| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675408 | A. Building<br>B. Wing | 11/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at Overton | 1110 Hwy 135 S<br>Overton, TX 75684 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review the facility failed to ensure residents were free from abuse for 1 of 6 residents (Resident #1) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #1 was free from physical abuse on 10/19/25 at approximately 5:46 p.m. when Resident #2 stomped on Resident #1's foot. This failure could place residents at risk of pain, injury, hospitalization, and diminished quality of life. Findings included: 1. Review of an admission Record for Resident #1 dated 10/21/25 indicated he was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of schizoaffective disorder bipolar type (schizophrenia symptoms combined with episodes of mania and/or depression), autistic disorder, and cognitive communication deficit (difficulty communicating due to cognition). Review of a quarterly MDS for Resident #1 dated 9/12/2025 indicated he had moderately impaired cognition with a BIMS of 12. He had not exhibited any physical, verbal, or other behavioral symptoms directed toward others. Review of the care plan for Resident #1 dated 8/14/25 indicated Resident #1 wandered due to diagnosis of Autism and required secure unit placement. Review of an admission Record for Resident #2 dated 10/21/25 indicated he was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of unspecified intellectual disability, cognitive communication deficit (difficulty communicating), and bipolar disorder (fluctuations between manic and depressive episodes). Review of a significant change of status MDS for Resident #2 dated 8/13/25 indicated he had severely impaired cognition with a BIMS of 7. He had not exhibited any physical, verbal, or other behavioral symptoms directed toward others. Review of the care plan for Resident #2 dated 7/12/25 indicated he had behavioral symptoms directed at other residents including telling other residents to shut up and leave him alone when no residents were talking to him. Appropriate interventions were in place including monitoring for behaviors, redirection, and referral to psychiatric services. Review of the care plan for Resident #2 dated 7/14/25 indicated Resident #2 required secure unit placement due to inappropriate touching of females, wandering, and poor safety awareness. Review of an event report by RN A dated 10/19/25 at 5:46 p.m. indicated Resident #1 had a bruise to his right foot, purple and black in color after Resident #2 kicked or stomped resident's foot. Resident #1 denied pain or discomfort. Review of an event report by RN A dated 10/19/25 at 5:58 p.m. indicated Resident #2 exhibited aggressive behavior evidenced by kicking another resident's (Resident #1) foot. During an interview on 10/20/25 at 10:30 a.m., CNA B said he was assigned to work on the men's secured unit on 10/19/25. CNA B said he observed Resident #2 kick or stomp on Resident #1's foot in the dining room. CNA B said Resident #1 moved his feet away from Resident #2. CNA B said Resident #2 attempted to kick or stomp on Resident #1's feet several times more before he could separate the residents. During an interview on 10/20/25 at 10:40 a.m., Resident #2 said he stomped on Resident #1's foot. Resident #2 said I did it out of meanness, I won't do it again. Resident #2 said he was upset because he missed his parents and wanted to leave the facility. During an observation and interview on 10/20/25 at 10:50 a.m., Resident #1 was observed in the dining room, sitting at a table with other residents. There were no visible marks, bruises, or skin tears. Resident #1 appeared to show no signs of fear while interacting with other residents. Resident #1 said he could not remember the altercation with Resident #2. Resident #1 said he felt safe in the facility, and he had no pain. During an interview on 10/20/25 at 11:00 a.m., the Hospitality Aide said Resident #2 had exhibited verbal behaviors which included yelling and cursing at other residents. She said she had not seen Resident #2 exhibit any physical behaviors. She said she had received training on resident-to-resident altercations and would separate the residents to ensure safety and then report the incident to the ADM. During an interview on 10/20/25 at 12:15 p.m., RN A said CNA B reported that Resident #2 had stomped or kicked Resident #1's foot. RN A said she conducted a head-to-toe assessment of Resident #1 and noted a light bruise on the side of his right foot. RN A said Resident #1 denied pain and showed no signs of behavioral changes post-incident. RN A said staff are expected to intervene in resident-to-resident altercations, separate residents, and notify the ADM of the incident. During an interview on 10/22/25 at 12:55 p.m., the DON said Resident #2 was having difficulty adjusting to the facility and he was receiving psychiatric services, and his medications had recently been adjusted to address the behaviors. The DON said all staff received training on abuse and neglect and resident-to-resident altercations. The DON said additional abuse and neglect in-service training for all staff was being conducted that began on 10/20/25. During an interview on 10/22/25 at 1:10 p.m., the ADM said Resident #2 was placed on 1-to-1 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours, for 1 of 6 residents (Resident #1) reviewed for abuse. The facility failed to ensure RN A and CNA B reported an allegation of abuse to the ADM immediately when Resident #2 stomped Resident #1's foot on 12/19/25. This failure could place residents at risk of continued abuse which could lead to risk of pain, injury, hospitalization, and diminished quality of life. Findings included: 1. Review of an admission Record for Resident #1 dated 10/21/25 indicated he was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of schizoaffective disorder bipolar type (schizophrenia symptoms combined with episodes of mania and/or depression), autistic disorder, and cognitive communication deficit (difficulty communicating due to cognition). Review of a quarterly MDS for Resident #1 dated 9/12/2025 indicated he had moderately impaired cognition with a BIMS of 12. He had not exhibited any physical, verbal, or other behavioral symptoms directed toward others. Review of the care plan for Resident #1 dated 8/14/25 indicated Resident #1 wandered due to diagnosis of autism and required secure unit placement. Review of an admission Record for Resident #2 dated 10/21/25 indicated he was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of unspecified intellectual disability, cognitive communication deficit (difficulty communicating), and bipolar disorder (fluctuations between manic and depressive episodes). Review of a significant change of status MDS for Resident #2 dated 8/13/25 indicated he had severely impaired cognition with a BIMS of 7. He had not exhibited any physical, verbal, or other behavioral symptoms directed toward others. Review of the care plan for Resident #2 dated 7/12/25 indicated he had behavioral symptoms directed at other residents including telling other residents to shut up and leave him alone when no residents were talking to him. Appropriate interventions were in place including monitoring for behaviors, redirection, and referral to psychiatric services. Review of the care plan for Resident #2 dated 7/14/25 indicated Resident #2 required secure unit placement due to inappropriate touching of females, wandering, and poor safety awareness. Review of a psychotherapy visit note dated 10/20/25 for Resident #2 indicated .referred to [provider] for adjustment difficulty, physically and verbal aggression.No medication changes today. Review of an event report by RN A dated 10/19/25 at 5:46 p.m. indicated Resident #1 had a bruise to his right foot, purple and black in color after Resident #2 kicked or stomped the resident's foot. Resident #1 denied pain or discomfort. Review of an event report by RN A dated 10/19/25 at 5:58 p.m. indicated Resident #2 exhibited aggressive behavior evidenced by kicking another resident's (Resident #1) foot. During an interview on 10/20/25 at 10:30 a.m., CNA B said he was assigned to work on the men's secured unit on 10/19/25. CNA B said he observed Resident #2 kick or stomp on Resident #1's foot in the dining room. CNA B said Resident #1 moved his feet away from Resident #2. CNA B said Resident #2 attempted to kick or stomp on Resident #1's feet several times more before he could separate the residents. CNA B said he reported the incident to RN A after it happened but did not report it to the ADM. During an interview on 10/20/25 at 10:40 a.m., Resident #2 said he stomped on Resident #1's foot. Resident #2 said I did it out of meanness, I won't do it again. Resident #2 said he was upset because he missed his parents and wanted to leave the facility. During an observation and interview on 10/20/25 at 10:50 a.m., Resident #1 was observed in the dining room, sitting at a table with other residents. There were no visible marks, bruises, or skin tears. Resident #1 appeared to show no signs of fear while interacting with other residents. Resident #1 said he could not remember the altercation with Resident #2. Resident #1 said he felt safe in the facility, and he was not having any pain. During an interview on 10/20/25 at 11:00 a.m., the Hospitality Aide said Resident #2 had exhibited verbal behaviors which included yelling and cursing at other residents. She said she had not seen Resident #2 exhibit any physical behaviors. She said she had received training on abuse and would report any witnessed or suspected abuse to the nurse and the ADM immediately. During an interview on 10/20/25 at 12:15 p.m., RN A said CNA B reported that Resident #2 had stomped or kicked Resident #1's foot. RN A said she conducted a head-to-toe assessment of Resident #1 and noted a light bruise on the side of his right foot. RN A said she notified Resident #1's provider and family members but did not notify the ADM of the incident. RN A said she had not received training on abuse when she was hired and did not know she was supposed to notify the ADM. During an interview on 10/22/25 at 12:55 p.m., the DON said Resident #2 was having difficulty adjusting to the facility and he was receiving psychiatric services, and his medications had recently been adjusted to address the behaviors. The DON |