeks, to ensure any allegations of abuse were reported by the education department (managers). Any concerns noted during the interviews will be immediately addressed and reported to the administrator. Persons responsible for interviews will be Department Heads or designee. 10/16/25 completed. 6. Progress notes and incident reports will be reviewed during morning clinical meetings and by the weekend supervisor to ensure any documented abuse or potential abuse was reported to the administrator or abuse coordinator and to HHSC per regulation. ADON, Wound Care Nurse, Weekend Supervisor and or Designee. 10/16/25 completed 7. Ad Hoc QAPI with the Medical Director regarding the alleged incident and the facility's plan for compliance with regulations. completed 10/15/25 Verification:1. An Action Plan was developed, and an Ad Hoc meeting was conducted with the Medical Director on 10/15/25.-Verified by surveyor: Record review and Medical Director interview on 12/31/25 at 4:00 p.m. 2.Resident #1 received a skin assessment with no injuries identified related to the incident and was observed at baseline without distress.-Verified by surveyor: Record review on 12/31/25 of skin assessment for 10/11/25 after incident and interview with LVN E on 12/31/25 at 2:30 p.m 3.A psychiatric note dated 11/20/25 documented the resident had no recollection of the incident and no behavioral changes were observed.-Verified by surveyor by Record review on 12/31/25. 4.Responsible Party, Police, Ombudsman, and Medical Director were notified. -Verified: Interviews on 12/30/25 between 12:00 p.m. and 4:00 p.m. with Resident #1's party responsible, Police Detective, and Medical director. 5.CNA A was reassigned verified on 10/11/25 and suspended pending investigation on 10/12/25 after working full shifts on 10/11/25 and 10/12/25. CNA A was terminated on 10/15/25 by the former DON as a result of the alleged abuse -Verified 12/31/25 and 1/8/26 by review of personnel files: Interview with CNA A on 12/31/25 at 10:00 a.m. 6.CNA A, CNA B and LVN D received education and disciplinary action and were subsequently terminated. -Verified: Record review of employee files and interviews revealed CNA A was suspended on 10/12/25 after 3:00 p.m. when she completed her shift. CNA A stated in an interview on 12/31/25 at 10:00 a.m. she was terminated on 10/15/25. LVN D was given disciplinary counseling by the Administrator on 10/21/25 and educated that she should have immediately intervened on 10/11/25. She self-terminated on 10/21/25. CNA B was given a written counseling by the ADON for failure to follow facility/company practices and procedures on 10/15/25. She self-terminated after she was counseled and finished her shift on 10/15/25. -CNA C was given a written warning on 10/15/25 by the ADON for failure to follow facility policy and report immediately; and always stop the aggressor and try to diffuse the situation. She stated she was in-serviced by ADON on abuse-related education and completed competency testing prior to working her next shift. Verified by record review of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	employee files and training records. 7. All residents on the secured unit received skin assessments on 10/15/25. -Verified: Record review on 1/2/26. There were no skin concerns. 8. Forty-two (42) residents able to answer safe survey questions. Department Heads conducted a safety questionnaire; no concerns identified. Thirty-four (34) residents unable to respond received skin assessments. Safe surveys were started and completed on 10/15/25. The skin assessments were started on 10/11/25 and completed on 10/17/25. -Verified: Interviews with Residents #'s 1 - 10 on 12/31/25 between 12:00 p.m. and 5:00 p.m. 9.Leadership staff received education by V/P of Clinical Operations on Abuse and Neglect, De-escalation, Aggressive Behavior, Mental Health Management, Resident Rights, and Dignity on 10/15/25.-Verified: Training records reviewed on 1/2/26. Interviews with ADON, DON, RNC, and VPO on 1/2/26 10.The Administrator received counseling from VPO and RNC for failure to appropriately investigate the allegation and suspend the alleged perpetrator immediately; and was instructed that all abuse allegations must be investigated and reported. -Verified: Record review of counseling in employee file on 12/31/25. Counseling occurred on 10/25/25 by VPO. 11.All staff received abuse-related education by department heads that had been educated by the RNC and VPO on 10/15/25 and completed competency testing prior to working their next shift. -Verified: Sign-in sheets, post-tests, and staff A, B, C, D, E, F, G, H, I, J interviews on 12/31/25 between 8:00 a.m. and 5:30 p.m. different shifts and positions. 12.The facility implemented weekly interviews by Department Heads of five staff and five residents for four weeks beginning 10/16/25 to monitor abuse reporting compliance.Surveyor Verified: Documentation review and interviews with ten staff members D, E, F, G, H, I, J, K, L, M, and seven, Residents #'s 2, 3, 4, 5, 6, 7, 8 on 12/31/25. 13. Daily review of progress notes and incident reports by the DON or weekend supervisor was implemented to ensure timely reporting to the Administrator/Abuse Coordinator and HHSC.-Verified: Staff interview with RN J on 12/31/25. DON and Administrator stated process involves going over them, signing off on them, and handing them to the administrator. 14.An ad hoc QAPI review was conducted with the Medical Director on 10/15/25. -Verified: Record review on 12/31/25.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement written policies and procedures that prohibit and prevent abuse of residents for 1 (Resident #1) of 7 residents reviewed for resident abuse. The facility failed to implement their policy and procedures to ensure Resident #1 was free from abuse when the facility failed to protect Resident #1 from CNA A on 10/11/25, when CNA A grabbed Resident # 1 by the ankles and dragged her approximately 40 feet down the hallway on the floor of the memory care unit. The facility failed to ensure staff immediately reported suspicions of abuse to the Abuse Coordinator when staff members CNA B, CNA C, and LVN D witnessed the abuse and failed to report or intervene immediately. The facility failed to immediately suspend alleged perpetrators of abuse when the facility allowed the alleged perpetrator to work 8.35 hours on 10/11/25 after the incident occurred and 7.57 hours on 10/12/25, before she was suspended. The noncompliance was identified as PNC. The IJ began on 10/11/25 and ended on 10/16/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of serious physical injuries, emotional trauma, decline in health and a decreased quality of life.Findings included: Record review of Resident #1's face sheet, dated 12/30/25, revealed she was a [AGE] year-old female initially admitted the facility on 10/2/25. She resided on the memory care unit and had the following diagnoses: vascular dementia (occurs when damaged blood vessels reduce oxygen and nutrient flow to the brain, impairing memory, thinking, and behavior), anxiety disorder, peripheral vascular disease (peripheral vascular disease is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in blood vessels), osteoarthritis of bilateral knees (degeneration of joint cartilage and the underlying bone which causes pain and stiffness especially in the hip, knee, and thumb joint), lipodermatosis (chronic inflammatory condition of the skin where the lower legs harden and thicken due to poor blood flow). Record review of Resident # 1's admission MDS, dated [DATE], reflected that she was incontinent of bowel and bladder and had a BIMS of four, (severe cognitive impairment), displayed wandering behaviors, inattention, disorganized thinking, and did not resist care or display behavioral symptoms or aggression toward others. Record review of the Care Plan, problem which was initiated and revised on 11/16/25, reflected Resident #1 had a problem of mixed bladder incontinence and an intervention was initiated on 11/16/25 to check the resident for incontinence every two hours. It also reflected that she had the problem of ADL self-performance deficit, initiated 10/16/25, with interventions that were also initiated on 10/16/25. Resident #1 required assistance of one staff to use the toilet and required total assistance with transfers but did not specify how many CNAs were required to assist with transfers. The care plans were updated and revised on 10/15/25 after the incident occurred on 10/11/25 to reflect that the resident resisted care and had the potential to be physically aggressive with staff. The care plan was revised on 10/16/25 to include: allow the resident to make decision about treatment regime to provide a sense of control, give clear explanation to all care activities, if resident resists with adl's leave and return in five-ten minutes and try again Record review of CNA A's timecard reports showed CNA A worked:10/11/25: 6:00 a.m. - 2:21 p.m.10/12/25: 6:36 a.m.- 2:10 p.m. Record review of daily staffing schedule for 10/11/25 showed that CNA A was the only CNA that worked the memory care unit from 6 a.m. - 2 p.m. Record Review of the daily staffing schedule for 10/12/25 showed that CNA A worked 6 a.m.-2 p.m. on the north side (the opposite side) of the building. Record review of CNA A's employe file reflected CNA A was not suspended until 10/12/25 after completing her shift and was terminated on 10/16/25. The record reflected The Investigation proved she did not follow policy and procedure. Record review of the incident investigation worksheet reflected that the incident (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was not reported to state authorities until 2/15/25. Record Review of the police report reflected that a police report was filed by the facility administrator three days after the alleged abuse occurred on 10/15/25 at 2:19 p.m Review of the facilities policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, stated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.Policy Interpretation and ImplementationReporting Allegations to the Administrator and AuthoritiesIf resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:1. The state licensing/certification agency responsible for surveying/licensing the facility;The local/state ombudsman;The resident's representative;Adult protective services (where state law provides jurisdiction in long-term care);Law enforcement officials;The resident's attending physician; andThe facility medical director. Immediately is defined as:1. within two hours of an allegation involving abuse or resulting in serious bodily injury; orwithin 24 hours of an allegation that does not involve abuse or result in serious bodily injury.Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone.Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. During an interview on 12/30/25 at 12:00 p.m., the administrator stated the incident with CNA A and Resident #1 occurred on 10/11/25 between 5:30 a.m. and 6:00 a.m and she was not informed until a little after 8:00 a.m. on 10/11/25 which was a Saturday. LVN D informed her of the incident at about 11:00 a.m She stated this was three hours after the incident occurred. She stated she started the investigation of the incident and began to get witness statements to find out if in fact abuse had occurred. She stated she did not report the incident at this time because she did not have any facts. She stated the incident seemed inappropriate, but she did not immediately report it because it just did not scream out in black and white that abuse had occurred, or if it was just inappropriate behavior by the employee. She stated she tried to contact the former DON, at the time that she was called, but she did not answer her phone until at least 5 hours later. She stated the incident occurred on the weekend, and the DON was coming into work that evening. She stated when the DON returned her call, she stated she would go on in and start the investigation. The administrator stated she came in and started interviews with staff and in-services on abuse and customer service. The administrator stated she told the DON to move CNA A off the hallway. She stated she determined it was appropriate to move the aide off of the hall on the 10/11/25 because they had nothing concrete that abuse occurred. She stated CNA A was suspended on the 12th and terminated on the 16th. She stated she determined on Tuesday the 14th of October that it was reportable and she called the incident in to state and federal authorities and did a self-report. She stated she also reported it to the police at this time. During an Interview on 12/30/25 at 1:30 p.m., the former DON stated on Saturday, 10/11/25 at approximately 12:00 p.m., she received a call from the Administrator, who described the incident as a near miss for abuse; and stated corporate determined it was highly inappropriate behavior rather than abuse. On Sunday, 10/12/25 at approximately 2:45 a.m. while she was working overnight CNA B and CNA C approached the DON stating that on 10/11/25 around 5:30 a.m., CNA A had grabbed Resident #1 out of a chair and dragged her down the hallway by her feet. They expressed concern that the incident was not being (continued on next page)

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	455574	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Weatherford	521 W 7th St Weatherford, TX 76086

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	handled appropriately. The DON stated at 3:03 a.m. on 10/12/25, she texted the administrator regarding staff concerns of abuse. The DON stated she obtained written statements from the staff involved. She stated these statements consistently and described CNA A grabbing the resident, dropping her to the floor, and dragging her by her feet . She also stated she emailed the statements to the administrator, RNC (RN Consultant, and VPO (Vice President of Operations at 4:40 p.m. on 10/12/25. She stated the Administrator instructed her to suspend CNA A at that time. The DON further stated that on 10/13/25 she discussed the need to self-report the allegations of abuse to the state and local authorities with the Administrator, and the Administrator stated corporate instructed her not to self-report. The DON stated that due to her continued concerns that the allegation of abuse had not yet been reported to state and local authorities, she also contacted the corporate leadership (VPO) to report her concerns. During an interview on 12/30/25 at 3:00 p.m., LVN D stated on 10/11/25 around 6:00 a.m., CNA A reported that Resident #1 was acting up, was dirty and refused to be changed. She stated she went to the memory care unit and saw Resident #1 sitting in a chair and Resident #1 smelled of feces. She stated CNA A was standing in front of her talking loudly to Resident #1. She stated CNA A tried to get Resident #1 to get up and stop yelling. Resident #1 refused to get up and continued to yell. LVN D stated CNA A then reached underneath Resident #1's arms and attempted to pick her up from the chair and Resident #1 grabbed the chair to resist CNA A and then Resident # 1 slid down to the ground. She said CNA A, then grabbed Resident #1's ankles and dragged her on the floor down the hall to her room. She stated Resident #1 was screaming, yelling, and resisting CNA A as she dragged her down the hallway. LVN D stated she did not intervene because she was shocked to see the incident and also stated CNA A was so agitated that she was afraid she would aggravate the situation further if she intervened before they got to Resident #1's room. She stated CNA C arrived at that time and she told CNA C to take over Resident #1's care from CNA A. She stated she told CNA A to go off the hall and take a break, and CNA A left the memory care unit. LVN D stated she was the night shift charge nurse when this incident happened, and she was getting ready to go off duty. LVN D stated she did not intervene because CNA A was a large woman and was terribly upset which made her hesitant to approach her. LVN D stated she did notify the abuse coordinator/administrator of the incident. She stated she also notified the physician and the responsible party. She stated she did not remember the time that she called the administrator, but she knew that it was close to 11:00 a.m. before she ever left the building that morning. During an interview on 12/30/25 at 3:40 p.m., CNA B stated she went outside the memory care unit a little after 5:00 a.m. to ask CNA A for assistance. CNA A came into the unit and started screaming at Resident #1 and told her she had until the count of 3 to get up. CNA B stated Resident #1 was sitting in a gray chair by the television. CNA B stated she saw CNA A grab Resident #1 and pick her up out of her chair and lower her onto the floor. She stated CNA A then grabbed Resident #1 by the ankles and dragged her, while she laid on the floor, from the gray chair in the lobby to her room down the hallway. She stated when they got to the room CNA C and herself intervened at that time and took over Resident #1's care, at the direction of LVN D. She stated she did not immediately intervene on the behalf of Resident#1 as she had been trained to do by the facility. She stated she did not notify the abuse coordinator/administrator because she thought LVN D notified the administrator/abuse coordinator During an interview on 12/31/25 at 10:00 a.m. CNA A stated she no longer works at the facility and did work on 10/11/25. State when she arrived at the facility on 10/11/25 a little after 5:00 a.m. that CNA B came to her and told her Resident #1 was out of control. She stated CNA B told her Resident #1 needed to be changed but had refused. She stated Resident #1 was yelling and screaming. CNA A stated she told Resident #1 she needed to get up from the chair and (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	let her change her brief. She stated Resident #1 would not get up from the chair, and she tried to assist her to stand and at that time Resident #1 threw herself out of the chair and kicked at her and had her arms wrapped around her legs. She stated she took Resident #1's arms off her legs and Resident #1 continued to kick. CNA A stated there were a lot of residents around and she was afraid for those residents safety, so she grabbed Resident #1's legs and pulled her on the floor to her room by her ankles. She stated CNA B, CNA C, and LVN D were there didn't try to help her. She stated LVN D was the nurse, and she just watched the whole thing. she stated she worked the full shift on the memory care unit on 10/11/25 and worked again on 10/12/25 for 8 hours before she was suspended. She stated she was terminated on 10/16/25 due to this allegation of abuse, and was currently employed as a CNA at another nursing facility. In an interview on 12/31/25 at 3:00 p.m., the Administrator stated she viewed a video on 10/14/25 that was recorded by the facilities electronic monitoring system that captured the incident on video. She stated the facility had recently undergone a change of ownership, and she had just recently been hired as the Administrator. She stated she viewed the video with the former DON, and the ADON when she became aware and after she saw the film she reported the incident to the police and the state and federal authorities. She stated the film was no longer available at the facility as the system only retained the video in the system for about a week. She stated the facility immediately began the following corrections / interventions. The facility was evaluated to be in past noncompliance based on the corrections implemented prior to entrance. Review of the plan reflected: 1. Resident # 1 received a skin assessment on 10/11/25. Responsible party, Responsible party, Ombudsman, and Medical Director notified. Police notified on 9/14/25.CNA reassigned on 9/12/25 and suspended pending investigation for the allegation of abuse on 10/12/25. 2. All residents in the secured unit were given a skin assessment on 10/15/25. Interviewable residents were given a safe survey and residents unable to answer safe survey questions were given a skin assessment 10/15/25. 3. Education provided to the designated educators (managers) on the following for all staff members to include the Administrator, Assistant Director of Nursing, Social Services, Activity director, and the Wound Care Nurse, over the following by the [NAME] President of Clinical Operations. Abuse and neglect, De-escalation, Aggressive Behavior, and Mental Health Management, Resident Rights, and dignity. A competency test was given to all staff after the in-service. Completed 10/15/25. 4. Education provided to all staff by the designated educators (managers) on the following for all staff members to include the Administrator, Assistant Director of Nursing, Social Services, Activity director, and the Wound Care Nurse, over the following by the [NAME] President of Clinical Operations. Abuse and neglect, De-escalation, Aggressive Behavior, and Mental Health Management, Resident Rights, and dignity. A competency test was given to all staff after the in-service. Completed 10/15/25. 5. Five staff and five residents interviewed weekly for 4 weeks, to ensure any allegation of abuse has been reported by the education department. Any concerns noted during the interviews will be immediately addressed and reported to the administrator. Persons responsible for interviews will be Department Heads or designee. 10/16/25 completed. 6. Progress notes and incident reports will be reviewed during morning clinical meetings and by the weekend supervisor to ensure any documented abuse or potential abuse has been reported to the administrator or abuse coordinator and has been reported to HHSC per regulation. ADON, Wound Care Nurse, Weekend Supervisor and or Designee. 10/16/25 completed 7. Ad Hoc QAPI with the medical Director regarding the alleged incident and the facilities plan to be in compliance with regulations. 12/25/25 Verification:1.An Action Plan was developed, and an ad hoc meeting was conducted with the Medical Director on 10/15/25.-Verified by surveyor: Record review and Medical Director interview on 12/31/25 at 4:00 p.m. 2.Resident #1 received a skin assessment with no (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	injuries identified related to the incident and was observed at baseline without distress.-Verified by surveyor: Record review on 12/31/25 of skin assessment for 10/11/25 after incident and Interview with LVN E on 12/31/25 at 2:30 p.m 3.A psychiatric note dated 11/20/25 documented the resident had no recollection of the incident and no behavioral changes were observed.-Verified by surveyor by Record review on 12/31/25. 4.Responsible Party, Police, Ombudsman, and Medical Director were notified. -Verified: Interviews on 12/30/25 between 12:00 and 4:00 p.m. with interviews with the party responsible, Police Detective, and Medical Director. 5.CNA A was reassigned on 10.11.25 and suspended pending investigation on 10/12/25 after working full shifts on 10/11/25 and 10/12/25. CNA A was terminated on 10/15/25 By the former DON. -Verified 12/31/25 and 1/8/26 by review of personnel files: Interview with CNA A on 12/31/25 at 10:00 p.m. 6.CNA B and LVN D received education and disciplinary action and were subsequently terminated. -Verified: Record review of employee files and interviews revealed CNA A was suspended on 10/12/25 after 3 p.m. when she completed her shift. CNA A stated in an interview on 12/31/25 at 10:00 a.m. she was terminated on 10/15/25. LVN D was given disciplinary counseling by the Administrator on 10/21/25 and educated that she should have immediately intervened on 10/11/25. She self-terminated on 10/21/25. CNA B was given a written counseling by the ADON for failure to follow facility/company practices and procedures on 10/15/25. She self-terminated after she was counseled and finished her shift on 10/15/25.-CNA C was given a written warning on 10/15/25 by the ADON, for failure to follow facility policy and report immediately; and always stop the aggressor and try to diffuse the situation. She stated she was in-serviced by ADON on abuse-related education and completed competency testing prior to working her next shift. 7.All residents on the secured unit received skin assessments on 10/15/25. -Verified: Record review on 1/2/26. 8. Forty-two (42) Residents able to answer safe survey questions. Department Heads conducted a safety questionnaire; no concerns identified. Thirty-four (34) Residents unable to respond received skin assessments. Safe surveys were started and completed on 10/15/25. The skin assessments were started on 10/11/25 and completed on 10/17/25.-Verified: Interviews with residents #'s one thru ten on 12/31/25 between 12 p.m. and 5 p.m. 9.Leadership staff received education by V/P of Clinical Operations on Abuse and Neglect, De-escalation, Aggressive Behavior, Mental Health Management, Resident Rights, and Dignity on 10/15/25.-Verified: Training records reviewed on 1/2/26. Interviews with ADON, DON, RNC, and VPO on 1/2/26 10.The Administrator received counseling from VPO and RNC for failure to appropriately investigate the allegation and suspend the AP immediately; and was instructed that all abuse allegations must be investigated and reported. -Verified: Record review of counseling in employee file on 12/31/25. Counseling occurred on 10/25/25 by VPO. 11.All staff received abuse-related education by department heads that had been educated by the RNC and VPO on 10/15/25 and completed competency testing prior to working their next shift. -Verified: Sign-in sheets, post-tests, and staff A, B, C, D, E, F, G, H, I, J interviews on 12/31/25 between 8 and 5:30 p.m. different shifts and positions. 12.The facility implemented weekly interviews by Department Heads of 5 staff and 5 residents for four weeks beginning 10/16/25 to monitor abuse reporting compliance. Surveyor Verified: Documentation review and interviews with ten staff members D, E, F, G, H, I, J, K, L, M, and seven residents #'s 2, 3, 4, 5, 6, 7, 8, on 12/31/25. 13.Daily review of progress notes and incident reports by the DON or weekend supervisor was implemented to ensure timely reporting to the Administrator/Abuse Coordinator and HHSC.-Verified: Staff interview with RN J on 12/31/25 DON, And Administrator, stated process involves going over them, signing off on them, and handing them to the administrator. 14.An ad hoc QAPI review was conducted with the Medical Director on 10/15/25. -Verified: Record review on 12/31/25.