STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455834	A. Building B. Wing	05/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Athens	150 Gibson Rd Athens, TX 75751

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 - Minimal harm or potential for actual harm 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, interviews and record review, the facility failed to ensure residents were free from physical abuse for 1 of 8 residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 was free from physical abuse when CNA B slapped Resident #1's arm during patient care on 5/10/26.This failure could place residents at risk for physical abuse, mental abuse, emotional abuse, and harm.Findings included:Record review of an undated Face sheet printed on 5/30/26 indicated Resident #1 was a [AGE] year-old male who admitted on [DATE] with diagnoses including dementia without behavioral disturbance (a clinical presentation where a person experiences progressive decline in cognitive functions (like memory, thinking, or language) that interferes with daily life, but without accompanying psychiatric or behavioral symptoms such as aggression, severe agitation, or delusions), chronic kidney disease (the progressive loss of kidney function over time, impairing the organ's ability to filter waste and excess fluid from your blood) and heart failure (occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath.)Record review of Resident #1's undated care plan indicated the following:Focus: The resident is/has potential to be physically aggressive due to poor impulse control. Intervention: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later.Focus: The resident is resistive to care due to impaired cognition and poor impulse control. Resident has refused oral care, oxygen, pericare, assistance with ADLs, overall care with well-being. Interventions: -If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. - Provide consistency in care to promote comfort with ADLs. Maintain consistency in timing of ADLs, caregivers and routine, as much as possible - Praise the resident when behavior is appropriate.Record review of quarterly MDS dated [DATE] indicated Resident #1 responded adequately to simple, direct communications only and his ability was limited to making concrete requests with a BIMS score of 2 which indicated he had severely impaired cognition and was not able to answer questions. He required extensive assistance in performing most ADLs. He was incontinent of bowel and incontinent of bladder. Resident #1 had no physical, verbal or other behavioral symptoms directed towards others.Record review of Resident #1's incident report dated 5/10/26 completed by the DON indicated the incident happened in Resident #1's room. Nursing Description: [CNA C] reported that during shift change rounds that [CNA B] hit [Resident #1's] hand when he grabbed [CNA B] Incident was reported to DON on 5/12/26 and Abuse coordinator, the Administrator. Report was filed with HHSC #1089798. We [facility] also reported incident to [Resident #1's family member] by phone and with local Police department. Office [name of police office] responded to call and stated, after speaking with his supervisor stated that no report would be filed and there were no criminal charges. He stated he would log the call and we [facility] should handle the issue internally. Resident Description: Unable to respond to questions; Immediate Action Taken: [CNA B], was suspended and left the building. [Resident #1] was interviewed and was unable to answer questions due to [stroke]. He (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 - Minimal harm or potential for actual harm Residents Affected - Few	[did] have a history of hitting staff. [CNA B's] other residents assigned to her care were interviewed and no one had any concerns about their treatment of care.Record review of Resident #1's Progress notes indicated the following: -On 05/12/26 at 8:13am; completed by DON: Met with [Resident #1] at bedside to evaluate his mental state. [Resident #1] is mostly non- verbal but occasionally will say yes/ no or thank you when offered a drink. [Resident #1] will grab at staff when they attempt to turn him or move any of his extremities but is easily refocused once they stop moving him . -On 05/13/26 at 12:21pm; completed by DON: Meeting held with [CNA B] [Administrator] DON, and HR to discuss incident. [CNA B] admits to swatting residents' hand away after he violently grabbed her arm. [CNA B] admits to being unaware that this was abuse and agrees to not ever do this again. She [CNA B] is permitted to return to work, and DON will continue to follow her closely. Record review of written statement dated 5/12/26 completed by CNA C indicated the following: On May 10th after 6pm I [CNA C] was doing the exchange with [CNA B]. As we got to [Resident #1], [CNA B] hit [Resident #1] hard on his arm. [Resident #1] did not touch [CNA B]. After [CNA B] hit [Resident #1] she proceeded to yell at [Resident #1]. I [CNA C] stepped away and told [LVN D]. [LVN D] told me that the DON would reach out to me [CNA C], and DON [had] not. [LVN D] said [DON] forgot to address the issue. I [CNA C] was unaware I [CNA C] didn't report this correctly.Record review of written statement dated 5/12/26 completed by CNA B indicated the following: During an interaction with patient [Resident #1], he struck my arm violently (it should be noted that this was the second such instance, as a report has already been filed). In response- much as one would do with a child, I [CNA B] tapped his [Resident #1] hand gently, telling him not to do it again. He [Resident #1] suffered no harm. I [CNA B] do not consider my conduct towards [Resident #1] to have been abusive, as I [CNA B] am committed to providing [Resident #1] with all the care to which he is entitled to.Record review of CNA Bs suspension employee counseling form dated 5/12/26, completed by the ADON indicated Details of Situation: [CNA B] to be suspended pending abuse allegation of a resident.Record review of CNA B written employee counseling form dated 5/13/26, completed by the Administrator indicated Details of Situation: Investigation Interview and resolution/ determination of inconclusive/guiltExpected outcome: [CNA B] was interviewed and questioned by [Administrator] DON and HR Regional Consultant. Determination - No intent to harm, reflective move to avoid second time from being slapped by [Resident #1]. Comment: Unsubstantiated allegation of Abuse, Reinstatement Authorized and payment due for one shift 5/12/26.Record review of the provider investigation report dated 5/15/26 indicated the facility reported an allegation of abuse involving Resident #1 and CNA B to HHSC on 5/12/26 at 7:25am. Further review indicated the alleged incident occurred on 5/10/26 at approximately 6:00pm.Record review of facility's typed investigation summary dated 5/15/26 completed by [Administrator] abuse/neglect coordinator revealed On Sunday evening, May 10, 2026, at approximately 6:00pm, [CNA B] and [CNA C] were tending to the needs of [Resident #1] in his room. During the care, [Resident #1] reached up to grab [CNA B's] face, and [CNA B] batted [Resident #1's] hand away. [CNA C] said she reported the physical contact to her nurse [LVN D] however the information did not arrive to the abuse coordinator until Tuesday morning May 12, 2026, at 5:45am. Treatment Nurse, performed a head-to-toe assessment on May 12, 2026, at 7:00am and found no injuries.Regarding late reporting: Witness [CNA C] was counselled for not following proper abuse reporting procedure.During an observation and attempted interview on 5/31/26 at 4:55pm, Resident #1 was in DR waiting for the dinner meal. He was not able to answer what his name was or the day and date when the Administrator asked Resident #1. Resident #1 was clean, well-groomed with no unpleasant odor. There were no visible bruising, skin tears or marks to Resident #1's upper body area.During an interview on 05/30/26 at 6:45 p.m., CNA C stated she had been employed at the facility since 4/12/26 and worked the 6:00pm to 6:00am shift. CNA C stated that on 5/10/26 she witnessed CNA B strike Resident #1 on the arm after the resident raised his arm. CNA C stated Resident #1 had a history of physical aggression toward staff; however, at the time of the incident, Resident #1 had not physically acted toward CNA B. CNA C stated she exited the room and (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported the allegation of abuse to LVN D. CNA C stated LVN D informed her that the DON had been notified via text message and showed CNA C the text message sent to the DON. CNA C stated that by 5/12/26 she had not been contacted by the DON regarding the allegation and subsequently notified LVN E of the incident. CNA C stated LVN E then sent a group text message notifying the Administrator and DON of the allegation involving CNA B and Resident #1. CNA C stated she later received disciplinary action for failing to notify the abuse coordinator. CNA C stated she was a new employee and was unaware of the facility's abuse reporting procedure, including the requirement to notify the abuse coordinator/Administrator directly.During an attempted interview on 5/31/2026 at 3:27pm, LVN D was called but she did not answer, and it went to voice mail, and a message was left to return the call related to the investigation. During an interview on 05/31/26 at 5:04 p.m., The DON stated she first became aware of the alleged abuse incident involving Resident #1 on 05/12/26 after LVN E sent a group text message to the DON and abuse coordinator reporting that CNA C had witnessed CNA B physically abuse Resident #1 on 05/10/26 and had previously reported the allegation to another staff member. During an interview on 05/31/26 at 5:55 p.m., the Administrator said he was the abuse coordinator and followed their abuse policy, did criminal history checks upon hire, did in-services with his staff and reported everything to the state. The Administrator said CNA B was written up due to the incident.During an attempted interview on 6/09/26 at 3:57pm, CNA B was called; however, there was no answer and the phone number did not have a voicemail option available.Record review of an undated abuse/ reportable events policy indicated the following: Residents have the right to be free from abuse, 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 physical or chemical restraint not required to treat the resident's symptoms .

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all 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 to the Administrator of the facility for 1 of 8 (Resident #1) residents reviewed for abuse. The facility failed to ensure CNA C and LVN D immediately reported an allegation of staff-to-resident abuse on 5/10/26 when CNA B slapped Resident #1's arm to the facility Administrator This failure could place residents at risk of injuries, abuse, and/or neglect.Findings included: Record review of an undated Face sheet printed on 5/30/26 indicated Resident #1 was a [AGE] year-old male who admitted on [DATE] with diagnoses including dementia without behavioral disturbance (a clinical presentation where a person experiences progressive decline in cognitive functions (like memory, thinking, or language) that interferes with daily life, but without accompanying psychiatric or behavioral symptoms such as aggression, severe agitation, or delusions), chronic kidney disease (the progressive loss of kidney function over time, impairing the organ's ability to filter waste and excess fluid from your blood) and heart failure (occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath.) Record review of Resident #1's undated care plan indicated the following:Focus: The resident is/has potential to be physically aggressive due to poor impulse control. Intervention: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Focus: The resident is resistive to care due to impaired cognition and poor impulse control. Resident has refused oral care, oxygen, pericare, assistance with ADLs, overall care with well-being. Interventions: -If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. - Provide consistency in care to promote comfort with ADLs. Maintain consistency in timing of ADLs, caregivers and routine, as much as possible - Praise the resident when behavior is appropriate. Record review of quarterly MDS dated [DATE] indicated Resident #1 responded adequately to simple, direct communications only and his ability was limited to making concrete requests with a BIMS score of 2 which indicated he had severely impaired cognition and was not able to answer questions. He required extensive assistance in performing most ADLs. He was incontinent of bowel and incontinent of bladder. Resident #1 had no physical, verbal or other behavioral symptoms directed towards others. Record review of Resident #1's incident report dated 5/10/26 completed by the DON indicated the incident happened in Resident #1's room. Nursing Description: [CNA C] reported that during shift change rounds that [CNA B] hit [Resident #1's] hand when he grabbed [CNA B] Incident was reported to DON on 5/12/26 and Abuse coordinator, the Administrator. Report was filed with HHSC #1089798. We [facility] also reported incident to [Resident #1's family member] by phone and with local Police department. Office [name of police office] responded to call and stated, after speaking with his supervisor stated that no report would be filed and there were no criminal charges. He stated he would log the call and we [facility] should handle the issue internally. Resident Description: Unable to respond to questions; Immediate Action Taken: [CNA B], was suspended and left the building. [Resident #1] was interviewed and was unable to answer questions due to [stroke]. He [did] have a history of hitting staff.[CNA B's] other residents assigned to her care were interviewed and no one had any concerns about their treatment of care. Record review of Resident #1's Progress notes dated 05/12/26 indicated the following:- at 7:20am; Completed by DON: LATE ENTRY - [Administrator], abuse coordinator contacted and self-reported incident to HHSC, report number 1089798. -at 8:13am; completed by DON: Met with [Resident #1] at bedside to evaluate his mental state. [Resident #1] is mostly non- verbal but occasionally will say yes/ no or thank you when (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered a drink. [Resident #1] will grab at staff when they attempt to turn him or move any of his extremities but is easily refocused once they stop moving him. Record review of written statement dated 5/12/26 completed by CNA C indicated the following: On May 10th after 6pm I [CNA C] was doing the exchange with [CNA B]. As we got to [Resident #1], [CNA B] hit [Resident #1] hard on his arm. [Resident #1] did not touch [CNA B]. After [CNA B] hit [Resident #1] she proceeded to yell at [Resident #1]. I [CNA C] stepped away and told [LVN D]. [LVN D] told me that the DON would reach out to me [CNA C], and DON [had] not. [LVN D] said [DON] forgot to address the issue. I [CNA C] was unaware I [CNA C] didn't report this correctly. Record review of CNA C's verbal employee counseling form dated 5/12/26, completed by the ADON indicated Details of Situation: [CNA C] did not report abuse allegation to the administrator at the time of incident. Expected outcome: Any and All abuse allegation are to be reported straight to the admin. Record review of the provider investigation report dated 5/15/26 indicated the facility reported an allegation of abuse involving Resident #1 and CNA B to HHSC on 5/12/26 at 7:25am. Further review indicated the alleged incident occurred on 5/10/26 at approximately 6:00pm. Record review of facility's typed investigation summary dated 5/15/26 completed by [Administrator] abuse/neglect coordinator revealed On Sunday evening, May 10, 2026, at approximately 6:00pm, [CNA B] and [CNA C] were tending to the needs of [Resident #1] in his room. During the care, [Resident #1] reached up to grab [CNA B's] face, and [CNA B] batted [Resident #1's] hand away. [CNA C] said she reported the physical contact to her nurse [LVN D] however the information did not arrive to the abuse coordinator until Tuesday morning May 12, 2026, at 5:45am. Treatment Nurse, performed a head-to-toe assessment on May 12, 2026, at 7:00am and found no injuries.Regarding late reporting: Witness [CNA C] was counselled for not following proper abuse reporting procedure. During an observation and attempted interview on 5/31/26 at 4:55pm, Resident #1 was in DR waiting for the dinner meal. He was not able to answer what his name was or the day and date when the Administrator asked Resident #1. Resident #1 was clean, well-groomed with no unpleasant odor. There were no visible bruising, skin tears or marks to Resident #1's upper body area. During an interview on 05/30/26 at 6:45 p.m., CNA C stated she had been employed at the facility since 4/12/26 and worked the 6:00pm to 6:00am shift. CNA C stated that on 5/10/26 she witnessed CNA B strike Resident #1 on the arm after the resident raised his arm. CNA C stated Resident #1 had a history of physical aggression toward staff; however, at the time of the incident, Resident #1 had not physically acted toward CNA B. CNA C stated she exited the room and reported the allegation of abuse to LVN D. CNA C stated LVN D informed her that the DON had been notified via text message and showed CNA C the text message sent to the DON. CNA C stated that by 5/12/26 she had not been contacted by the DON regarding the allegation and subsequently notified LVN E of the incident. CNA C stated LVN E then sent a group text message notifying the Administrator and DON of the allegation involving CNA B and Resident #1. CNA C stated she later received disciplinary action for failing to notify the abuse coordinator. CNA C stated she was a new employee and was unaware of the facility's abuse reporting procedure, including the requirement to notify the abuse coordinator/Administrator directly. During an attempted interview on 5/31/2026 at 3:27pm, LVN D was called but she did not answer, and it went to voice mail, and a message was left to return the call related to the investigation. During an attempted interview on 5/31/26 at 3:50pm, CNA B was called; however, there was no answer and the phone number did not have a voicemail option available. During an interview on 05/31/26 at 5:04 p.m., the DON stated she never received a text message from LVN D regarding the alleged abuse incident on 05/10/26. The DON stated she later discovered LVN D did not have the correct contact number for her. The DON stated she first became aware of the alleged abuse incident involving Resident #1 on 05/12/26 after LVN E sent a group text message to the DON and abuse coordinator reporting that CNA C had witnessed CNA B physically abuse Resident #1 on 05/10/26 and had previously reported the allegation to another staff member. The DON stated both CNA C and LVN D should have notified the abuse coordinator directly and expected staff to immediately report all allegations of abuse and neglect to the abuse coordinator. The DON stated LVN (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D was a newly hired nurse and that 05/10/26 was LVN D's first solo shift as charge nurse. The DON stated it was possible LVN D was unaware she was required to contact the abuse coordinator directly rather than only notifying the DON. The DON stated LVN D no longer worked at the facility and had worked only a few shifts following the 05/10/26 incident prior to resigning. During an interview on 05/31/26 at 5:55 p.m., the Administrator stated he served as the facility's Abuse Coordinator and was responsible for ensuring compliance with the facility's abuse policy and State reporting requirements. The Administrator stated the facility became aware of an allegation of potential staff-to-resident abuse involving CNA B and Resident #1 on 05/10/26 at approximately 6:00 p.m.; however, he was not notified of the allegation until the morning of 05/12/26. The Administrator stated the allegation was reported to the State agency upon his notification. The Administrator stated staff was expected to immediately report allegations of abuse to the Abuse Coordinator. The Administrator said the facility failed to report the allegation to the State agency within the required timeframe after the allegation became known to the facility, due to CNA C not following the facility's reporting procedures. The Administrator further stated CNA C received disciplinary action for failure to timely report the allegation to facility administration. During an attempted interview on 6/09/26 at 3:57pm, CNA B was called; however, there was no answer and the phone number did not have a voicemail option available. Record review of an undated abuse/ reportable events policy indicated the following: .Reporting: Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC.If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.