STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675668	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Mineola	320 Greenville Highway Mineola, TX 75773

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure residents were free from physical abuse for 1 of 10 residents (Resident #1) reviewed for abuse.The facility failed to ensure Resident #1 was free from physical abuse when CNA B was in Resident #1's room on the secured unit handled Resident #1 in a rough manner during patient care, pinning Resident #1 down multiple times. CNA B placed his forearm and hands on Resident #1's chest/ neck area, and CNA B placed both hands around Resident #1's neck in a choking manner while pushing Resident #1 into his bed. Resident #1 suffered bruising to his chest, right forearm, and left forearm from CNA B physical force and abuse towards him on 5/5/26.The noncompliance was identified as past noncompliance (PNC). The IJ began on 5/5/26 and ended on 5/6/26. The facility had corrected the noncompliance before the survey began.This failure could place residents at risk for physical abuse, mental abuse, emotional abuse, and harm.Findings included: Record review of Resident #1's admission record printed on 5/8/26, indicated he was a [AGE] year-old male who originally admitted on [DATE] and readmitted on [DATE] to the secured unit with diagnoses including anxiety disorder (is a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), neurocognitive disorder with Lewy bodies (a progressive brain disorder causing cognitive decline, confusion, hallucinations, and movement difficulties), depressive disorder (a mood disorder associated with persistent sadness and loss of interest in activities), and vascular dementia (cognitive impairment caused by reduced blood flow to the brain resulting in memory loss, confusion, and behavioral changes). Record review of Resident #1's significant change MDS dated [DATE] indicated the resident had unclear speech and was limited to making concrete requests. Resident #1 responded adequately to simple, direct communication only. Section C1000 indicated Resident #1's cognitive skills for daily decision-making were severely impaired, meaning the resident rarely or never made decisions. Resident #1 required extensive assistance with bed mobility, transfers, dressing, eating, personal hygiene, and toileting. Resident #1 was incontinent of bowel and bladder, used a manual wheelchair, and had hospice services initiated within the last 14 days while a resident of the facility. Record review of Resident #1's undated care plan initiated on 3/10/26 indicated: *Resident #1 had cognitive loss. Intervention included: anticipate needs and observe, for non-verbal cues, approach in calm manner, explain what you intend to do while providing care, introduce yourself, and orient PRN to person, place and time. Record review of an undated Termination request template indicated CNA B's DOH was on 3/16/26; Summary of Facts: 5/5/26, employee choked [Resident #1]. Incident occurred on unit and involved [CNA B and Resident #1] and caught on surveillance provided by a family member. On 5/6/26 [CNA B] was arrested for Abuse. Impacts: Policy violation; Professional conduct and code of conduct; Automatic Termination. This Request meets the threshold for termination approval. A clear final incident had been identified with specific details and written documentation. Documentation supported violation of company policy and expectations. Progressive discipline had been appropriately followed. Record review of CNA B's termination record dated 5/5/26 completed by the Administrator indicated CNA B's DOH was 3/16/26. Last Day Worked: 5/5/26; (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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Termination Date: 5/5/26. Reason for termination: misconduct; Notes: Was there a final incident that led to the decision: Abuse of a resident. Record review of Resident #1's Progress notes indicated the following:-On 5/6/26 at 10:16 am; completed by DON: this nurse was informed by CNA that [Resident #1's family] had made report that a male CNA [CNA B] had been seen on video with his hands around [Resident #1's] neck; [Resident #1's family] was able to provide video for this nurse to view; administrator notified immediately and police were called to facility; [Resident #1's family] remained present officer arrived and took report; video had been sent to officer; pictures taken by officer with [Resident #1's family] present, officer provided report number and will update with any further findings or needs from facility.-On 5/6/26 at 10:35 am; completed by LVN C: [Resident #1] was sent out to the ER via/EMS to be evaluated and treated via family request. DON/ADON aware. NP notified of [Resident #1] being transferred to the ER for evaluation. Family aware.-On 5/6/26 at 10:52 am; completed by LVN C: Skin Issue#001-New. Location: Right front axilla (front region of the right armpit). Laterality/orientation: Medial. Issue type: Brusing. Wound acquired in-house. Exact dated: 5/6/26 Painful: No; Length (cm): 7 Width (cm):10; Other additional care: monitor.Skin Issue#002- New. Location: Left front axilla (front region of the left armpit). Laterality/Orientation: Lateral. Additional location information: Resident has petechiae (tiny red, flat spots that appear on your skin. They are a sign of blood leaking from capillaries under your skin) to lower bilateral arms Issue type: Bruising. Wound acquired in-house. Wound is new. Signs and symptoms of infection: None. Painful: No; Other additional care: monitor.Skin Issues Note: [Resident #1] has bruising to bilateral upper arms, petechiae to chest and lower armsSkin issue notification: Family. Skin issue notification: Provider. Skin issue notification: Manager.-On 5/6/26 at 2:10 pm; completed by LVN C: [Resident #1] returned to facility via facility vehicle with no new orders received. [Resident#1] was alert and responsive but confused/disoriented x3 per resident's baseline. No distress noted. Record review of Resident #1's incident report dated 5/6/26 completed by the DON indicated the incident happened in Resident #1's room on the secured unit. Incident Description: Nursing Description- Notified by CNA that [Resident #1's family] was there and had reported to [DON] that [Resident #1] had been assaulted by a male [CNA B] last night. Resident Description: [Resident #1] unable to give description. Immediate Action Taken: [Resident #1] was assessed from head to toe; administrator, RNC, RDO and police notified, [Resident #1] to transferred to ER for evaluation. Injuries Observed at Time of Incident: Bruise to chest; Bruise to Right forearm; Bruise to Left forearm. Level of Pain: Zero. Predisposing physiological factors: confused and impaired memory. Record review of Resident #1's ER after visit summary dated 5/6/26 indicated reason for visit Assault victim. Diagnosis: Assault. Notes:[Resident #1] arrived by EMS from [name of facility] for physical assault by NH staff member [CNA B]. NH reports to EMS there was video footage of [Resident #1] lying in bed last night when [CNA B] grabbed [Resident #1] by the shoulders and shook [Resident #1] by pressing [Resident #1] into the bed. NH also reported [Resident #1] was grabbed by the throat and shook. EMS stated bruising was found to [Resident #1's] shoulders but none to neck or chest. A police investigation was active, and x-rays of [Resident #1] chest, shoulders, and forearms had been requested. [Resident #1] denied pain and did not remember the incident. [Resident #1 resided in the memory care unit and staff reported [Resident #1 mental status was at its baseline. Record review of Resident #1's hospice note dated 5/6/26 indicated it was a PRN visit following [Resident #1's] return from the ER after an incident of assault by [CNA B], where [CNA B] allegedly tried to chock and restrain [Resident #1]. Though no significant injuries were reported, ER transfer was per policy. On arrival, [Resident #1] was reclined in the memory care unit sleeping soundly. Facility staff informed hospice staff that [Resident #1] had also had a fall last night with no injuries. [Resident #1] briefly awoke, asked about food, and then returned to sleep. Resident #1 was assessed and monitored for pain and/or anxiety/agitation; no bruising was noted on his neck. Staff mentioned bruising on his arms, possibly from restraint, though due to [Resident #1] frequent falls, it was difficult to differentiate. Overall, [Resident #1] was stable and comfortable at the time of the visit. Record review of provider self-reporting of LTC incident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1088520 printed on 5/6/26 indicated Incident Date 5/5/26; Date/Time Facility first learned of the incident: 5/6/26 at 8:45am; Incident Category: Abuse; Resident/Client: [Resident #1]; Alleged perpetrator information: [CNA B]; Brief narrative of the incident: [Resident #1's family member] made a report that a male [CNA B] had been seen on video with his hands around [Resident #1's] neck; [Resident #1's family member] provided video for nurse to view; police were called to facility; [Resident #1's family] remained present; officer arrived and took report; video had been sent to officer; and pictures taken by officer with [Resident #1's family] present; officer provided report number and will update with any further findings or needs from facility.; [Resident #1] was assessed and noted bruising to bilateral forearms and chest area; no respiratory distress present; no injury visible to neck; spoke with MD and order received to send to ER for evaluation; [Resident #1] was unable to recall incident at that time due to poor cognition. On what shift did the incident occur: Night; Actions and Notifications: Notified the local police department, MD, medical director, family, ombudsman, employee was suspended pending investigation, initiated safe surveys with residents potentially affected, employee interviews, in-service on abuse and neglect policy and procedure; full skin assessment for all residents on the affected unit; interviews with various residents on opposing assignments on which the employee had worked previously; employee had not worked since 4/21/26. Record review of the police report dated 05/12/2026 indicated that on 05/06/2026 at approximately 9:13 a.m., an officer with the local Police Department responded to [Name of Facility] regarding a report and video footage of staff-to-resident abuse involving [CNA B and Resident #1]. Facility staff reported observing video footage showing [CNA B] physically assaulting [Resident #1] during incontinent care on 05/05/2026 at approximately 7:45 p.m. According to the police report and video review, [CNA B] was observed forcibly pushing [Resident #1] backward onto the bed, striking [Resident #1] in the chest with an open hand, and repeatedly placing his hands and forearm around [Resident #1's] throat while [Resident #1] struggled and gasped for air. [Resident #1], who has late-stage dementia and was fully dependent on staff for care, could be heard saying, I can't, and was observed resisting care throughout the incident. The police report further indicated [CNA B] was heard making threatening and intimidating statements toward [Resident #1] during the encounter. The police report indicated the reporting party and facility administration provided the video footage to law enforcement. The report further indicated [Resident #1's] family member requested criminal charges. The responding officer documented visible injuries to [Resident #1] through photographs and determined [Resident #1] lacked the mental capacity to provide an interview regarding the incident. Based on the investigation and video evidence, the responding officer sought an arrest warrant for [CNA B] for Injury to a Child, Elderly Individual, or Disabled Individual under Texas Penal Code S22.04, a first-degree felony. On 05/07/2026, CNA B was taken into custody at [Name of Facility] and transported to the local county detention center. A $100,000 bond was issued. The case was forwarded to the local Police Department Administrative Division for further review and investigation. During an observation and attempted interview on 5/8/26 at 6:13pm, Resident #1 was sitting in his wheelchair stationed directly in front of the west nurse station. Resident #1 was clean, well-groomed with no unpleasant odor and there were no visible bruising, skin tears or marks. Resident #1 was not interviewable due to cognitive impairment and inability to provide reliable information regarding the incident. During a telephone interview on 5/8/26 at 4:25 p.m. with Resident #1's family member, she stated she was the individual who initially observed the video footage involving CNA B and Resident #1 and immediately notified facility administration of the incident. Resident #1's family member stated it was very upsetting and difficult to watch the video showing CNA B physically abusing Resident #1. She voiced concerns regarding Resident #1's safety and wellbeing due to the nature of the incident. Resident #1's family member stated she felt the facility addressed the allegation immediately after being notified and was satisfied with how the facility handled the situation, including contacting law enforcement and removing CNA B from the facility. Resident #1's family member stated she felt the physical and emotional impact on Resident #1 had (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	been significant, as Resident #1 had experienced increased confusion, periods of incoherence, fearfulness, emotional distress, and a loss of trust in caregivers following the incident. Resident #1's family member stated the family was deeply concerned that the combination of the alleged abuse, rough handling, inconsistent care, and other ongoing issues had contributed to both Resident #1's physical decline and emotional trauma during an already vulnerable stage of his life. CNA B was not interviewed due to being incarcerated during the time of investigation on assault charges related to the alleged incident involving Resident #1. During an interview on 5/8/26 at 1:20 p.m., the Administrator said he was the abuse coordinator and followed their abuse policy, did criminal history checks upon hire, did in-services with his staff and reported everything to the state. The Administrator said CNA B was terminated due to the incident and said he could not control other human behaviors. During an interview on 5/8/26 at 6:42 p.m., LVN E stated he was the charge nurse assigned to the secured unit during the 6pm to 6am night shift and had worked at the facility for approximately one year. LVN E stated he did work the night of the incident, but he was not aware of the alleged incident involving Resident #1 and CNA B until the following day on 5/6/26. LVN E stated he provided a witness statement regarding the incident and said the information contained in the statement was accurate. LVN E stated Resident #1 could become combative at times during care. LVN E stated he had not observed CNA B handle residents aggressively and had not received complaints from residents or staff regarding CNA B's care or conduct toward residents. During a telephone interview on 5/9/26 at 1:54 p.m., LVN C stated she was the charge nurse assigned to the secured unit during the 6am to 6pm day shift and had worked at the facility for approximately two months. LVN C stated she worked on 5/6/26, the morning following the alleged incident involving Resident #1 and CNA B. LVN C stated she observed bruising to Resident #1's upper arms and chest area, which appeared consistent with someone having grabbed or held the resident down. LVN C stated she was the nurse who sent Resident #1 to the emergency room for evaluation, and Resident #1 returned the same day with no new orders. LVN C stated she did not know CNA B personally and had not previously worked with him.During an interview on 5/9/26 at 6:41 p.m., CNA D stated she was assigned to the secured unit during the 6pm to 6am shift and had been employed at the facility since 2017. CNA D stated she worked the night of the alleged incident involving Resident #1 and CNA B but was unaware of the incident until the following day on 5/6/26 when a nurse contacted her asking if she had witnessed anything. CNA D stated she provided a witness statement and confirmed the information in the statement was accurate. CNA D stated she was assisting other residents to bed and recalled walking past Resident #1's room and noticing his call light on. CNA D stated she entered Resident #1's room and recalled Resident #1 attempting to tell her something, repeatedly asking, where's that heavy set man? CNA D stated she could not fully understand Resident #1 and knelt closer to hear him. CNA D stated she touched Resident #1's arms and noticed he was clammy and sweating, which she stated was not normal for him. CNA D stated Resident #1's roommate then began coughing, making it difficult to hear Resident #1. CNA D stated that prior to Resident #1's cognitive decline, he often preferred male CNAs for care assistance. CNA D stated she assumed Resident #1 was asking for the male CNA to assist him. CNA D stated that after learning of the allegation, she felt horrible because she unknowingly brought CNA B back into Resident #1's room shortly after the alleged incident. CNA D stated she had never previously witnessed CNA B handle residents roughly and had not heard complaints from residents or family members regarding CNA B. During an interview on 5/11/26 at 4:35 p.m., the Regional Nurse said placing hands on around a resident's neck, pinning them down or placing forearms on a resident's chest was never appropriate while providing care. He said CNA B had been trained on abuse neglect and exploitation and resident rights. The Regional Nurse said CNA B should have given Resident #1 space and provided behavioral interventions to de-escalate Resident #1combative behaviors and situation. Record review of revised Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy dated April 2021 indicated the following: Residents have the right to be free from abuse, neglect, misappropriation of resident property and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. The facility had corrected the noncompliance on 5/6/2026 by the following: -They immediately suspended CNA B pending investigation. -On 5/6/26 Resident #1 was assessed head - to - toe -On 5/6/26 Resident #1 went to the ER for evaluation. -On 5/6/26 Hospice nurse assessed Resident #1 after return from ER. -On 5/6/26 Full skin assessments completed on all 18 residents on the secured unit. -On 5/6/26 Local police were notified and arrived at the facility. With police corroboration, CNA B was not suspended immediately until he returned for his shift on 5/6/26 . Police returned to the facility and CNA B was arrested in the parking lot when he arrived for his 6p-6a shift. CNA B did not enter the facility prior to his arrest. -On 5/6/26 Facility had in-serviced and trained staff in the following areas: Abuse and Neglect, Resident Rights, De- Escalation, and managing a difficult/combative resident. In-Services addressed immediate recognition and reporting of any behaviors or incidents that may place a resident at risk. Staff were in-serviced on Effective de-escalation methods, including calm verbal responses, allowing personal space, avoiding confrontation, and using redirection techniques. Resident rights, ensuring residents are treated with dignity, and staff do not use any form of intimidation or retaliation. Staff were educated on accurate and timely documentation of resident behavior, attempted interventions, and escalation to supervisory personnel. In-service emphasized following individualized care plans, including implementing interventions for residents with behavioral risks and increasing monitoring when indicated. This was verified by record review of staff in-services signature sheets and staff interviews. -On 5/6/26 Safe surveys throughout the facility were completed. The residents reported that staff were courteous, respectful, and kind, and stated they felt comfortable and safe with the care provided. The residents indicated that staff were careful when assisting or transferring them and confirmed that they were receiving the care they needed. This was verified by record review of safe survey sheets. Interviews and record reviews were conducted from 5/8/26 through 5/11/26 from 9:00 a.m. to 7:30 p.m. and included 4 LVNs, 11 CNAs, 2 CMAs, ADON, RN, and MDS Coordinator. Staff were able to explain abuse and neglect prevention, resident rights, and the facility's expectations for immediate intervention and reporting. Staff were able to explain how to identify early signs of behavioral escalation and proper use of effective and calm communication techniques and apply de-escalation strategies. Staff had knowledge to intervene immediately, maintain resident dignity, notify supervisory staff and the physician without delay, follow the care plan, and accurately document all actions taken. During observations from 5/8/26 through 5/11/26 at various times from 9:00 a.m. to 7:30 p.m. on the secured memory care unit, residents were noted to engage in calm and non-confrontational interactions. Residents appeared generally quiet, with limited verbal engagement, and interactions were primarily passive or casual in nature. Some residents were observed walking in common areas or sitting near one another without signs of agitation or distress. No instances of verbal or physical aggression were observed. Residents did not demonstrate behaviors that suggested intimidation or fear. Staff were present in the area, providing routine supervision and re-direction as needed, and were observed promptly intervening if any residents began to appear anxious or confused. Residents appeared to be appropriately monitored, and no residents displayed behaviors that posed a risk to others during the period of observation. Interactions were consistent with the cognitive and functional levels of the residents on the memory care unit. The noncompliance was identified as past noncompliance (PNC). The IJ began on 5/05/26 and ended on 5/06/26. The facility had corrected the noncompliance before the survey began.