STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Pittsburg	123 Pecan Grove Pittsburg, TX 75686

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse for 1 of 8 (Resident #1) residents reviewed for abuse. 1.The facility failed to prevent MA A from physically abusing Resident #1 on 5/23/25 witnessed by Resident #2's family member. 2. The facility failed to protect other residents in the building from potential abuse when on 05/23/2025 the facility did not suspend MA A for 1 month after the incident leading to MA A's termination on 06/27/2025. The noncompliance was identified as PNC. The IJ began on 5/23/25 and ended on 6/30/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for physical and verbal abuse, psychosocial harm, and decreased quality of life. Findings included: 1. Record review of the face sheet dated 7/1/25 indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including dementia, psychosis, restlessness and agitation, and anxiety disorder. Record review of the MDS dated [DATE] indicated Resident # 1 sometimes understood others and was sometimes understood by others. The MDS indicated Resident #1 had a BIMS of 00 and was severely cognitively impaired. The MDS indicated during the 7-day look back period, Resident #1 did not have any physical or verbal behaviors towards others. Record review of the care plan last updated 3/12/25 indicated Resident #1 had a diagnosis of anxiety and exhibited signs and symptoms of anxiety/behaviors of pacing and aggression. Record review of the PIR dated 6/23/25 indicated Resident #2's (another resident residing in the secured unit) family member reported to the DON that they witnessed MA A punch Resident #1 in the chest after Resident #1 kicked MA A on 5/23/25. The PIR indicated Resident #2's family member reported the incident to the former ADON on 5/27/25. The PIR indicated Resident #2's family member said the former ADON told them he had removed MA A from the secured unit, and that MA A would no longer be assigned to cover the secured unit. The PIR indicated Resident #2's family member said the reason they were disclosing this information now was because MA A had been assigned to an overnight shift on the unit on 6/20/25. The PIR indicated a skin assessment was performed on 6/23/25 on Resident #1, MA A was suspended and later terminated, safe surveys were completed, notifications were made to the NP and Resident #1's family, staff were in-serviced regarding abuse/neglect, mandatory notifications, and behavior management and de-escalation, and the former ADON was given a one-to-one in-service regarding abuse/neglect and mandatory notifications. During an interview on 7/1/25 at 11:28 a.m. the former ADON said he remembered on 5/23/25 he walked on to the secured unit and heard staff talking about something (He was not sure what was being discussed). He said he gathered it had something to do with MA A. The former ADON said he left the secured unit, and no one reported anything to him while he was on the unit. The former ADON said about 30 minutes later MA A was walking past his office and he asked her to come in and talk to him. The former ADON said he asked MA A what was going on. The former ADON said MA A told him she almost lost it on Resident #1 after he (Resident #1) kicked her, but she did not lose it and that the former ADON should be proud of her. The former ADON said MA A said Resident #2's family member had witnessed the incident. The former ADON said later (date not given) Resident #2's family member told him she had seen Resident #1 trip MA A. The former ADON said Resident #2's family member said it could have been bad and they did not know what would have happened if they had not witnessed the incident. The former ADON said Resident #2's family member had told him they did not feel MA A should be working on the secured unit. The former ADON said he changed MA A's work assignment and took her off the secured unit. The former ADON said he informed Resident #2's family member of who the abuse coordinator was, and they said they did not want to report anything. The former ADON said he did not report the incident to the Administrator due to nothing being specifically reported to him regarding abuse. The former ADON said he resigned from his ADON position, but had chose to remain at the facility as a charge nurse. During an interview on 7/1/25 at 11:38 a.m. MA A said on 5/23/25 she was walking around a table to sit down when Resident #1 tripped/kicked her, and she fell into the table. MA A said she pushed Resident #1 in the shoulder and told him no we don't do that. MA A said staff should never lay hands on a resident because it was considered abuse. MA A said she had just reacted that day and did not think anything of it because it was more of a push than a hit. During an interview on 7/1/25 at 1:05 p.m. Resident #2's family member said they witnessed the incident between MA A and Resident #1. Resident #2's family member said MA A was walking past Resident #1 when he kicked her in the butt. Resident #2's family member said MA A stumbled and almost fell. Resident #2's family member said

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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 - Immediate jeopardy to resident health or safety 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 interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but , but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury for 1 of 8 (Resident #1) residents reviewed for abuse and neglect. The facility failed to ensure an allegation of abuse on 05/23/2025 was reported within 2 hours to the abuse coordinator on 5/27/25 when Resident #2's family member reported the abuse of Resident #1 to the former ADON. This failure to report resulted in MA A continuing to work with residents and being assigned to Resident #1's unit again on 06/20/2025. MA A continued to work until the family member reported the incident to the Administrator on 06/23/2025. The facility failed to report the allegation of abuse within 24 hours on 05/23/2025 when MA hit Resident #1. The facility failed to suspend MA A for 1 month after the incident. The noncompliance was identified as PNC. The IJ began on 5/23/25 and ended on 6/30/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings included: Record review of the face sheet dated 7/1/25 indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including dementia, psychosis, restlessness and agitation, and anxiety disorder. Record review of the MDS dated [DATE] indicated Resident # 1 sometimes understood others and was sometimes understood by others. The MDS indicated Resident #1 had a BIMS of 00 and was severely cognitively impaired. The MDS indicated during the 7-day look back period Resident #1 did not have any physical or verbal behaviors towards others. Record review of the care plan last updated 3/12/25 indicated Resident #1 had a diagnosis of anxiety and exhibited signs and symptoms 0f anxiety/behaviors of pacing and aggression. Record review in TULIP on 7/1/25 indicated the incident of alleged abuse by MA A to Resident #1 that occurred on 5/23/25 was not reported to the state agency until 6/23/25. (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the PIR dated 6/23/25 indicated Resident #2’s family member reported to the DON that they witnessed MA A punch Resident #1 in the chest after Resident #1 kicked MA on 5/23/25. The PIR indicated Resident #2’s family member reported the incident to the former ADON on 5/27/25. The PIR indicated Resident #2’s family member said the former ADON told them he had removed MA A from the secured unit, and that MA A would no longer be assigned to cover the secured unit. The PIR indicated Resident #2’s family member said the reason they were disclosing this information now was because MA A had been assigned to an overnight shift on the unit on 6/20/25. The PIR indicated a skin assessment was performed on Resident #1, MA A was suspended and later terminated, safe surveys were completed, notifications were made to the NP and Resident #1’s family, staff were in-serviced regarding abuse/neglect, mandatory notifications, and behavior management and de-escalation, and the former ADON was given a one-to-one in-service regarding abuse/neglect and mandatory notifications. During an interview on 7/1/25 at 11:28 a.m. the former ADON said he remember on 5/23/25 he walked on to the secured unit and heard staff talking about something (He was not sure what was being discussed). He said he gathered it had something to do with MA A. The former ADON said he left the secured unit, and no one reported anything to him while he was on the unit. The former ADON said about 30 minutes later MA A was walking past his office and he asked her to come in and talk to him. The former ADON said he asked MA A what was going on. The former ADON said MA A told him she almost lost it on Resident #1 after he (Resident #1) kicked her, but she did not lose it and that the former ADON should be proud of her. The former ADON said MA A said Resident #2’s family member had witnessed the incident. The former ADON said later (date not given) Resident #2’s family member told him she had seen Resident #1 trip MA A. The former ADON said Resident #2’s family member said it could have been bad and they did not know what would have happened if they had not witnessed the incident. The former ADON said Resident #2’s family member had told him they did not feel MA A should be working on the secured unit. The former ADON said he changed MA A’s work assignment and took her off the secured unit. The former ADON said he informed Resident #2’s family member of who the abuse coordinator was, and they said they did not want to report anything. The former ADON said he did not report the incident to the Administrator due to nothing being specifically reported to him regarding abuse. The former ADON said he resigned from his ADON position but had chosen to remain at the facility as a charge nurse. I During an interview on 7/1/25 at 1:05 p.m. Resident #2’s family member said they witnessed the incident between MA A and Resident #1. Resident #2’s family member said MA A was walking past Resident #1 when he kicked her in the butt. Resident #2’s family member said MA A stumbled and almost fell. Resident #2’s family member said when MA A regained her balance, she doubled up her fist and hit Resident #1 in the chest. Resident #2’s family member said they reported the incident to the former ADON 4 days later and they did not know what came of it. Resident #2’s family member said they had recently reported the incident to the Administrator because MA A was working on the secured unit again and they were afraid of what might happen if MA A was on the unit at night by herself with no witness. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/3/25 at 2:25 p.m. the Administrator said she expected staff to act professional and not hit the residents. The Administrator said all residents had the right to be safe from abuse. The Administrator said she reported the incident of alleged abuse on 5/23/25 as soon as she found out about the incident on 6/23/25. The Administrator said she expected staff to immediately report any incidents of alleged or suspected abuse to her immediately. The Administrator said the importance of reporting abuse to the state agency in a timely manner was to aide in preventing further abuse and to protect the residents from abuse. Record review of the facility’s Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy last revised September 2022 indicated, “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….Reporting Allegations to the Administrator and Authorities: 1. If 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…3. “Immediately” is defined as: a. withing two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in bodily injury…12. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete…” The Administrator was notified on 7/1/25 at 4:45 p.m. that a Past Non-Compliance Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 7/1/25 at 4:52 p.m. The facility had corrected the noncompliance prior to surveyor entrance by the following: • Suspending and Terminating MA A• In-servicing staff regarding abuse and neglect, mandatory notifications, and behavior management and de-escalation. The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by: • Record review of Record of Employee Counseling dated 6/27/25 indicated on 6/23/25 an allegation of abuse was made against MA A. The Record of Employee Counseling indicated MA A was immediately suspended on 6/23/25 pending investigation. The Record of Employee Counseling indicated the outcome of the investigation was that MA A, by her own statement, did place her hands on Resident #1’s chest and push him. The Record of Employee Counseling indicated MA A was terminated on 6/27/25.• Record review of Record of Employee Counseling dated 6/26/25 indicated the former ADON received written counseling regarding failing to notify the Administrator, abuse coordinator, of an allegation of abuse. The Record of Employee Counseling indicated the former ADON would immediately report any knowledge of allegations of abuse/neglect to the Administrator (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.• Record review of in-services dated 6/23/25 indicated all staff were in-serviced regarding abuse and neglect and immediate notifications required to be made to the Administrator and DON• Record review of in-services dated 6/30/25 indicated all staff were in-serviced regarding dementia, aggressive behaviors, and de-escalation of a situation.Staff interviewed (CNA B, LVN C, LVN D, CNA E, CNA F, CNA G, LVN H, Housekeeper J, CNA K, and the Director of Housekeeping) on 7/1/25 between 2:00 p.m. and 2:20 p.m. were able to name all types of abuse, what to do in the event of witnessed or reported abuse, and who the Abuse Coordinator was. Record review of the Skin assessment dated [DATE] indicated Resident #1 did not have any skin issues Record review of the Safe 'Surveys conduct on 6/23/25 indicated residents interviewed did not have any concerns or complaints, felt staff treated them with dignity and respect, felt safe and comfortable at the facility, had not witnessed or heard anyone be mistreated, and was not afraid of any resident or visitor. Observations made between 7/1/25 and 7/3/25 indicated staff treated resident with dignity and respect. Residents interviewed (Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) on 7/1/25 and 7/2/25 between 9:20 a.m. and 3:15 p.m. said they were treated well at the facility, were not scared of anyone in the facility, and no one in the facility had ever abused them physically or verbally. The noncompliance was identified as PNC. The IJ began on 05/23/2025 and ended on 06/23/2025. The facility had corrected the noncompliance before the survey began.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress from 1 of 11 staff members (MA A) and 1 of 8 residents (Resident #1) reviewed for abuse.The facility failed to protect residents from potential abuse when MA A was not suspended after an allegation of physical abuse was reported to the former ADON on 05/27/25. This failure to report resulted in MA A continuing to work with residents and being assigned to Resident #1's unit again on 06/20/2025. MA A continued to work until the family member reported the incident to the Administrator on 06/23/2025. The noncompliance was identified as PNC. The IJ began on 5/27/25 and ended on 6/30/25. The facility had corrected the noncompliance before the survey began.This failure could place residents at risk for further abuse from a staff member. Findings included: Record review of the face sheet dated 7/1/25 indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including dementia, psychosis, restlessness and agitation, and anxiety disorder. Record review of the MDS dated [DATE] indicated Resident # 1 sometimes understood others and was sometimes understood by others. The MDS indicated Resident #1 had a BIMS of 00 and was severely cognitively impaired. The MDS indicated during the 7-day look back period Resident #1 did not have any physical or verbal behaviors towards others. Record review of the care plan last updated 3/12/25 indicated Resident #1 had a diagnosis of anxiety and exhibited signs and symptoms 0f anxiety/behaviors of pacing and aggression. Record review of the PIR dated 6/23/25 indicated Resident #2’s family member reported to the DON that they witnessed MA A punch Resident #1 in the chest after Resident #1 kicked MA on 5/23/25. The PIR indicated Resident #2’s family member reported the incident to the former ADON on 5/27/25. The PIR indicated Resident #2’s family member said the former ADON told them he had removed MA A from the secured unit, and that MA A would no longer be assigned to cover the secured unit. The PIR indicated Resident #2’s family member said the reason they were disclosing this information now was because MA A had been assigned to an overnight shift on the unit on 6/20/25. The PIR indicated a skin assessment was performed on Resident #1, MA A was suspended and later terminated, safe surveys were completed, notifications were made to the NP and Resident #1’s family, staff were in-serviced regarding abuse/neglect, mandatory notifications, and behavior management and de-escalation, and the former ADON was given a one-to-one in-service regarding abuse/neglect and mandatory notifications. Record review of MA A’s daily timecard dated 5/23/25 through 6/23/25 indicated MA A worked on the following days:5/23/25-8.07 hours5/24/25-8.43 hours5/26/25-7.82 hours5/27/25-8.15 hours5/28/25-8.03 hours5/29/24-7.87 hours5/30/25-7.48 hours5/31/25-8.32 hours6/2/25-8.00 hours6/3/25-5.82 hours6/4/25-7.87 hours6/5/25-7.98 hours6/6/25-8.05 hours6/9/25-8.07 hours6/10/25-13.20 hours6/11/25-0.43 hours6/12/25-8.13 hours6/13/25-8.32 hours6/16/25-7.10 hours6/17/25-7.13 hours6/18/25-8.00 hours6/19/25-7.97 hours6/20/25-14.70 hours6/23/25-2.85 hoursThe daily timecard did not indicate where in the facility MA A had worked on these days. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/1/25 at 11:28 a.m. the former ADON said on 5/23/25 he walked on to the secured unit and heard staff talking about something. He said he gathered it had something to do with MA A. The former ADON said he left the secured unit and no one reported anything to him while he was on the unit. The former ADON said about 30 minutes later MA A was walking past his office and he asked her to come in and talk to him. The former ADON said he asked MA A what was going on. The former ADON said MA A told him she almost lost it on Resident #1 after he kicked her but she did not and that the former ADON should be proud of her. The former ADON said MA A said Resident #2’s family member had witnessed the incident. The former ADON said later (date not given) Resident #2’s family member told him she had seen Resident #1 trip MA A. The former ADON said Resident #2’s family member said it could have been bad and they did not know what would have happened if they had not witnessed the incident. The former ADON said Resident #2’s family member had told him they did not feel MA A should be working on the secured unit. The former ADON said he changed MA A’s work assignment and took her off the secured unit. The former ADON said informed Resident #2’s family member of who the abuse coordinator was and they said they did not want to report anything. The former ADON said he did not report the incident to the Administrator due to nothing being specifically reported to him regarding abuse. During an interview on 7/1/25 at 1:05 p.m. Resident #2’s family member said they witnessed the incident between MA A and Resident #1. Resident #2’s family member said MA A was walking past Resident #1 when he kicked her in the butt. Resident #2’s family member said MA A stumbled and almost fell. Resident #2’s family member said when MA A regained her balance, she doubled up her fist and hit Resident #1 in the chest. Resident #2’s family member said they reported the incident to the former ADON 4 days later and they did not know what came of it. Resident #2’s family member said they had recently reported the incident to the Administrator because MA A was working on the secured unit again and they were afraid of what might happen if MA A was on the unit at night by herself with no witness. During an interview on 7/3/25 at 2:25 p.m. the Administrator said she expected staff to act professional and not hit the residents. The Administrator said all residents had the right to be safe from abuse. The Administrator said she reported the incident of alleged abuse on 5/23/25 as soon as she found out about the incident on 6/23/25. The Administrator said she expected staff to immediately report any incidents of alleged or suspected abuse to her immediately The Administrator said the former ADON should have reported the alleged abuse to her immediately and that MA A should have been suspended on 5/27/25. The Administrator said the importance of reporting abuse to the state agency in a timely manner was to aide in preventing further abuse and to protect the residents from abuse. Record review of the facility’s Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy last revised April 2021 indicated “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 residents’ symptoms. The resident abuse, neglect and exploitation prevention 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 but not necessarily limited to: a. facility staff…5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems…10. Protect residents from any further harm during investigations…” (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility’s Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy last revised September 2022 indicated, “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….Reporting Allegations to the Administrator and Authorities: 1. If 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…3. “Immediately” is defined as: a. withing two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does no involve abuse or result in bodily injury…12. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete…”Record review of the Long-Term Care Regulatory Provider Letter issued 7/10/19 indicated, “…The facility becomes aware of, or receives, an allegation of suspected abuse, neglect, exploitation, or another reportable incident….Report the incident within 24 hours of within 2 hours depending on the incident. Complete an internal investigation of the incident, Take appropriate corrective action. Report the investigation findings within 5 working days from the initial report to HHSC on form 3613-A. Maintain evidence demonstrating results of all incidents for no less than three years after the reported allegation.” The Administrator was notified on 7/1/25 at 4:45 p.m. that a Past Non-Compliance Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 7/1/25 at 4:52 p.m. The facility had corrected the noncompliance prior to surveyor entrance by the following: • Suspending and Terminating MA A• In-servicing staff regarding abuse and neglect, mandatory notifications, and behavior management and de-escalation. The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by: • Record review of Record of Employee Counseling dated 6/27/25 indicated on 6/23/25 an allegation of abuse was made against MA A. The Record of Employee Counseling indicated MA A was immediately suspended on 6/23/25 pending investigation. The Record of Employee Counseling indicated the outcome of the investigation was that MA A, by her own statement, did place her hands on Resident #1’s chest and push him. The Record of Employee Counseling indicated MA A was terminated on 6/27/25.• Record review of Record of Employee Counseling dated 6/26/25 indicated the former ADON received written counseling regarding failing to notify the Administrator, abuse coordinator, of an allegation of abuse. The Record of Employee Counseling indicated the former ADON would immediately report any knowledge of allegations of abuse/neglect to the Administrator .• Record review of in-services dated 6/23/25 indicated all staff were in-serviced regarding abuse and neglect and immediate notifications required to be made to the Administrator and DON• Record review of in-services dated 6/30/25 indicated all staff were in-serviced regarding dementia, aggressive behaviors, and de-escalation of a situation.Staff interviewed (CNA B, LVN C, LVN D, CNA E, CNA F, CNA G, LVN H, Housekeeper J, CNA K, and the Director of Housekeeping) on 7/1/25 between 2:00 p.m. and 2:20 p.m. were able to name all types of abuse, what to do in the event of witnessed or reported abuse, and who the Abuse Coordinator was. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Pittsburg	123 Pecan Grove Pittsburg, TX 75686

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Skin assessment dated [DATE] indicated Resident #1 did not have any skin issues Record review of the Safe 'Surveys conduct on 6/23/25 indicated residents interviewed did not have any concerns or complaints, felt staff treated them with dignity and respect, felt safe and comfortable at the facility, had not witnessed or heard anyone be mistreated, and was not afraid of any resident or visitor. Observations made between 7/1/25 and 7/3/25 indicated staff treated resident with dignity and respect. Residents interviewed (Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) on 7/1/25 and 7/2/25 between 9:20 a.m. and 3:15 p.m. said they were treated well at the facility, were not scared of anyone in the facility, and no one in the facility had ever abused them physically or verbally. The noncompliance was identified as PNC. The IJ began on 05/23/2025 and ended on 06/30/2025. The facility had corrected the noncompliance before the survey began.