

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER Avir at Magnolia		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 N Magnolia Luling, TX 78648	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents had the right to be free from physical abuse and neglect for two (Resident #1 and Resident #2) of five residents reviewed for abuse and neglect. 1. The facility failed to ensure Resident #1 was not physically abused by CNA A, on an unknown date, and witnessed by NA B and NA C, when CNA A put soap in Resident #1's eyes in the shower room.2. The facility failed to ensure Resident #2 was not physically abused by CNA A, on an unknown date, and witnessed by NA B and NA C, when CNA A physically restrained Resident #2 in his room while providing peri-care. The noncompliance was identified as PNC. The IJ began on 09/26/2025 and ended on 10/13/2025. The facility had corrected the noncompliance before the survey began on 10/14/2025. These failures placed residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Review of Resident #1's admission record, dated 10/14/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including depression (a mood disorder with persistent feelings of sadness and loss of interest), dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgment), epilepsy (a neurological disorder causing seizures), blindness in one eye (inability to see out of one eye), conductive hearing loss (when sound cannot reach the inner ear due to issues in the outer or middle ear) and cognitive communication deficit (a problem with communication caused by cognition rather than a language or speech deficit). Review of Resident #1's Quarterly MDS assessment, dated 08/27/2025, reflected a BIMS score of 07, indicating moderate cognitive impairment. Section GG (Functional Abilities) reflected she required substantial/maximal assistance for showering/bathe self. Review of Resident #1's care plan, dated 05/06/2025, reflected she was at risk for ADL self-care deficit with an intervention of providing assistance with ADLs/IADLs as needed. During an interview on 10/14/2025 at 12:20 PM, Resident #1 stated the facility and care provided to her was fine. Resident #1 stated no staff member had intentionally been mean to her or attempted to cause her harm. Resident #1 stated she felt safe in the facility. Review of Resident #2's admission record, dated 10/15/2025, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and most recent readmission on [DATE] with diagnoses including hemiplegia and hemiparesis (paralysis and weakness on one side of the body), dementia severe with mood disturbance (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgment causing behaviors), seizures, type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), depression (a mood disorder with persistent feelings of sadness and loss of interest), cerebral infarction (a blood clot blockage that impairs blood flow through the brain artery), dysphagia (difficulty swallowing), and cognitive communication deficit (a problem with communication caused by cognition rather than a language or speech deficit). Review of Resident #2's Quarterly MDS assessment, dated 08/21/2025, reflected a BIMS score of 06, indicating severe cognitive impairment. Section GG (Functional Abilities) reflected he was dependent on staff for toileting hygiene. Review of Resident #2's care plan, date initiated 07/23/2025, reflected he was at risk for harm: self-directed or other-directed with interventions that included: if resident poses a potential threat to injure self or others notify provider, utilize calming touch, and if safe, allow resident personal space. Review of Resident #2's care plan, dated 07/23/2025, reflected he was at risk for ADL self-care deficit with an intervention of providing assistance with ADLs/IADLs as needed. During an interview on 10/14/2025 at 1:04 PM, Resident #2 stated the care provided to him was alright. Resident #2 stated someone hurt him but was unable to provide a name or further information. Resident #2 then began asking for his mother. During a phone interview on 10/15/2025 at 09:23 AM, FM #2 stated Resident #2 had a history of physical abuse, though she was unsure of the details of the history of abuse. FM #2 stated Resident #2 is confused with short-term memory loss and some long-term memory loss. She stated she did not have any concerns related to staff taking care of Resident #2 and thought, when he stated someone hurt him, he was referring to his history of abuse prior to his admission to the facility. FM #2 stated Resident #2 had refused care and had increasing agitation but that started several months prior. She stated she didn't notice any changes in demeanor over the past couple of weeks. FM #2 stated she had no concerns for Resident #2's safety or the care provided to him. During a phone interview on 10/15/2025 at 11:24 AM, NA B stated she had worked at the facility for the past 5 months. She stated she witnessed, on an unknown date, CNA A place soap directly on Resident #1's face in a manner that would cause the soap to run directly into</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegations are made to the abuse coordinator for two (Resident #1 and Resident #2) of five residents reviewed for abuse. The facility failed to notify the abuse and neglect coordinator (ADM) of the alleged abuse by CNA A towards Resident #1 and Resident #2 so it could be investigated and handled appropriately to ensure the residents' safety. The noncompliance was identified as PNC. The IJ began on 09/26/2025 and ended on 10/13/2025. The facility had corrected the noncompliance before the survey began on 10/14/2025. These failures could place residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: Review of Resident #1's admission record, dated 10/14/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including depression (a mood disorder with persistent feelings of sadness and loss of interest), dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgment), epilepsy (a neurological disorder causing seizures), blindness in one eye (inability to see out of one eye), conductive hearing loss (when sound cannot reach the inner ear due to issues in the outer or middle ear) and cognitive communication deficit (a problem with communication caused by cognition rather than a language or speech deficit). Review of Resident #1's Quarterly MDS assessment, dated 08/27/2025, reflected a BIMS score of 07, indicating moderate cognitive impairment. 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Review of Resident #2's admission record, dated 10/15/2025, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and most recent readmission on [DATE] with diagnoses including hemiplegia and hemiparesis (paralysis and weakness on one side of the body), dementia severe with mood disturbance (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgment causing behaviors), seizures, type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), depression (a mood disorder with persistent feelings of sadness and loss of interest), cerebral infarction (a blood clot blockage that impairs blood flow through the brain artery), dysphagia (difficulty swallowing), and cognitive communication deficit (a problem with communication caused by cognition rather than a language or speech deficit). 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She stated she witnessed, on an unknown date, CNA A place soap directly on Resident #1's face in a manner that would cause the soap to run directly into Resident #1's eyes. NA B stated CNA A then handed Resident #1 a washcloth with soap on it for Resident</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to the state survey agency within five working days of the incident for two of five residents (Resident #1 and Resident #2) reviewed for abuse and neglect. The facility failed to thoroughly investigate two allegations of abuse regarding Resident #1 and Resident #2 to identify a timeframe of when alleged abuse occurred and failed to notify the local law enforcement. This deficient practice placed residents at risk of abuse due to not having a thorough investigation done for facility reported incidents. Findings included: Review of Resident #1's admission record, dated 10/14/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including depression (a mood disorder with persistent feelings of sadness and loss of interest), dementia (a disease that causes a general decline in cognitive abilities that can affect the ability to perform everyday activities, memory loss, and poor judgment), epilepsy (a neurological disorder causing seizures), blindness in one eye (inability to see out of one eye), conductive hearing loss (when sound cannot reach the inner ear due to issues in the outer or middle ear) and cognitive communication deficit (a problem with communication caused by cognition rather than a language or speech deficit). Review of Resident #1's Quarterly MDS assessment, dated 08/27/2025, reflected a BIMS score of 07, indicating moderate cognitive impairment. 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The template also reflected the local law enforcement was not notified. Review of facility's Provider Investigation Report, signed on 10/02/2025, reflected Incident Date: Unknown and Time of Incident: ___:___ o a.m. o p.m. The report also reflected that the police were notified but there was no case number or documentation provided. During an interview on 10/14/2025 at 1:04 PM, Resident #2 stated the care provided to him was alright. Resident #2 stated someone hurt him but was unable to provide a name or further information. Resident #2 then began asking for his mother. During a phone interview on 10/15/2025 at 09:23 AM, FM #2 stated Resident #2 had a history of physical abuse, though she was unsure of the details of the history of abuse. FM #2 stated Resident #2 is confused with short-term memory loss and some long-term memory loss. 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