

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  Avir at Texarkana		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 10 residents (Resident #1) reviewed for abuse. 1. The facility failed to ensure Resident #1 was free from physical abuse on 01/30/26, when CNA A open-handed slapped Resident #1 in the face, which was witnessed by CNA B. 2. The facility failed to ensure Resident #1 was protected from further abuse by CNA A on 01/30/26, when CNA B briefly left the room to notify the nurse. The noncompliance was identified as PNC. The immediate jeopardy (IJ) began on 01/30/26 and ended on 02/02/26. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of serious adverse psychosocial outcome such as fear, anxiety, shame or guilt, depression, withdrawal from activities, helplessness, low self-worth, and post-traumatic responses such as flashbacks, nightmares, or increased startle responses. The findings included: Record review of the face sheet, dated 04/29/26, reflected Resident #1 was an [AGE] year-old male who admitted to the nursing facility on 03/16/21 with a diagnoses of heart failure (the heart muscle is unable to pump enough blood to meet the body's need for blood and oxygen), unspecified dementia (memory loss) with agitation and other behaviors, and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, eventually impairing the ability to carry out the simplest tasks). Record review of the quarterly MDS assessment, dated 03/23/26, reflected Resident #1 had a BIMS score of 0, which indicated severe cognitive impairment. Resident #1 had no behaviors or refusal of care episodes during the look-back period. The MDS reflected Resident #1 required total staff assistance with hygiene, dressing, and bathing. Record review of the comprehensive care plan, dated 05/01/25, reflected Resident #1 had impaired cognitive function and became combative with staff at times. The interventions included: . do not attempt to care for resident when physically abusive, allow time and revisit task later. Staff do not attempt to care for resident when physically abusive, staff educated to allow time and revisit task later. staff educated on explaining care task the best they could prior to completing the task. Record review of the Email Self-Report Template, dated 01/30/26, reflected the Administrator reported an incident that occurred on 01/30/26 at 3:35 p.m., where [CNA A] slapped [Resident #1] across the face after he kicked her on the leg. The incident was witnessed by CNA B. Record review of CNA A's signed witness statement, dated 01/30/26, reflected, Me and [CNA B] was changing a [patient] and [Resident #1] hit me in the leg and I hit him back. I was not trying to it was reaction. Record review of CNA B's signed witness statement, undated, reflected . On 01/30/26 at approximately 3:35 p.m., myself and [CNA A] were working 200 Hall and were attempting to clean up [Resident #1]. [Resident #1] was laying down when we began working on him. After we secured his brief, he began to sit up and resist. He sat himself on the side of the bed facing [CNA A] and swung, hitting her in the leg. [CNA A] immediately slapped him in his face hard. I looked at her, shocked, and then headed to get help. [CNA A] was asking if I was going to report her and telling me she didn't mean to do it. I reported the abuse immediately. Record review of a typed statement, dated 02/06/26, reflected the Administrator interviewed CNA A on 01/30/26 at approximately 3:50 p.m. The conversation was as follows: [CNA A] started the conversation off describing what happened upon (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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We [CNA A and CNA B] stopped and [CNA B] ran out of the room and reported me to the nurse. [ADON D] and the nurse escorted me off of the hall/unit. When asked if [Resident #1] has ever hit her before she stated Yes, he has hit me before, but we just leave him alone until he calms down. [CNA A] was asked why [01/30/26] was any different and why she hit him back today. Per [CNA A], He kicked my hurt leg, and I reacted and hit him back. I fell during the ice storm and hurt my left leg and that kick really hurt my leg. [CNA A] was asked if she had ever hit a resident before and she denied hitting [Resident #1] or any of the other residents before. After the interview with the cops, [CNA A] changed her reason for her leg hurting and she said that she takes insulin and that is the leg that she used to inject her insulin. She was escorted to the front door after interviewing with [Administrator] and giving the police a statement on the events that led to her hitting [Resident #1]. [CNA A] has been informed that she is out pending the investigation and that she will be notified of the final decision in 3 working days.[CNA A] was informed not to come back to the facility nor enter the facility until Human Resources or Administrator notifies of the final decision regarding her employment status with the company in this facility. She voiced understanding and left the facility at approximately 5:30 p.m. Record review of Resident #1's progress notes, reflected the following:1. ADON D documented on 01/30/26 at 5:32 p.m., Reported that [Resident #1] was slapped on forehead on the right side by [CNA B] on hall. At that point [Resident #1] was assessed with no injuries or obvious distress noted. No fearful behavior. No increased anxious behavior noticed. Attempted to contact [responsible party] with no answer left [voicemail] for call back. Contacted [Nurse Practitioner] new orders to monitor for delayed injuries [times or for] 3 days, monitor for increased anxiousness or fearful behavior.2. ADON D documented on 01/30/26 at 5:40 p.m., Skin warm &amp; dry, skin color [within normal limits] and turgor (skin's elasticity, or its ability to change shape and return to normal) is normal. Skin Issues Note: No obvious skin issues noted .3. LVN E documented on 01/31/26 at 12:20 a.m., No delayed injuries noted post altercation with [CNA A] on previous shift. Supine position (flat on back) in bed at this time; laying quietly awake on secured unit. No visible [signs or symptoms] of distress or discomfort noted. No skin break or bruising noted. Will report any changes. Record review of the comprehensive care plan, dated 01/30/26, reflected Resident #1 would remain free from injuries or mental anguish caused by the incident of being slapped on the face/forehead. The interventions included: . monitor for mental distress and increase anxiety. monitor his face for 72 hours for redness or abrasion. report any changes to the doctor. Record review of the Record of Employee Counseling form, dated 01/30/26, reflected CNA A was suspended after she slapped a resident in his face after resident kicked her on the left leg. The expectation/outcome was Restrain and to walk away from the situation. Record review of the in-service, dated and signed on 01/30/26 by CNA B, reflected she was provided 1:1 education on, If you witness a resident being physically abused or abused in any way do not leave resident with the person that is being abusive. Bring the person out into the open with you or if you are not safe yell, get someone's attention. Resident to resident altercation - remove resident from danger. Anytime a resident is in a potentially dangerous situation we removed them from danger first. Record review of the in-service, dated 01/30/26, reflected that all nursing staff were provided in-service education on making sure residents were safe, not leaving them alone if abuse was witnessed, behaviors, abuse and neglect policy and procedure, and unmanageable residents. There were 43 staff signatures. Record review of the (continued on next page)</p>		

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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>Interview Statements, dated from 01/31/26 to 02/02/26, reflected MA F, CNA G, CNA H, CNA K, CNA L, NA M, CNA N, and LVN O had worked with CNA A and not witnessed any physical abuse to other residents. Record review of the Resident Safe Surveys, dated 02/02/26, reflected Resident #2, Resident #3, and Resident #4 felt safe in the facility, felt staff were helpful and responsive, and had reported no one at the facility had hurt or threatened them during their stay. Record review of the Provider Investigation Report, dated 02/05/26, reflected on 01/30/26 at 3:35 p.m., CNA B witnessed CNA A slap Resident #1 across the face after Resident #1 kicked CNA A in the leg. An assessment was completed by ADON D on 01/30/26 at 3:45 PM, which reflected Resident #1 had no redness, open areas, scratches, bruises, etc. to the area on his cheek or forehead. He had no changes in his normal behavior or signs of mental anguish. The incident was reported to the police department. The Nurse Practitioner, Ombudsman, and responsible party were notified. CNA A was immediately removed from the secured unit and taken to the business office manager's office. Statements were obtained from residents and staff. The allegation of abuse was confirmed, and CNA A was terminated post investigation. Record review of the Record of Employee Counseling form, dated 02/02/26, reflected CNA A was terminated after the investigation was completed. During an observation on 04/28/26 beginning at 11:15 AM, Resident #1 was lying in bed with eyes closed. He opened his eyes when the state surveyor knocked on the door but was unable to answer questions appropriately related to his disease process. Resident #1 did not appear nervous, or anxious. During an interview on 04/28/26 at 1:26 p.m., CNA B stated she vividly remembered the incident on 01/30/26 when CNA A slapped Resident #1 in the face. She said CNA A and herself were getting Resident #1 ready to get up from his nap. She said CNA A and herself sat Resident #1 up on the side of the bed when he became combative and kicked or hit CNA A in the leg. CNA B said Resident #1's hit or kick was more of a light tap and was not hard at all. She said CNA A reared back and slapped the dog [s-word] out of Resident #1, hard. She said CNA A hit the left side of his face and it was a little red. CNA B stated Resident #1 just looked stunned and froze in place. She stated he appeared nervous, like he was afraid to move. She stated she immediately left the room briefly to report the incident to the charge nurse. CNA B stated she returned with the charge nurse to Resident #1's room and CNA A was sitting on the opposite bed. She stated CNA A kept saying she did not mean to do it, was really sorry, and did not want to get into trouble. CNA B stated she had not witnessed CNA A physically abuse residents before. She said CNA A reacted so instinctively and did not hesitate in her reaction. CNA B stated Resident #1 had been resistive and combative with care prior to that incident, but it depended on the approach staff used. CNA B stated she was provided one on one in-service education on 01/30/26 about not leaving residents alone with an abuser. During an interview on 04/28/26 at 2:17 p.m., ADON D stated she used to be the ADON but no longer worked at the facility. ADON D stated she remembered the incident that occurred on 01/30/26 when CNA A slapped Resident #1. ADON D stated it was reported that CNA B had witnessed CNA A slap Resident #1 on the secured unit. ADON D said she immediately removed CNA A from the secured unit and escorted her to one of the offices. She stated the police department was notified and arrived at the facility to obtain statements. She said CNA A was suspended pending the investigation and was not allowed to return to work. She said she was the nurse who assessed Resident #1 after the incident. She said Resident #1 had no redness or marks that she observed. ADON D stated Resident #1 had no observed distress or changes in his behavior from baseline. ADON D said Resident #1 was normally combative or resistive during care. She said Resident #1 was observed 72 hours post incident for any delayed injuries and education was provided to the staff on abuse and neglect policies, resident behaviors, and unmanageable residents. During interviews on 04/28/26 between 1:58 p.m. - 3:54 p.m., with staff over all shifts, NA S, CNA B, CNA C, CNA H, CNA P, CNA R, CNA T, CNA U, CNA V, CNA W, CNA X, CNA Z, CNA BB, CNA CC, LVN Q, and LVN Y were able to verify they were provided in-service education after the incident on 01/30/26 when CNA A slapped Resident #1. The staff stated they were in-serviced on the types of abuse to include physical abuse. They were able to verbalize the abuse coordinator, and abuse should be reported immediately, after (continued on next page)</p>		

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