STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676035	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kingsland	3727 W Ranch Rd 1431 Kingsland, TX 78639

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. **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 6 residents (Resident #2) reviewed for abuse.The facility failed to ensure Resident #2 did not experience physical abuse when Resident #1 struck Resident #2 with a cane, resulting in an abrasion on the head on 4/20/26. Findings Included:Resident #1Record review of the Quarterly Minimum Data Set (MDS) dated [DATE] reflected Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses including non-Alzheimer's dementia (a function cognitive decline in memory), alcoholic fibrosis and sclerosis of the liver (scaring of the liver tissue), chronic pain, cataracts (a clouding of the lens on the eye affecting vision), and constipation. The resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS reflected no physical behavior. Record review of Resident #1's care plan dated 10/14/25 reflected moderately impaired decision-making related to dementia and included interventions such as encouraging participation in activities of daily living and following directions. The care plan did not address or include interventions for potential aggressive or combative behaviors.Record review of Resident #1's progress note dated 04/20/2026 at 10:45 PM reflected staff heard yelling and observed Resident #1 striking Resident #2 with a cane two times to the head and two times to the arm while stating, I'm going to kill him. Staff intervened, removed the cane, and separated the residents. Emergency Medical Services (EMS) and law enforcement were notified, and Resident #1 was transferred to the hospital for evaluation.Resident #2Record review of Resident #2's Quarterly MDS dated [DATE] reflected he was a [AGE] year-old male with diagnoses including Alzheimer's disease and muscle wasting, with impaired memory.Record review of Resident #2's progress note dated 04/21/2026 reflected he sustained two superficial scratches to the posterior scalp and exhibited guarding of the right upper extremity. Resident #2 reported pain to his head and arm.During an interview conducted on 04/29/2026 at 12:22 PM, Resident #2 stated he had been struck in the head with a cane by another resident. He stated staff intervened immediately and reported he felt safe at the time of the interview.During an interview on 4/29/26 at 2:30 pm CNA A stated Resident #1 had not previously demonstrated physical aggression but had been wandering prior to the incident. CNA A stated that after hearing yelling, staff observed the altercation, intervened immediately, removed the cane, and placed Resident #1 on 1:1 supervision until transfer to the hospital. He stated Resident #1 was easily redirected back to his room and laid down in his bed until EMS arrived. During an interview on 04/29/2026, at 4:15 pm the Director of Nursing (DON) stated Resident #1 had experienced increased confusion and paranoia prior to the incident. The charge nurse had notified the medical doctor, laboratory tests and referrals had been initiated; however, the behavior escalated prior to further interventions being implemented. She stated Resident #1 remained 1:1 supervision after the altercation until he was transferred to the Hospital. She stated Resident #1 had not had any behavioral outburst prior to this episode. The DON stated the hospital did confirm Resident #1 had a urinary tract infection. She stated an initial assessment that was completed on Resident #2 found two superficial scratches to the posterior scalp and exhibited guarding of the right upper extremity. She (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 - Minimal harm or potential for actual harm Residents Affected - Few	stated for safety an x ray was obtained of the right extremity. The Xray was negative except for an old injury from a motorcycle accident prior to admission. The DON stated all other residents residing on the 500 hall were provided safe resident surveys in which no other residents reported any incidents of abuse or neglect. The DON stated all staff were in-serviced on abuse and neglect, and dealing with residents who have aggressive behaviors. During an interview on 04/29/2026 4:30 PM the Administrator stated staff had notified him immediately following the incident and confirmed Resident #1 was transferred to a hospital and subsequently discharged to another facility better equipped to manage behavioral health needs. He stated the facility followed policy for abuse and neglect. He stated 911 was in the building within 8 minutes of the incident, also the county had a mental health coordinator that arrived with the police. All staff were educated on abuse and neglect and dealing with residents with aggressive behaviors. Staff were able to verbalize understanding of education. Facility Policy Review:Record review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2001 reflected 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 seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms.