STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676069	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Texarkana	4925 Elizabeth St Texarkana, TX 75503

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 interview and record review the facility failed to ensure residents were free from abuse for 2 of 11 residents (Resident's #20 and #38) reviewed for resident abuse. The facility failed to ensure Resident #20, and Resident #38 were free from physical abuse, when Resident #20 pulled Resident #38's ear, and Resident #38 bit Resident #20 on the right wrist, on 05/27/25. The non-compliance was identified as past non-compliance. The noncompliance began on 05/27/25 and ended on 05/27/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of physical harm, mental anguish, or emotional distress. The findings included: 1. Record review of the face sheet, dated 06/10/25, reflected Resident #20 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of unspecified convulsions (seizures), bipolar disorder (mental health condition that causes extreme mood swings), severe dementia with anxiety (memory loss), history of alcohol abuse with alcohol-induced dementia (memory loss), paranoid schizophrenia (characterized by intense paranoia and delusional thinking), and panic disorder (anxiety disorder characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress). Record review of the quarterly MDS assessment, dated 05/14/25, reflected Resident #20 had clear speech and was understood by others. Resident #20 was usually able to understand others. The MDS reflected Resident #20 had a BIMS score of 5, which indicated severe cognitive impairment. The MDS reflected Resident #20 had disorganized thinking that did not fluctuate. Resident #20 had delusions (misconceptions or beliefs that are firmly held, contrary to reality). No other behaviors were included on the MDS assessment. (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	Record review of the comprehensive care plan, initiated on 05/27/25, reflected Resident #20 had episodes of verbal and physical aggression. Resident #20 grabbed another resident's ear on 05/27/25. The interventions included: Administer medication per orders, anticipate behaviors and redirect, notify doctor and family, ensure staff is aware of behaviors and successful interventions, maintain calm environment, psychiatric consult per orders, every 15 minute checks, separate residents, and monitor right wrist bruising until resolved. Record review of the physical aggression incident report, dated 05/27/25, reflected Resident #20 walked into the main dining area and pulled another resident's ear and he bit her on the right wrist. The immediate action taken included: residents were separated from each and redirected, assessed for injury, small area noted to right wrist, no break in skin, resident denies pain at this time. Injuries included: hematoma to right wrist. The incident report reflected Resident #20 did not like it when Resident #38 talks loudly, which is his normal due to hearing impairment. The incident report reflected the family, physician, and DON were notified of the incident. Record review of the skin assessment, dated 05/27/25, reflected Resident #20 had bruising to her right wrist. The area was small, but no measurements were indicated. 2. Record review of the face sheet, dated 06/10/25, reflected Resident #38 was an [AGE] year-old male who initially admitted to the facility on [DATE] with diagnosis of Alzheimer's disease (brain condition that progressively damages memory, thinking, and learning skills). Record review of the quarterly MDS assessment, dated 05/18/25, reflected Resident #38 had clear speech and was usually understood by others. Resident #38 was sometimes able to understand others. The MDS reflected Resident #38 had a BIMS score of 1, which indicated severe cognitive impairment. Resident #1 had inattention that did not fluctuate. The MDS reflected Resident #38 had no behaviors or refusal of care during the look-back period. Record review of the comprehensive care plan, initiated 05/27/25, reflected Resident #38 had episodes of verbal and physical aggression. Resident #38 bit another resident. The interventions included: Administer medications per orders, anticipate behaviors and redirect, encourage to attend social activities, maintain calm environment, monitor and chart behaviors every shift and report to doctor as needed, provide psychiatric consult per orders, refer to social services as needed, resident immediately separated, refer to psychiatric services at next visit, and 15 minute monitoring. Record review of the physical aggression incident report, dated 05/27/25, reflected Resident #38 was in the dining room and another resident pulled his ear and Resident #38 responded by biting her on the right wrist. The immediate action taken included: Residents were separated from each other immediately and assessed for injury, none found. The incident report reflected the doctor, DON, and responsible party were notified of the incident. Record review of the skin assessment, dated 05/27/25, reflected Resident #38 had no injuries or skin concerns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/09/25 beginning at 11:39 AM, CNA A stated Resident #20 and Resident #38 were constantly yelling, cursing, or hitting at each other. CNA A stated when Resident #20 and Resident #38 started acting out, she notified RN E. CNA A stated these behaviors happened almost every day. CNA A stated she kept the residents separated and redirected them when the behaviors started. CNA A stated on 05/27/25, Resident #20 walked up to Resident #38 and pulled his ear. CNA A stated Resident #38 turned his head and bit Resident #20 on the wrist. CNA A stated both residents were separated and placed on 15 minute checks. CNA A stated Resident #20 had a small bruise to her wrist, but no further injuries occurred. CNA A stated Resident #20 and Resident #38 had no changes in their behaviors related to the incident. During an interview on 06/09/25 beginning at 2:50 PM, the Psychiatric Consultant stated she visited with several residents on the secured unit every month. The Psychiatric Consultant stated Resident #38 and Resident #20 were visited. The Psychiatric Consultant stated Resident #38 talks loudly because he was hard of hearing. She said she had never had any behavioral issues with either resident, but the staff reports they were non-cooperative with cares. During an interview on 06/10/25 beginning at 3:37 PM, LVN D stated she was hired in December of 2024 and recently switched to part time status. LVN D stated she normally worked 2-10 shift on the secured unit. LVN D stated Resident #20 and Resident #38 did not hit each other regularly. LVN D stated there was an incident approximately a few weeks ago. LVN D stated Resident #20 pulled Resident #38's ear, and Resident #38 bit Resident #20. LVN D stated it was documented and 15 minute checks were initiated. LVN D stated when resident to resident altercations happened, the staff documented in the electronic charting system, notified the DON, family, and doctor, and placed it on the 24 hour report sheet for continued monitoring. LVN E stated they were trained to separate the residents, attempt to redirect them, and usually place them on 15 minute checks. LVN D stated it had not been reported that Resident #20 and Resident #38 had verbal or physical altercations daily. During an interview on 06/10/25 beginning at 3:48 PM, the DON stated it was brought to her attention on 05/27/25 that Resident #20 and Resident #38 had a physical altercation. The DON stated it was reported that Resident #20 pulled Resident #38's ear, and he bit her in response. The DON stated it had not been reported that verbal or physical behaviors happened daily between Resident #20 and Resident #38. The DON stated if physical or verbal behaviors happened, she expected it to be reported. The DON stated on 05/27/25, Resident #20 and Resident #38 were separated immediately and placed on 15 minute checks. She stated they were assessed, and Resident #20 had a small bruise to her right wrist. The DON stated in-service education was provided to the staff to include abuse and neglect, and resident to resident altercations. The DON stated the Administrator was on vacation during the incident, so it was reported to her regional compliance nurse. The DON stated the family, doctor, and herself were notified after the incident. The DON stated no further incident has occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 beginning at 7:14 AM, RN E stated it had not been reported Resident #20 and Resident #38 had verbal or physical altercations daily. RN E stated approximately a few weeks ago, Resident #20 pulled Resident #38's ear and Resident #38 bit her. RN E stated both residents were immediately separated and placed on 15 minute checks. RN E stated Resident #20 was aggressive and was moved off the female secured unit because she was hitting the other female residents. RN E stated staff were to ensure the residents were supervised and redirected as needed. RN E stated when resident to resident altercations happened, the staff documented in the electronic charting system, notified the DON, family, and doctor, and placed it on the 24 hour report sheet for continued monitoring. LVN E stated they were trained to separate the residents, attempt to redirect them, and usually place them on 15 minute checks. RN E stated no further incidents have occurred since 05/27/25. Record review of the Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy, revised April 2021, reflected residents have the right to be free from abuse .this includes but is not limited to freedom from . physical abuse . protect residents from abuse . by anyone including . other residents . Record review of the Resident-to-Resident Altercations policy, revised September 2022, reflected All altercations, including resident to resident abuse, are investigated and reported to DON and Administrator .if two residents are involved in an altercations, staff: separate the residents, and institute measure to calm the situation, identified what happened, notify family, doctor, and facility management, make any changes to care plan, document in the record, complete an incident report, consult with psychiatric services The facility had corrected the non-compliance on 05/27/25 by the following: 1. Record review of the physical aggression incident report, dated 05/27/25, reflected Resident #20 walked into the main dining area and pulled another resident's ear and he bit her on the right wrist. The immediate action taken included: residents were separated from each and redirected, assessed for injury, small area noted to right wrist, no break in skin, resident denies pain at this time. Injuries included: hematoma to right wrist. The incident report reflected Resident #20 did not like it when Resident #38 talks loudly, which is his normal due to hearing impairment. The incident report reflected the family, physician, and DON were notified of the incident. 2. Record review of the skin assessment, dated 05/27/25, reflected Resident #20 had bruising to her right wrist. The area was small, but no measurements were indicated. 3. Record review of the physical aggression incident report, dated 05/27/25, reflected Resident #38 was in the dining room and another resident pulled his ear and Resident #38 responded by biting her on the right wrist. The immediate action taken included: Residents were separated from each other immediately and assessed for injury, none found. The incident report reflected the doctor, DON, and responsible party were notified of the incident. 4. Record review of the skin assessment, dated 05/27/25, reflected Resident #38 had no injuries or skin concerns. 5. Record review of the 15 Minute Checks Sheet, dated 05/27/25, 05/28/25, and 05/29/25 reflected 15 minute checks were completed for Resident #20 and Resident #38. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Record review of the comprehensive care plan, initiated on 05/27/25, reflected Resident #20 grabbed another resident's ear on 05/27/25. The interventions included: . every 15 minute checks, separate residents, psychiatric referral, and monitor right wrist bruising until resolved. 7. Record review of the comprehensive care plan, initiated 05/27/25, reflected Resident #38 bit another resident. The interventions included: . resident immediately separated, refer to psychiatric services at next visit, and 15 minute monitoring. 8. Record review of the abuse and neglect in-service training, dated 05/27/25, reflected staff was provided education. There were approximately 34 staff signatures. 9. Record review of the resident to resident altercation in-service training, dated 05/27/25, reflected staff was provided education. There were approximately 34 staff signatures. 10. During interviews between 06/09/25 at 11:39 AM and 06/11/25 at 1:49 PM, Housekeeper R, CNA A, CNA B, CNA C, CNA F, CNA H, CNA S, MA Q, LVN D, LVN J, RN E, the Maintenance Supervisor, and the Housekeeping Supervisor (different shifts who worked in the secured unit) were able to verbalize the different types of abuse, when to report abuse, and the abuse coordinator. The staff were able to outline the policy and procedure for resident to resident altercations including separating the residents and notifying the abuse coordinator. The noncompliance was identified as PNC. The noncompliance began on 05/27/25 and ended on 05/27/25. The facility had corrected the noncompliance before the survey began.