

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455923	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/09/2026
NAME OF PROVIDER OR SUPPLIER  Avir at Beeville		STREET ADDRESS, CITY, STATE, ZIP CODE  600 S Hillside Dr Beeville, TX 78102	

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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to ensure that one of five residents (Resident #1) and RP was notified of the transfer or discharge and the reasons for the move in writing as soon as practicable before transfer or discharge. The facility failed to provide written notice of discharge to Resident #1 and his RP before he was discharged from the facility on 03/25/26. This failure could put residents at risk for inappropriate discharge from the facility. The findings included: Record review of Resident #1's face sheet dated 04/09/26 revealed a [AGE] year-old male with an initial admission date of 06/14/25 and a discharge date of 03/25/26. The pertinent diagnoses included schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions, disorganized speech) with a major mood disorder, such as depression or bipolar disorder) and dementia (a progressive syndrome characterized by a decline in memory, language, and thinking severe enough to disrupt daily life). Record review of Resident #1's Discharge MDS dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. Record review of Resident #1's care plan dated 04/09/26 revealed the focuses: [Resident #1] had an episode of physical aggression towards a staff member and a resident. He raised his hand in a motion to hit a staff member but did not follow through. He was observed yelling and swinging on staff members initiated on 08/01/25. [Resident #1] has a behavior problem R/T Dementia. He urinated all over his room and in main common area. He can be easily agitated and angered towards other noises. At times, he has been sexually inappropriate with staff members. He is easily redirected initiated on 11/26/25. Record review of Resident #1's Discharge Summary on 04/09/26 revealed Resident #1 was discharged from the facility at 6:44 AM on 03/25/26, released to a different facility, RP was notified of the discharge and Resident #1 was not expected to return. In an interview with the DON at 2:19 PM on 04/09/26, the DON stated there was no formal written notice of discharge given to the RP for Resident #1. The DON stated no formal written notice was given because the transfer was agreed upon by the RP. The DON stated no one disputed the discharge. The DON stated the ADM was usually the one that issued 30-day notices to residents and their RPs. The DON stated she told the RP about the discharge the day before it happened on 03/24/26. The DON stated it had been an ongoing situation with Resident #1 and they had been looking for a new facility for him for a while. The DON stated the RP had been aware of the search for a new facility and was in support of the decision to send Resident #1 to a new facility. The DON stated this discharge was urgent because Resident #1 posed a safety risk to himself and others in the facility. The DON stated if a written notice was not provided then the RP could forget information about the discharge. In an interview with the ADM at 2:26 PM on 04/09/26, the ADM stated to her knowledge no written discharge notice was given to Resident #1's RP. The ADM stated she usually sent the discharge notices to all necessary entities when appropriate. The ADM stated the RP never expressed to her that the RP was against the discharge. The ADM stated this discharge was urgent because Resident #1 posed a safety risk to himself and others in the facility. The ADM stated if important information is not written down and provided to the RP then they may forget it after a meeting. A facility policy was provided by the ADM at 1:30 PM on 04/07/26 (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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>concerning transfers and discharges from the facility, but it did not state a formal written discharge notice must be given to the RP during a discharge when the health and safety of others were at risk.</p>		