STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675641	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Seguin	1215 Ashby Seguin, TX 78155

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 - 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 interviews and record reviews, the facility failed to protect right of residents to be free from physical abuse for 1 of 4 (Resident #1) reviewed for abuse.Resident #1 was hit on the head by NA B.The noncompliance was identified as a PNC. The facility corrected the noncompliance on 8/6/2025 before the surveyor's entry to the facility.This failure could place residents at risk for abuse with injury, intimidation and a decreased quality of life. The findings were: Record review of Resident #1's face sheet dated 1/29/2026 revealed an [AGE] year-old male was admitted to the facility on [DATE] with diagnoses: major depressive disorder, dementia, hypertension (high blood pressure) and anxiety disorder. Record review of Resident #1's CP dated 08/11/2025 revealed he was care planned for impaired cognitive function due to dementia, fall risk, and aggressive behaviors of throwing objects, and trying to hit staff.Record review of Resident#1's QMDS dated [DATE] revealed he had a BIMS score of 3, indicative of severe cognitive deficit.Record review of NA B's witness statement dated 8/6/2025 stated, My co-worker CNA C was only telling me to lay Resident #1 down only. I was getting ready to lock his wheelchair to get him ready to be change out of nowhere Resident #1 had hit me in face. I had hit him back in the head out of reflexes. Record review of Resident #1's progress note dated 8/6/2025 revealed Resident #1 was assessed by LVN A and a light discoloration was noted to his forehead without bruising. LVN A stated there was possible edema noted to jaw area and slight discoloration to left upper ribs. X - rays were ordered (8/6/2025) to skull, jaw and ribs series for precautions. Interview on 1/29/2026 at 8:17AM CNA D said, when NA B hit Resident #1, NA B came out of the room and was talking about what happened to everyone as if she was in shock it happened. CNA D said NA B was new and was removed immediately from the floor. Interview on 1/29/2026 at 12:03PM the ADM said NA B was providing care for Resident #1 and Resident #1 swung and hit NA B in the face and NA B hit Resident #1 back in the head. The ADM said NA B was told to pass water but NA B refused, sitting in a chair in the main dining room, crying. The ADM said she told NA B to clock out because she was not fit to take care of the residents and that was when NA B admitted what she had done when she was on the secured unit and Resident #1 hit her. The ADM said NA B was terminated immediately and sent to the Human Resources office. The ADM said the police were called. Interview on 1/30/2026 at 11:46AM CNA C said she was in the room with another resident when she heard NA B yell, Don't do that! CNA C said by the time she ran out of the room to see what happened, NA B told CNA C that Resident #1 hit her and she hit Resident #1 back. Interview on 1/30/2026 at 12:15PM the ADM said it was important to keep the residents safe from abuse because they have the right to be safe in the place they live and to maintain the safest quality of life. Interview on 1/30/2026 at 12:25PM the HR said she had gone on the secured unit to get NA B to talk with her about something else, but was not aware of what happened until NA B confessed it to the ADM. NA B told her after she was terminated and waited for the police that: my mother always told me growing up that if somebody hit you, you hit them (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: 675641	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Avir at Seguin		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 Ashby Seguin, TX 78155	

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 - Actual harm Residents Affected - Few	back. The HR said that lesson may not have been the best lesson for NA B to learn. Record review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation Prevention Program dated April 2021 stated in part: Residents have the right to be free from abuse; 1. Protect residents from abuse.by anyone including facility staff. Record review on 1/29/2026 of the 3613- facility's self-report revealed an investigation was done with Resident #1 who said, he was roughed up and with staff; NA B admitted to hitting the resident in the head and was immediately terminated and the police were called. Interviews on 1/29 and 1/30/2026 revealed 17 employees from different disciplines and schedules verbalized they understood the in-services for Abuse and Neglect and Dealing with Difficult Residents.Record review on 1/30/2026 of NA B's personnel file revealed NA B was hired 5/4/2025 and was terminated immediately on 08/ 6 /2025 for resident abuse. The ADM made a referral to EMR for employee misconduct. Record review on 1/30/2025 revealed the police report was dated 8/6/2025. Record review of Resident #1's progress notes dated 8/6/2025 revealed the physician and the family were notified and an assessment of injuries was done, and x-rays were ordered for precautions. Record review of staff in-service training for Abuse and Neglect and Dealing with Difficult Residents dated 8/6/2025 revealed all staff received the in-services. The staff who were not on duty that day received the in-service by phone or before they were allowed to work on the units on their scheduled day.