STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675850	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Portland	221 Cedar Drive Portland, TX 78374

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 0609 Level of Harm - Minimal harm or potential for actual harm 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 interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse to the administrator of the facility, for 1 (Resident #1) of 6 residents reviewed for abuse/neglect.The facility failed to report an allegation of verbal abuse immediately to the Administrator when CNA B witnessed CNA A using foul language at the bedside within earshot of Resident #1 on [DATE] around 1:00 am. This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse.The findings were:Record review of Resident #1's face sheet revealed a [AGE] year-old female with an admission date of [DATE] and an original admission date of [DATE]. Diagnoses included respiratory failure, Stage 2 pressure ulcer of the sacrum (lower back), encephalopathy (a change in how the brain functions, including confusion or agitation. It can be temporary, or it could permanently damage the brain. It can be caused by an infection or an underlying condition. Treatment depends on the cause), gastrostomy (a minimally invasive procedure that inserts a feeding tube through the abdominal wall and into the stomach), anemia, diabetes, malnutrition, non-Alzheimer's dementia, depression, high blood pressure, severe chronic kidney disease, difficulty walking, failure to thrive, leukemia (cancer of the blood) in remission, and bone marrow transplant.Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 07, indicating severe cognitive impairment. Behaviors included delusions and inattentiveness. She was dependent on staff for personal hygiene, upper and lower body dressing, toileting, positioning, and transfers. Her active diagnosis was medically complex conditions. She was always incontinent of bladder and bowel. She received nutrition by way of a feeding tube and a therapeutic diet.Record review of Resident #1's care plan dated [DATE] revealed a focus that the resident is at risk for psychological distress and potential harm related to an allegation of verbal abuse by facility staff, compounded by cognitive impairment and limited ability to communicate concerns. Date initiated [DATE]. Interventions included 1. Monitor for signs and symptoms of physical injury, emotional distress, fearfulness, withdrawal, agitation, crying, anxiety, or changes in behavior for at least 72 hours and thereafter as indicated. 4. Ensure each resident receives care in a respectful, dignified, and supportive manner by all staff. 5. Report all allegations, suspicions, or observations of abuse, neglect, or mistreatment immediately according to facility policy and state regulations.Focus: Resident #1 has a terminal prognosis related to senile degeneration of the brain and was on hospice. Date initiated [DATE]. Goal: Resident #1's dignity and autonomy will be maintained at the highest level through the review date of [DATE]. Record review of the Provider Investigation Report (PIR) dated [DATE], corporate Termination Request Draft dated [DATE] for CNA A revealed Witness statements alleged that CNA A spoke to residents in a loud, angry, and disrespectful manner during resident care activities. One witness reported observing the employee tell a resident to shut up while providing care. Another witness reported observing the employee yell at a resident and use inappropriate language while in the resident room. Incident occurred during resident care activities on the nursing unit and involved (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple staff witnesses, including CNA B. Impact: Resident dignity and emotional well-being may have been compromised. Conduct is inconsistent with resident rights and expectations for professional caregiving. Policy Violations: Resident Rights - Dignity and Respect, Abuse Prevention Policy, Employee Conduct / Professional Behavior Standards.Observation and interview with Resident #1 on [DATE] at 10:00 am, she said she did not think any staff member had been disrespectful to her. She went on to talk about her childhood, enjoying ice cream, and wishing to speak with her deceased family member. She was lying in bed on her back with her head raised, dressed in clean clothes, and her hair combed. There were no foul odors and her room was neat.In an interview with the DON on [DATE] at 10:10 am, she said between 8:30 & 9:30 am on [DATE], CNA B approached her in her office and alleged verbal abuse by CNA A toward Resident #1 on [DATE] around 1:00 am. The DON said CNA B told her that she was in Resident #1's room heard the alleged verbal abuse by CNA A. She said CNAs A and C were attending to Resident #1, and Resident #1 was trying to pull on her feeding tube. The DON said she had recently (about a week) been investigating CNA A for poor performance (not changing patients) before this incident. The DON said CNA A did not fight the allegation nor admit the allegation when she spoke to her about the allegation of verbal abuse. The DON said CNA A told her she had been overwhelmed lately, but not with work, and did not want to tell her what was going on with her. The DON said CNA A had already left the faciity on [DATE] by the time she arrived at the facility on the morning of [DATE] around 8:00 am, but spoke with CNA A that afternoon. She said CNA A was suspended, then terminated on the 3rd or 4th day after the allegation. She said during a phone call, CNA A told her if she was getting fired, she would just rather not come back, and corporate said that was fine. The DON said she reported the allegation to the ADM, who came to her office immediately.In an interview with CNA B on [DATE] at 11:23 am, she said she had worked with CNA A for about 2-3 months. She said CNA A was always negative. She would speak disrespectfully to residents who could not defend themselves. Things like, Oh, look, you shit the bed or arguing/refusing to take care of one of the residents that had scabies, or within earshot of a resident that had a rash [not scabies]. CNA B said she was in Resident #1's room on [DATE] around 1:00 am, waiting for help with peri care from CNA A, when she heard CNA A call Resident #1 a bitch. She said she told CNA A she can't say things like that, and CNA A just looked at her. She said Resident #1 was messing with her feeding tube. She said CNA A was speaking sternly to Resident #1 to stop messing with it, which she did, turned to her and said loudly, This Bitch won't stop messing with her tube. CNA B said she told a couple of other (unnamed) CNA's and they told her she should report it, but she waited until about 9 or 10 am because she was pondering if she should report it because she knew CNA A's daughter was having a wedding soon, and she knew she was stressed and did not want to jeopardize CNA A's position. CNA B said she ultimately chose to report the allegation of verbal abuse by CNA A in person to the DON at the facility (the same day, [DATE], around 9:00 am) after going home and taking her daughter to school because it was the right thing to do for the residents. She said she spoke with the DON, the ADON, and the ADM. CNA B said she knew better and that she should have called immediately, especially in light of CNA A's past actions. CNA B said she had never been in that position before.In an interview with the ADON on [DATE] at 12:27 pm, she said CNA B reported to her on [DATE] around 10:00 am that CNA A kept redirecting Resident #1 to not mess with her feeding tube then told CNA B, this bitch keeps messing with her g tube in earshot and not in a whisper and CNA B said, it just didn't feel right. The ADON said CNA A told her on the afternoon of [DATE] that she had not heard of anyone being inappropriate, and she had been frustrated that night because two residents were very busy. The ADON said CNA A told her she did not tell anyone she had been frustrated and denied saying anything inappropriate to Resident #1, but did say Resident #1 had kept messing with her g-tube. The ADON said she was present during the corporate and CNA A's meeting, and CNA A told corporate the same thing; Just that she was frustrated and Resident #1 was messing with her g-tube. The ADON said CNA B told her that she told CNA A she can't say that. The ADON said CNA A had been a CNA for about 2 years. The ADON said (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the next steps were in-services for all staff about reporting allegations immediately, suspending CNA A, getting statements from staff, and conducting safe surveys with the residents. The ADON said, Having an eyewitness and how [CNA A] presented herself negatively in her tone, rude came across as rude, and the residents were not children. Customer service was key and CNA A saying things such as stop doing that to redirect instead of asking if Resident #1 needed anything was unacceptable. The ADON said CNA A asked if she was going to get fired and if so, could it be over the phone. The ADON said CNA A's face said it all, meaning she knew she was caught. In an interview with CNA C on [DATE] at 1:20 pm, she said she had been a CNA for 2 years and worked at the facility after she passed the CNA class. She said she had been trained on abuse and reporting last on [DATE], she thought. She said the training was about speaking up if they heard or saw inappropriate behavior between staff & residents, resident to resident, or staff to staff, and telling the ADM immediately. She said she was not sure about the 2-hour limit. She said she was not at the facility on [DATE].In an interview with CNA D on [DATE] at 1:35 pm, she said she worked at the facility for 2 years after she passed the CNA program. She said she was trained on abuse and reporting two weeks ago. She said she had worked with CNA A before, and she would rather do it herself than ask CNA A to help because of her negative attitude. CNA D said, About a week ago, we were showering a resident who was obese and self-conscious about it. CNA A was holding her nose during his shower and saying things like 'are we done already, ' and it obviously made him feel bad because she could see it in his face, and after she said that he wanted to end his shower. She said she told the nurse and ADON about it. She said CNA A complained about everything except her job-staffing, management, and she was pretty much getting paid for nothing. In an interview with CNA E on [DATE] at 1:49 pm, she said she worked at the facility for 2 years after finishing the CNA classes. She said the last time she was trained on abuse was a month ago during an in-service. She said the in-service covered abuse-see it, hear it, who to call ADM [Abuse coordinator] or nurse immediately. She said she couldn't remember the exact timeframe for reporting. In an interview with the ADM on [DATE] at 3:32 pm, she said she was unaware of CNA A's behavior until this incident, when CNA B spoke about it, then incidentally, when the ADON conducted staff interviews. She said the incident occurred on [DATE] around 1:00 am, but was not reported to her by the DON until [DATE], around 9:00 or 9:15 am, at which time she reported the alleged verbal abuse to the state authority. She said CNA B told her she did not report right away because she was going back and forth in her head about it, and finally decided it was the right thing to do. She said she called the corporate team, who assisted and participated in the investigation and final determination of termination. She said the corporate team participated in the abuse reporting and all staff in-services. She said the frequency of the training was at least monthly, whenever there was an incident, and in the quarterly training modules. She said an ad hoc QAPI (Quality Assessment and Performance Improvement Plan) was done on [DATE].CNA A was unavailable for interview.Record review of CNA A's personnel file revealed she had no previous allegations of abuse or disciplinary action. Her signature was noted on the employee handbook validation page. Record review of the Record of Employee Counseling form dated [DATE] for CNA A revealed Termination due to alleged misconduct based on an internal investigation.Record review of in-service training: [DATE]-Patient/Resident Rights. [DATE]- Abuse, Neglect, and Reporting. [DATE]-Professional courtesy and Customer Service. Record review of the facility employee handbook dated Dec. 2025.You are expected to treat all residents and patients with respect. You are expected to approach customers, clients, residents, patients, and families in a professional, courteous, and efficient manner.Record review of an ad hoc QAPI dated [DATE] under Identified Concerns: Reporting Abuse, Neglect, and Exploitation Timely Abuse Neglect and Exploitation; Education and In-Service have been completed.Record review of the facility policy revised [DATE] titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, under Policy Statement: 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Under Policy Interpretation: 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. 9. Investigate and report any allegations within timeframes required by federal requirements.Record review of the facility policy revised [DATE] titled, Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, 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 (Health and Human Services Commission) reporting guidelines. 3. Immediately is defined as: a. within 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 serious bodily injury.Record review of the facility policy revised [DATE] titled, Identifying Types of Abuse, under Policy interpretation: 1. Abuse of any kind against residents is strictly prohibited. 4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. c.Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Mental and Verbal Abuse: 1. Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. 2. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. 3. Examples of mental and verbal abuse include, but are not limited to: a. harassing a resident; b. mocking, insulting, ridiculing; c. yelling or hovering over a resident, with the intent to intimidate. Psychosocial Outcomes: 1. Some situations of abuse do not result in an observable physical injury, or the psychosocial effects of abuse may not be immediately apparent. In addition, the alleged victim may not report abuse due to shame, fear, or retaliation. Other residents may not be able to speak due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), cannot recall what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. Neither physical marks on the body nor the ability to respond and/or verbalize is needed to conclude that abuse has occurred.