STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675220	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Place Kirbyville	700 N Herndon Kirbyville, TX 75956

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. (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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(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	**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 for 1 of 7 residents (Resident #50) reviewed for resident abuse. The facility failed to ensure Resident #50's was free from physical abuse when Resident #3 pushed a rolling bedside table into his roommate Resident #50 causing a skin tear and Resident #50 to fall to the ground on 03/25/25. This failure could place residents at risk of physical harm, mental anguish, or emotional distress.The findings include: 1. Record review of Resident #3's face sheet dated 09/09/25 indicated he was a [AGE] year-old-male admitted on [DATE] and readmitted [DATE] with diagnoses of Alzheimer's disease (progressive brain disorder that causes a gradual and irreversible loss of memory, thinking skills and the ability to carry out daily activities), dementia with psychotic disturbance (involves symptoms like hallucinations (seeing hearing or smelling things that are not there) delusion (false, fixed beliefs) such as paranoia) and anxiety disorder (a mental health condition characterized by excessive worry, fear or apprehension that is difficult to control and interferes with daily life). Record review of a skin assessment dated [DATE] for Resident #50 indicated he received a skin tear to his left forearm 8 cm x 5.1 cm in size. Record review of Resident #3's Annual MDS assessment dated [DATE] indicated he had a BIMS of 3 which indicated he was severely impaired of cognition. The assessment indicated Resident #3 behaviors present including inattention that comes and goes, disorganized thinking continuously. The assessment indicated Resident #3 had diagnoses of Alzheimer's disease and dementia with psychotic disturbance and received an antianxiety medication received during the last 7 days. Record review of Resident #3's Care plan updated 08/27/25 indicated he was at risk for delirium and confusion episodes related to Alzheimer's disease and dementia and had a behavior problem on 03/20/25 Resident #3 pushed a bedside table into another male resident causing Resident #50 to fall to the floor. The care plan did not indicate any other behavior problems. Record review of Resident #3's SBAR (a standard communication tool to communicate a resident's status) dated 03/20/25 indicated a behavior change of Resident #3 told his roommate to get out of their room, then pushed resident with a bedside table knocking Resident #50 to the floor. The SBAR indicated orders received to send Resident #3 to in patient hospice. Record review of Resident #3's nursing note dated 03/20/25 indicated a resident-to-resident behavior observed. Resident #3 pushed a bedside table into Resident #50 knocking him down. Resident #3 was redirected away from the area, placed on one-on-one supervision. The nurse's note indicated that Resident #3 stated his roommate stole his belongings. Record review of Q 15 Minute Monitoring dated 03/20/25 indicated Resident #3 was monitored one on one and every 15 minutes documentation until discharged to inpatient hospital. During an observation and interview on 09/08/25 at 12:30 p.m. Resident #3 was sitting in a chair and said he was treated well and denied any residents were rough, hit or pushed him. Resident #3 denied he pushed or hit Resident #50 with a bedside table or any other resident. 2. Record review of Resident #50's face sheet dated 09/09/25 indicated he was a [AGE] year-old-male admitted on [DATE] and readmitted [DATE] with diagnoses of Alzheimer's disease, dementia with psychotic disturbance, hallucinations and anxiety disorder. Record review of Resident #50's quarterly MDS assessment dated [DATE] indicated he had a BIMS of 3 which indicated that he was severely impaired of cognition. The assessment indicated Resident #50 diagnoses of Alzheimer's disease and received an antidepressant and antipsychotic medication received during the last 7 days. Record review of Resident #50's Care plan updated 09/08/25 indicated he had impaired cognition, refused care and had a communication problem, and had difficulty understanding some verbal content related to Alzheimer's disease and dementia. The care plan indicated Resident #50 had a fall on 03/20/25, he was knocked down by a bedside table pushed into him by his roommate. The care plan did not indicate any other behavior problems. Record review of Resident #50's nursing note dated 03/20/25 indicated Resident #50 received a skin tear to left upper arm. During an observation and interview on 09/08/25 at 12:20 pm, Resident #50 was sitting in a chair and denied any residents were rough, hit or pushed him. Resident #3 denied he pushed or hit Resident #50 with a bedside table or anything. Record review of the investigation worksheet for Resident #3's dated 03/20/25 indicated the allegation was made on 03/20/25 at 3:00 p.m. and was reported to state on 03/20/25 at 4:32 p.m. Record review of Resident #3's Provider Investigation Report dated 03/20/25 indicated a resident-to-resident altercation in which Resident #3 pushed a bedside table into Resident #50 causing a skin tear and Resident #50 to fall to the floor. The findings indicated inconclusive for the allegation of abuse. Investigation Summary indicated the intent of Resident #3

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 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 observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 7 residents (Resident #101) reviewed for accidents and supervision. The facility failed to provide adequate supervision for Resident #101 on 05/12/25 when the resident was removed from the secured unit and brought out to the main dining room for an activity. The resident exited the facility through a door that did not alarm and without staff knowledge and was found walking outside the back of the facility walking down a sidewalk. The non-compliance was identified as past non-compliance (PNC). The Immediate Jeopardy began on 05/12/2025 and ended on 05/12/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of not receiving appropriate supervision and interventions which could lead to residents sustaining serious injury or harm. Findings include: Record review of a face sheet dated 09/09/25 indicated Resident #101 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included catatonic schizophrenia (severe mental condition combined with pronounced psychomotor disturbances) dementia (loss of cognitive functioning), chronic obstructive pulmonary disease (lung disease that causes difficulty breathing by blocking airflow from the lungs), hemiplegia (paralysis of one side of the body associated with varying degrees of abnormal muscle tone, impaired sensation, visual impairment and loss of movement control on the affected side) and anxiety (persistent and excessive worry that interferes with daily activities). Record review of a quarterly MDS, dated [DATE], indicated Resident #101 had a BIMS score of 3 indicated severely impaired cognition and cognitive patterns of inattention and disorganized thinking continuously. Diagnoses were dementia, schizophrenia, anxiety, and chronic obstructive pulmonary disease. The assessment indicated Resident #101 wandered 1 to 3 days of the look back period and was independent of sitting to stand and walking 150 feet in a corridor or similar space. Record review of Resident #101's care plan, with a target date of 12/04/25, indicated Resident #101 was at risk for wandering related to impaired safety awareness and required secure unit placement due to being a wander threat, elopement risk, disorientation and impaired safety awareness. The care plan indicated Resident #101 had an actual elopement attempt; he wandered outside the facility unattended initiated on 05/12/25. Resident #101's care plan interventions included resident will reside in the secure unit. Record review of Resident #101's Elopement Risk assessment dated [DATE], indicated Resident #101 was a high elopement risk and resided on a secure unit. Record review of a progress note dated 05/12/25, LVN G indicated it was reported to the DON that Resident #101 was brought off the secured unit to attend a facility activity in the dining room and when staff were returning residents to the unit Resident #101 was not readily available. The progress note indicated staff immediately made a thorough search of the facility and surrounding premises and noted Resident #101 walking along the sidewalk. Resident was returned to the secure unit with no injury or pain noted. The progress note indicated a family member and physician were notified Resident #101 had wandered outside unsupervised. Record review of an Event Nurses' Note Elope or Attempt dated 05/12/25 indicated Resident #101 was brought off the secured unit to attend a facility activity in the dining room and when staff was returning residents to the secured unit, Resident #101 was not readily available. The note indicated staff immediately made a thorough search of the facility and surrounding premises and noted the resident outside the facility walking along the sidewalk. Resident was returned to the secured unit. The note indicated he exited the left side dining room door, was missing less than 5 minutes, and was discovered on the sidewalk at the left side rear of the building. The note indicated Resident #101 was cognitively impaired, wandered, and required cueing and acquired no injury. Record review of the investigation worksheet for Resident #101's dated 05/12/25 indicated the allegation was made on 05/12/25 at 3:00 p.m. and was reported to state on 05/12/25 at 5:14 p.m. Record review of Resident #101's Provider Investigation Report dated 05/12/25 indicated the nursing facility was hosting a carnival in the dining room. Several residents from the Secured unit were brought out to enjoy the festivities. Resident #101 was sitting on the left side of the dining room with several residents from the secure unit. Resident #101 was not at the table. The facility began a search and called code orange. The DON located Resident #101 as he was walking on the sidewalk. She asked why he was outside and his response was not clear, but the DON walked Resident #101 back inside with no hesitation. Resident #101 was assessed with no injury or pain. The investigation summary indicated Resident #101 was outside for 1-2 minutes at most. Resident 101 was returned to the