STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676252	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Veterans Memorial	1424 Fallbrook Drive Houston, TX 77038

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 - 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 interviews, and record review, the facility failed to ensure residents were free from abuse for 2 of 7 (Resident #1 and Resident #2) residents reviewed for abuse.1. The facility failed to ensure each resident was free from abuse when R#1 was hit on the hand by CNA A and2. The facility failed to ensure each resident was free from abuse when Resident #2 received rough ADL treatment by CNA AThis failure placed residents at risk of physical harm, emotional distress, and mental anguish.Findings IncludeRecord review or Resident #1's face sheet revealed an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnosis of Alzheimer's (irreversible brain disorder affecting memory, thinking, and behavior) disease.Record review of Resident #1's Comprehensive MDS assessment, dated 02/42026, reflected the Resident #1had a BIMS score of 03, which indicated a severe problem with thinking and memory. Record review of Resident #1's care plan reflected the following:Focus: Resident #1 was resistive to ADL care and oftentimes refuses showers. Staff encouragement is met with resistance and avoidance. Goal: Resident #1 will cooperate with ADL care and improve decision making processes as it relates to participation in tasks through the next review dateInterventions: Allowed Resident #1 to make decisions about ADL care and tasks to promote a sense of control. When decisions have the possibility to intercept in meeting overall care goals; offer alternatives that align with the goals. Encourage as much participation by Resident #1 as possible during care activities. Ensure Resident #1 can complete the task independently with only supervision or as tolerable, capable. Provide her with the tools to complete each task. Give clear explanation of all care activities prior to and as they occur during each contact. If possible, negotiate the time for ADL so that the resident participates in the decision-making process. Return at the agreed upon time. If resident resists ADL care, reassure resident that you respect her decision, however, you will try again at a later time.Record review of Resident #1's Orders revealed, Sertaline 50MG tablet by mouth for major depressive disorder, recurrent mild (start 10/29/26 at 9:00am), Divalproex Sodium oral capsule 125 MG used for mood disorder (start 8/8/25 a t9:00pm), Namenda tablet 10 MG, give 1 by mouth every morning and at bedtime for dementia (start 5/5/25 9:00pm),During a telephone interview on 5.5.26 at 3:02pm with FM A she revealed she put a surveillance camera in Resident #1's room on 5.2.26 because she became concerned with Resident #1's ADL care after visiting, and on a few occasions, Resident #1 would always have on the same clothing and her brief needed changing. FM A stated she observed no sheets on the bed earlier and was getting ready to visit. She stated while getting dressed to come to the facility, she further observed CNA A come in Resident #1's room to change her, and get her up out of the bed. FM A stated Resident #1 did not want to be changed or to get out of bed. FM A stated CNA A began grabbing Resident #1, then Resident #1 hit her on the arm, and CNA A hit Resident #1 on the hand. FM A stated on Sunday 5.3.26, she arrived during CNA A's shift and spoke with CNA A. FM A stated, during this time, Resident #1 still was not changed and CNA A told her that Resident #1 would not allow her to change her. FM A stated then CNA A said Resident #1 had hit her. FM A stated, on the video, CNA A was pulling on Resident #1 and Resident #1 told CNA A to stop and CNA A continued (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 - Actual harm Residents Affected - Few	trying to pull Resident #1 up and get her out of bed. She stated then the resident hit CNA A on arm, and CNA A hit Resident #1 on her hand and said, you are not going to do this to me I'm trying to help you. FM A stated the CNA A began to explain to another family member who told FM A that CNA A told them FM A was upset that there was no linen on the bed.Record review of video recording in Resident #1's room, revealed Resident #1 swatted at CNA A in an attempted to make CNA A stop pulling on her. At this time, CNA A hit the resident on her right hand while Resident #1 was lying on her side. CNA A then stated to Resident # 1, don't you do that I'm trying to help you sit up so come on. Don't do that to me.During observation and interview with Resident #1 on 5.5.26 at 3:20pm revealed Resident #1 was in her room, sitting on her bed call light was within reach. Resident #1 immediately was asked about being hit on her hand by CNA A and she stated, baby ain't nobody ever hit me. If they did, I would hit them back. She stated her aide is really nice. Resident #1 denied being hit.During an interview on 5.5.26 at 3:53pm with the DON, she stated she received a telephone call from FM A on Monday after 5.4.26 regarding concerns about her Resident #1. DON stated at that time she was informed that CNA A had assaulted Resident #1. DON stated she immediately completed a head-to-toe assessment on Resident #1 herself. The DON stated she questioned Resident #1 regarding the incident and Resident #1 could not recall the incident or being hit. DON stated she notified the Admin, who was the abuse coordinator and Resident #1's physician. The DON stated there were orders for CBC (blood test to detect any type of infection), and Urinalysis. The DON stated she contacted non-emergency police. The DON stated police came to assess and interview Resident #1 that evening, but Resident #1 could not remember the incident. She stated Resident #1 told the police that she was not hit. The police case report was completed and case number given to facility. The DON stated CNA A was contacted and asked about this incident. She stated CNA A initially stated Resident #1 didn't want to get up so she just left her room. However, the DON She stated she told CNA A that the camera said otherwise. The DON stated CNA A then told her that CNA A's behavior (hitting Resident #1) was a reaction, and she didn't think anything of it. The DON stated CNA A was suspended immediately pending outcome of investigation. The DON stated she told CNA A her license would be reported and police notified. The DON stated termination documents were sent to HR to terminate CNA A's employment. The DON stated CNA A's behavior was considered physical abuse. During an on interview on 5.6.26 at 5:30pm with the Admin stated CNA A was immediately suspended and termination of her employment has been recommended. The Admin stated she immediately started a safe survey for residents to answer questions regarding their encounter with CNA A (to question each resident regarding their feelings of being abused or uncomfortable speaking with staff about any issues they may have had and to ensure they were comfortable). The Admin stated that the management staff members are involved in the Angel rounds program, which they are assigned to certain rooms and residents. She stated management staff are to speak with each resident daily and report any concerns in the morning meeting so any issues can be immediately addressed. There was one resident (did not get her name) she spoke with that felt uncomfortable with CNA A because the resident stated her brief wasn't put on correctly. She stated at this time the resident was informed of the open lines of communication with her and other nursing staff and encouraged to voice concerns as they arise. During a telephone interview on 5.6.26 at 8:00pm with CNA A, she stated was terminated from the facility. She stated, regarding the incident with Resident #1, she had gone into Resident #1's room to wake her up and get her up for breakfast. CNA A stated Resident #1 usually get up to go to the dining room for 7:00-7:15am breakfast. She stated when she went in, she tried to get Resident #1 up by grabbing her shoulders because Resident #1 said her back hurt. CNA A stated Resident #1 reached out her hand to her and when she grabbed her hand, Resident #1 fell back on the bed. CNA A stated she attempted to pick Resident #1 up by the side of her shoulders, but Resident #1 stated she did not want to get up. CNA A stated, Resident #1 tapped her on the hand during the time she was trying to pick her up or put a pillow under her (she can't remember which one) and she had tapped her hand back. CNA A stated she had no intent to harm Resident #1. CNA A stated it was a small tap. She (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	stated she reported the incident too. She stated she did not report the swatting to anyone but Resident #1's FM A.2.Record review of Resident #2's undated face sheet revealed, an [AGE] year-old female who was admitted to the facility with diagnoses of congestive heart failure (heart unable to pump blood , which leads to fluid buildup in the lungs and other parts of the body), hypertension (force of blood against artery walls), diabetes type 2, hypothyroidism, chronic kidney disease stage 4, chronic pulmonary disease with acute lower respiratory infection, lymphedema, muscle weakness, difficulty in walking, and acute respiratory failure with hypoxia (need additional oxygen to breath).Record review of Resident #2's Comprehensive MDS revealed resident has a BIMS score of 13 which indicates Resident #2'scognition was intact.Record review of Resident #2's Orders revealed, Acetaminophen ER Oral tab 650mg 3 times daily -start date 4/17/26 at 7:00pm; Methocarbamol Oral tablet 750 MG give on tablet by mouth 3 times day for muscle spasm-start date 4/17/26; Oxycodone 5 mg give 1 tablet by mouth 3 times a day for severe back pain-start date 4/17/26; Pregabalin oral capsule 75 MG by mouth 3 times a day for pain).During an interview on 5.5.26 at 1:26am with Resident #2, she stated she had a lot of health issues and she was blind in one eye. She stated that she had a lot of issues with CNA A and one of the issues was CNA A is rough with her during ADL care, which is why she'd refuse ADL care when she works. Resident #2 stated when receiving ADL care from CNA A, the bed is usually lowered, which puts a lot of pressure and pain on her legs. Resident #2 stated she told CNA A that letting the bed down all the way hurts her back and legs, but telling CNA A didn't seem to matter as on some occasions, CNA A would put the head of the bed down all the way and leave saying she was going to get a gown, but would not returned. She stated she would be in a lot of pain and cry. Resident #2 stated she did not mention it to nursing staff because she didn't want to get anyone in trouble and didn't want retaliation. Resident #2 stated all other care providers were nice and helpful to her. Resident #2 stated nursing staff came around with a questionnaire about feeling safe or feeling misused. She stated she found out CNA A was no longer working so she told the truth at this time. Resident #2 stated she felt safe.During an interview on 5.5.26 at 1:44pm with Resident #3, she stated that she was Resident #2's roommate and she witnessed some of the rough treatment between her roommate CNA A. She stated that she witnessed CNA A pull on Resident #2's legs while providing care and Resident #2 telling her that it hurt. Resident #3 stated that she believes it is a personality difference. She stated that she could hear Resident #2 telling CNA A that she was being too rough during her care.During an interview on 5.6.26 at 1:46pm with LVN Ahe stated that Resident #2, during the safe survey questionnaire, stated CNA A was rough with her while completing her ADL's. LVN A stated that Resident #2 also stated she asked CNA A if she would rearrange her bedside table so that she can eat her meals because there was so many things on top of it, and CNA A responded that she was able to do it herself. LVN A stated, he asked during an interview on 5.5.26 at 1:26am with Resident #2, why didn't she say anything before? Resident #2 stated she did not want to get anyone in trouble. LVN A stated that he did not speak with the CNA A because she was not working and in fact had been suspended when he was informed. LVN A stated that the behaviors of CNA A could be considered abuse. LVN A stated that he was informed of this issue on 5.4.26 during safe surveys. He stated he did not report the complaint to the abuse coordinator because it was already reported by Resident #2's angel life assigned staff, which was SW. During an interview on 5.6.26 at 3:53pm with the SW she stated Resident #2 was assigned to her as one of her angel life residents. She stated during her rounds on Monday 5.4.26, Resident #2 informed her that her CNA (later identified as CNA A) was a little rough with her during ADL care. SW stated Resident #2 did not explain what she meant by rough in that she asked CNA A to get something off her bedside table, and CNA A told her she can do a lot for herself that she says she can't do and then CNA A walked out of the room without assisting Resident #2. SW stated she informed the Admin and also put it on a grievance form.During a Telephone Interview on 5.6.26 at 8:00pm with CNA A, she denied treating residents bad. She stated Resident #2 was always in a lot of pain, and a lot of times will refuse care. CNA A stated when she does provide ADL care to Resident #2, she is very careful not to cause any (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	more pain than Resident #2 is already dealing with. CNA A denied not assisting Resident #2 with moving items off of her tray to make room for her food. She stated if she did it's because she was on her way providing care for another resident and probably told Resident #2 she'd be right back. She stated she just can't remember this alleged incident.During a follow -up interview with Resident #2 on 5.7.2026 at 11:00am she stated she is now receiving the respect and care she needs from staff. She states she really enjoys the facility and does not want to leave. She stated she knows the abuse coordinator is the administrator and next time she will ensure to inform her of any mistreatment.Record review of grievances dated 5.4.26 revealed the SW completed her interview documentation and the grievance on Resident #2's behalf.Record review of In-Service Training report completed 5/4/2026 revealed DON, ADON, SC, CNAs A, B, C, and D, LVN A, LVN B and housekeeping staff were immediately in-serviced on managing unmanageable residents, Resident rights, dignity & respect, Types of abuse & recognizing signs and symptoms, Communication (explaining care to be provided to resident and allowing resident time to process what is being communicated).Record review of the facility's Unmanageable Residents policy dated April 2010 revealed that each resident will be provided with a safe place of residence.Should a resident's behavior become abusive, hostile, assaultive, or unmanageable in any way spent with jeopardize his or her safety or the safety of others, the nurse supervisor slash charge nurse must immediately:c. Notify the director of nursing services; andd. Notify the residence representative (sponsor).Record review of the facility's Abuse and Neglect policy revised April 2021 revealed, 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 second religion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the residents symptoms.5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.9. Investigate and report any allegations within timeframes required by federal requirements.10. Protect residents from any further harm during the investigations.