STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	02/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Bandera	222 Fm 1077 Bandera, TX 78003

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 observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involved abuse, to the Administrator and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for freedom from abuse, neglect, and exploitation.The facility failed to report to HHSC that Resident #1 had made an allegation of sexual misconduct against CNA A.This failure could place residents at risk of abuse, neglect, and exploitation.The findings were:Record review of Resident #1's face sheet dated 2/7/26 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included pneumonia (infection of one or both of the lungs caused by bacteria, viruses, or fungi), urinary tract infection (when bacteria enter the urinary tract through the urethra and begins to spread in the bladder), and dementia in other diseases classified elsewhere unspecified severity without behavioral, psychotic, or mood disturbance and anxiety (general term for loss of memory, language, problem-solving and other thinking abilities caused by another, underlying disease, classified elsewhere, with no behavioral, psychotic, or mood disturbances, or anxiety).Record review of Resident #1's admission MDS dated [DATE] revealed the resident had minimal difficulty hearing, had impaired vision but did not wear eyeglasses, had clear speech, and a BIMS score of 12 out of 15 indicating the resident was moderately cognitively impaired. The resident needed partial assistance with bathing, dressing, and toileting but was independent in ambulation and used a walker and a manual wheelchair and the resident was always incontinent of bowel and bladder.Record review of Resident #1's care plan, undated, had a focus initiated on 2/4/26 and revised on 2/5/26 for behavior problems related to delusions and stating to staff that someone had been in her room and touching her inappropriately, requests female caregivers only. Interventions included 2 caregivers, female caregivers only, anticipate and meet the resident's needs, and if reasonable, discuss the resident's behavior and explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.Record review of Resident #1's nursing notes revealed a nursing note by the DON dated 2/5/26 at 12:42 p.m. It was reported to me by staff from therapy that resident stated she had been touched. I interviewed resident. I asked her when she was touched? she stated, oh you know here and there. Then I asked when this happened? She stated again here and there. Then I asked Who did this? She said, I am not telling you that.Review of CNA A's employee file revealed background check completed on 12/19/25. The EMR, and NAR checks were completed on 12/11/25 with no concerns. ANE statement and senate bill statement on ANE was signed by CNA A on 12/20/25. CNA A completed ANE training on 12/23/25, 12/26/25, and 2/5/26. And had no disciplinary actions. In an observation and interview on 2/7/26 at 12:05 p.m. Resident #1 was lying on top of her bed, well-groomed (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	and dressed appropriately. The resident was alert and oriented to person and place. The resident stated staff treated her good. The resident denied any inappropriate touching by any staff member and denied any ANE at the facility. The resident stated she had some sweaters go missing but that was the only issue and showed me she was wearing 2 sweaters and had more in her closet.In an interview on 2/7/25 at 1:02 p.m. the Administrator stated the allegation was reported on the 4th (2/4/26) to the DON who had interviewed the resident but the Administrator was not notified until 2/5/26 and immediately suspended the accused CNA and started an investigation. The Administrator stated they had a meeting with their corporate staff, and it was determined that it was not reportable. The Administrator stated she understood that it should have been reported to her immediately and to HHSC. In an interview on 2/7/26 at 1:40 p.m. the DON stated therapy had come to her on Wednesday 2/4/26 and informed her Resident #1 had stated she had been touched in a sexual manner. The DON stated she interviewed the resident and the resident stated she was not going to tell her that. The DON stated she did not report it to the Administrator on Wednesday. The DON did report it to the Administrator on Thursday 2/5/26 during the morning meeting. The DON stated she should have reported it to the Administrator immediately.In an interview on 2/7/26 at 3:00 p.m. the Administrator stated the possible consequences of allegations not being reported to her immediately and the state agency was that it could continue to happen but in this case it was untrue, and she consulted with corporate and due to it not being true, did not report to HHSC. In multiple interviews on 2/7/26 1:00 p.m. to 2:30 p.m. 6 residents denied any ANE including any inappropriate touching by staff. In a telephone interview on 2/7/26 at 3:51 p.m. CNA A denied the allegation and stated he had never touched any residents inappropriately.Review of the facility policy on ANE reporting and investigating revised September 2022 indicated all reports of abuse. are reported to local, state, and federal agencies as required by current regulations. 1. If resident abuse, neglect, exploitation. is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying and licensing the facility. 3. Immediately is defined as a. within 2 hours of an allegation involving abuse.