

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2025
NAME OF PROVIDER OR SUPPLIER Avir at Luling		STREET ADDRESS, CITY, STATE, ZIP CODE 501 W Austin St 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)		
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. (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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(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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents were free from physical abuse for one (Resident #1) of four resident reviewed for abuse. 1. 1. The facility failed to ensure Resident #1 was not physically abused by Resident #2 on 07/12/2025. 2. 2. The facility failed to implement interventions to ensure Resident #1 was not physically abused by Resident #2 on 07/13/2025. This failure could place residents at risk of ongoing abuse, injury and psychosocial harm. Based on interview and record review, the facility failed to ensure all residents were free from physical abuse for one (Resident #1) of four resident reviewed for abuse. 1. 1. The facility failed to ensure Resident #1 was not physically abused by Resident #2 on 07/12/2025. 2. 2. The facility failed to implement interventions to ensure Resident #1 was not physically abused by Resident #2 on 07/13/2025. This failure could place residents at risk of ongoing abuse, injury and psychosocial harm. Findings include: Review of Resident #1's face sheet dated 07/21/2025 reflected a [AGE] year-old man admitted on [DATE] with diagnoses of cerebral infarction (condition where part of the brain doesn't receive enough blood flow), dysphagia (difficulty swallowing), anxiety disorder (group of mental health conditions characterized by excessive fear and worry), major depressive disorder (serious mental illness characterized by persistent sadness or loss of interest in activities), and difficulty in walking and unsteadiness on feet. Review of Resident #1's annual MDS dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment. Review reflected Resident #1 exhibited no physical or behavioral symptoms directed towards others. Review of Resident #1's care plan dated 06/20/2025 reflected he had impaired social interaction with intervention to encourage resident to participate in social situations and monitor interactions with others. Review of a progress note for Resident #1 by ADON dated 07/12/2025 reflected raised voices were heard from dining area and AD was presented and informed ADON that Resident #2 hit Resident #1. Resident #2 was observed yelling and cussing at the AD. ADON escorted Resident #1 away from the area and Resident #1 reported to ADON that he asked about the television and Resident #2 started to cuss and swing his hand at Resident #1 and hit his arm and leg. ADON performed a skin assessment, and no redness was observed. Review of an incident report dated 07/12/2025 by ADON reflected raised voices were heard from the dining area. AD present and informed ADON that Resident #2 hit Resident #1. Resident #2 was observed yelling and cussing at AD and Resident #1. Resident #1 had a skin assessment completed and no redness was observed. Resident #1 indicated he asked about the television and Resident #2 started to cuss at Resident #1 and Resident #2 swung his hand at Resident #1 and hit him on the arm and leg. Review of a progress note for Resident #1 dated 07/13/2025 by LVN A reflected Resident #1 notified LVN A there was an incident and both residents were separated. LVN A assessed Resident #1 and redness and tenderness was noted to Resident #1's left upper arm with complaints of pain to sight. Review of an incident report dated 07/13/2025 by LVN A reflected Resident #1 notified LVN A that he was hit by Resident #2. Resident #1 reported he got up from his table without his walker and touched Resident #2's wheelchair handle and Resident #2 stated keep your hands off my fucking chair, next time imma kill you then Resident #2 punched Resident #1 with a closed fist and hit Resident #1 with an opened hand to Resident #1's left upper arm. Resident #1 stated that arm had already bothered him and Resident #2 made it worse. LVN A performed a skin assessment and noted redness and handprint to left upper arm of Resident #1 and the area was tender to touch. Resident was provided with PRN pain medication. Review of a psychiatric progress note for Resident #1 for telecommunication visit dated 07/13/2025 reflected Resident #1 discussed two incidents that involved being hit by Resident #2 and since the incident Resident #1 reported feeling unsafe, anxious and hypervigilant around Resident #2. Resident #1 also reported difficulty sleeping and feeling shaky. Resident #1 expressed sadness and emotional distress about his lack of safety in the environment. Review of Resident #1's progress notes reflected no follow up by facility staff (social worker, DON, ADM) were documented after incidents with Resident #2. During an interview on 07/21/2025 at 10:17 AM, Resident #1 stated that he had two incidents with Resident #2. Resident #1 stated that he was in the dining room and tried to get by Resident #2's chair and put his hands on the handle of Resident #2's chair and that Resident #2 stated get your fucking hands off my chair and then Resident #2 hit him on the shoulder and arm. Resident #1 stated the previous day Resident #2 hit Resident #1 on the leg. Resident #1 stated AD was present the first day that Resident #2 hit Resident #1 on the leg. Resident #1 stated he felt Resident #2 knew Resident #1 had a bum shoulder. During a subsequent interview on 07/21/2025 at 10:50</p>		