STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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 - Immediate jeopardy to resident health or safety 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 the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 out of 8 residents (Resident #1) reviewed for abuse/neglect. 1.The facility failed to ensure Resident #1 was free from abuse when RN A verbally abused Resident #1 by calling her a whore and a slut.2. The facility failed to ensure Resident #1 was free from abuse when RN A physically abused by forcefully pushing the resident's wheelchair and forcefully removing her clothes on 10/4/25 around 5:20 a.m. The noncompliance was identified as PNC. The IJ began on 10/4/25 and ended on 10/8/25. The facility had corrected the noncompliance before the investigation began. This deficient practice could place residents at risk injury and psychosocial harm. Findings included: Record review of Resident #1's admission record, dated 1/7/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included diffuse traumatic brain injury with loss of consciousness of unspecified duration (injury to multiple areas of the brain from a traumatic event), mood disorder due to known physiological condition with mixed features (mood disorder that is directly linked to a physiological condition such as a stroke), anxiety disorder (mental health condition characterized by intense, excessive, and persistent fear or worry), unsteadiness on feet, cognitive communication deficit, insomnia (sleep disorder that makes it hard to fall asleep or stay asleep), conversion disorder with seizures (a condition where psychological stress leads to abnormal neurological symptoms that cannot be explained by medical condition), other speech and language disorder following cerebral infarction, cerebral infarction (occurs when blood flow to a part of the brain is obstructed, typically by a blood clot, brain tissue begins to die), and hemiplegia (complete paralysis of one side of your body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting left non-dominant side. Resident #1 was discharged on 11/5/25. Record review of Resident #1's discharge MDS assessment, dated 11/5/25, revealed the resident had moderately impaired cognition for daily decision-making skills with a BIMS score of 10. Record review of Resident #1's care plan, initiated 9/15/25, reflected Resident #1 had a history of claiming no care had been provided when it had been provided, and staff was tossing her down the hallways when no evidence of injury had occurred. She would throw herself out of bed, and when she was questioned, she claimed someone else threw her. Record review of a statement dated 10/4/25, LVN B wrote at approximately 5:20 [a.m.] I was at my desk.I heard [CNA C] calling from [Resident #1's] room, she stated [Resident #1] was kicking and punching her and needed me to witness [Resident #1's] Behaviors. Behaviors were documented in a nurses note at approximately 0535. [RN A] arrived at that time and [Resident #1] tried taking off her shirt, [CNA C] put on a shirt and Resident # 1 came out of her room shirtless with her breasts out, [RN A] shouted with [CNA C] as a witness What is this a fucking whore house, out hear [sic] for everybody to see your tits and wheeled her to her room when and I followed her to [Resident #1's] (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	room, [RN A] pulled [Resident #1's] shirt off [sic] aggressively and continued the verbal abuse saying Your [sic] being a fucking whore showing your fucking tits off this is a place of business not a whore house. [CNA C] and I witnessed that and [RN A] saw our face of concern and surprise and stated maybe I went a little overboard, I know that was verbal abuse, but you know how [Resident #1] is. [CNA C], [RN A], and I (LVN B) walked outside to the front where we sat for a few minutes while [RN A] smoked. While talking we see in the window [Resident #1] was again without her shirt and her breast exposed. [RN A] put her cig out and said Oh fuck no, I'm done got up and I followed. She pushed [Resident #1] to her room really fast and aggressively leaning to [Resident #1's] ear and told her you're a fucking whore showing your fucking tits acting like a slut, this is why your husband left you here because he doesn't want a whore she then at full force pushed her into her room and let go of the wheelchair like threw her in the wheelchair to roll into the room at full force. I heard [Resident #1] scream and heard a loud thud and ran into the room. I thought [Resident #1] crashed and fell into the floor but it was her wheelchair that slammed into her bed from [RN A] throwing her into the room. [RN A] ripped off the shirt off her contracted arm and [Resident #1] stated stop that hurts you bitch [RN A] aggressively and forcefully ripped off the sweater and put on her other shirt she had on prior and continued the verbal abuse calling [Resident #1] a slut and whore. [RN A] just looked at me and didn't say anything, left [Resident #1] in her room, walked out and slammed the door shut behind her. Record request for the facility's investigation report of the incident that occurred on 10/4/25 revealed one was not completed for this incident. Record review of Resident #1's nursing progress note, dated 10/4/25, at 5:47 a.m. stated Resident hitting and kicking CNA. Nurse and another CNA there to assist and witness. Resident changed into clean clothes and yelling at staff. Resident came out of room naked with breasts showing because she took off her clean shirt. Resident instructed to keep clothes on, Resident is now wearing clothes at this time. Written by LVN B. Record review of Resident #1's nursing progress note, dated 10/4/25, at 8:36 a.m. stated digging on trays taken from rooms after those residents have eaten. Written by RN A. Record review of Resident #1's nursing progress note, dated 10/5/25, at 8:04 a.m. stated res seen taking large amt of sugar packets from coffee cart and putting them in her shirt. when told not to do that she said it is paidfor by her so she can do what she wants with it. When told it is for everyone to use and she is not even using it she says to hell with them it ishers to take. Written by RN A. Record review of Resident #1's skin assessment, dated 9/30/25, revealed no alteration in skin integrity noted. The assessment was completed by RN A. Record review of Resident #1's skin assessment, dated 10/7/25, revealed the resident had no new or unusual markings or bruises to any part of her body. The assessment was completed by LVN D. Record review of the nursing staff schedule from 10/4/25 revealed RN A worked the 6 a.m. shift to 6 p.m. shift on the A hallway where Resident #1 resided on 10/4/25. Record review of the nursing staff schedule from 10/5/25 revealed RN A worked the 6 a.m. shift to 6 p.m. shift on the A hallway where Resident #1 resided on 10/5/25. Record review of RN A's employee file revealed she was rehired on 7/1/23, her last day worked was on 10/5/25, and she was terminated on 10/8/25 without being eligible for rehire. The file also contained 3 corrective actions: -10/31/17- Stated RN was informed that any resident-to-resident altercations are to be reported to the Administrator. -1/12/24- Stated RN A was heard by 2 CNAs making inappropriate comments about another staff member. -1/15/25- Stated RN A made a statement in a public area with Residents around stating she had a 380 and could just blow away others. Record review of document titled Safe Survey-Abuse dated 10/7/25, revealed 2 Residents were interviewed and stated they felt safe. One resident stated they heard loud voices on 10/4/25 but did not know what they were saying. During an interview on 1/7/26 at 10:06 a.m. LVN B confirmed (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the events in her statement are what she witnessed on the morning of 10/4/25. LVN B stated she checked the resident for injuries after the incident, and none were found but she forgot to document it in a nursing note or assessment. LVN B stated after the incident she had not have any one-on-one coaching or training but did receive an in service on 10/7/25 over abuse and neglect reporting. She stated she also had annual abuse training in December of 2025. During an interview on 1/7/25 at 3:05 p.m. the Administrator stated the incident was reported to him the morning of 10/7/25 by LVN B. The Administrator confirmed The alleged perpetrator explained that the resident was not cooperative the morning of the incident and kept taking off their shirt. The Administrator then asked the alleged perpetrator (RN A) did you call the resident [Resident #1] a Whore? The alleged perpetrator responded that she told the resident that 'she was acting like a whore,' but insisted she did not call the resident a whore. The Administrator then asked if the alleged perpetrator shoved the resident in their wheelchair into their room. The alleged perpetrator stated she didn't push the resident hard, but she did push the resident into their room without controlling the wheelchair. Following the conversation with the alleged perpetrator the administrator terminated the employee, due to them confirming the allegations of abuse. The Administrator stated staff were expected to immediately report incidents like this to him. The Administrator stated after the incident they completed an in-service on reporting abuse and neglect, and all staff also completed annual abuse and neglect training in December of 2025, and he interviewed residents who had good cognition and would have maybe over heard the incident. The Administrator stated the residents reported feeling safe and only heard loud voices but not what was said. During an interview on 1/7/25 at 6:03 p.m. CNA C stated on the morning of 10/4/25 Resident #1 was combative and agitated. She stated she saw RN A get aggressive with Resident #1 by pushing her into her room, calling her a slut, and shutting her door. CNA C stated she had checked on Resident #1 and she stated RN A always treated her like that and was a bitch to her. CNA C stated her and LVN B agreed LVN B would report the incident. CNA C stated she received an in-service after the incident on 10/4/25 over reporting abuse and neglect and had annual training for abuse and neglect in December of 2025. During an interview on 1/9/26 at 10:20 a.m. the DON stated she interviewed the Resident on 10/7/25 the day after she was informed because the resident was already asleep when she was told on 10/6/25. The DON stated they had a video visit with a psychiatric provider on 10/7/25, but could not provide any notes. The DON stated a skin assessment was completed on 10/7/25, and the resident had no injuries. The DON stated she could not recall what the resident stated happened, but that she was not affected by the incident because she was seen socializing during dining service as she normally would. The DON stated this incident could have mentally affected the resident. During an interview on 1/9/25 at 4:17 p.m. Resident #3 stated on 10/4/25 she was woken up to RN A yelling at an unknown resident. She stated she heard RN A calling someone a whore and a slut. Resident #3 stated later she asked RN A who she was yelling at, and she stated she was talking to Resident #1 because she was naked. Resident #3 stated RN A was never abusive to her, but she was vulgar with other residents. Record review of the facility's policy, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 2001, revised April 2021, stated Policy Statement 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 seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: I. Protect residents from abuse, neglect, exploitation or misappropriation of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	property by anyone including, but not necessarily limited to:a. facility staff;b. other residents;c. consultants;d. volunteers;e. staff from other agencies;f. family members;g. legal representatives;h. friends;i. visitors; and/orj. any other individual.2. Develop and implement policies and protocols to prevent and identify:a. abuse or mistreatment of residents;b. neglect of residents; and/orc. theft, exploitation or misappropriation of resident property.4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has:a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; orc. a disciplinary action in effect against his or her professional license by a state li censure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.5. Establish and maintain a culture of compassion and caring for al\ residents and particularly those with behavioral, cognitive or emotional problems. 6. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. 7. Implement measures to address factors that may lead to abusive situations, for example:a. adequately prepare staff for caregiving responsibilities;b. provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation;c. instruct taff regarding appropriate ways to address interpersonal conflicts; andd. help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts.8. Identify and in estigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident prope1ty.9. Investigate and report any allegations within timeframes required by federal requirements .10. Protect residents from any further ham, during investigations . This noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 10/4/25 and ended on 10/8/25. The facility had corrected the noncompliance before the investigation began. The facility took the following actions to correct the non-compliance:-10/7/25 Incident reported to HHSC. -10/7/25 Inservice over abuse and neglect of all staff was started.-10/7/25 Head to toe Assessment completed by nursing for Resident #1.-10/7/25 RP of Resident #1 was notified of incident. -10/7/25 Resident safe interviews were conducted. -10/8/25 RN A was terminated on.-10/16/25 Resident #1 was evaluated by a mental health professional. During interviews with the staff, from various shifts, 2 LVNs, 1 RN and 2 CNAs on 1/6/26-1/9/26, all staff stated they were in-serviced on abuse and neglect, they were able to define the types of abuse, and they stated they would immediately report any abuse, neglect, or exploitation to the abuse coordinator, the Administrator. Review of Resident #1's Administration notes revealed a note, dated 10/7/25, The administrator spoke with the family of the resident to speak with them about an incident that occurred with the resident. The administrator told the family of the reported issue that occurred, and notified them of the active investigation and the outcome. Record review of an Inservice dated, 10/7/25, revealed the topic was Abuse and Neglect presented by the DON. The in-service was signed by 42 of 43 staff. One housekeeper did not sign the in-service. Record review of Resident #1's skin assessment, dated 10/7/25, revealed the resident had no new or unusual markings or bruises to any part of her body. The assessment was completed by LVN D. Record review of RN A's employee file revealed she was rehired on 7/1/23, her last day worked was on 10/5/25, and she was terminated on 10/8/25 without being eligible for rehire. Record review of document titled Safe Survey-Abuse dated 10/7/25, revealed 2 Residents were interviewed and stated they felt safe. One resident stated they heard loud voices on 10/4/25 but did not know what they were saying. Review of Resident #1's progress notes date range 10/07/25 to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11/07/25 revealed the resident was seen for a psychiatric periodic evaluation on 10/16/25 and noted patient is not in acute danger to self or others. An Immediate Jeopardy (IJ) existed from 10/4/2025 - 10/08/2025. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety 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, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused result in serious bodily injury for 1 of 8 residents (Resident #1) whose records were reviewed for abuse and neglect: The facility failed to ensure verbal and physical abuse that occurred on 10/4/25 at 5:20 a.m. of Resident #1 by RN A was immediately reported to the abuse coordinator. The abuse was reported to the administrator on 10/7/25.The noncompliance was identified as PNC. The IJ began on 10/4/25 and ended on 10/8/25. The facility had corrected the noncompliance before the investigation began.These deficient practices could affect residents by contributing to further abuse and neglect. The findings were: Record review of Resident #1's admission record, dated 1/7/26, reflected a [AGE] year-old female who was admitted to the facility on 3/21/23. Resident #12 had diagnoses which included diffuse traumatic brain injury with loss of consciousness of unspecified duration (injury to multiple areas of the brain from a traumatic event), mood disorder due to known physiological condition with mixed features (mood disorder that is directly linked to a physiological condition such as a stroke), anxiety disorder (mental health condition characterized by intense, excessive, and persistent fear or worry), unsteadiness on feet, cognitive communication deficit, insomnia (sleep disorder that makes it hard to fall asleep or stay asleep), conversion disorder with seizures (a condition where psychological stress leads to abnormal neurological symptoms that cannot be explained by medical condition), other speech and language disorder following cerebral infarction, cerebral infarction (occurs when blood flow to a part of the brain is obstructed, typically by a blood clot, brain tissue begins to die), and hemiplegia (complete paralysis of one side of your body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting left non-dominant side. Resident #1 was discharged on 11/5/25. Record review of Resident #1's discharge MDS assessment, dated 11/5/25, revealed the resident had moderately impaired cognition for daily decision-making skills with a BIMS score of 10. Record review of Resident #1's care plan, initiated 9/15/25, reflected Resident #1 had a history of making false accusations against staff/other residents. Resident had a history to claim no care had been provided while it had been provided, staff is tossing her down the hallways when no evidence of injury had occurred, and would throw self out of bed. When she was questioned she claimed someone else threw her. Record review of a statement dated 10/4/25, LVN B wrote at approximately 5:20 [a.m.] I was at my desk.I heard [CNA C] calling from [Resident #1's] room, she stated [Resident #1] was kicking and punching her and needed me to witness [Resident #1's] Behaviors. Behaviors were documented in a nurses note at approximately 0535. [RN A] arrived at that time and [Resident #1] tried taking off her shirt, [CNA C] put on a shirt and Resident # 1 came out of her room shirtless with her breasts out, [RN A] shouted with [CNA C] as a witness What is this a fucking whore house, out hear [sic] for everybody to see your tits and wheeled her to her room when and I followed her to [Resident #1's] room, [RN A] pulled [Resident #1's] shirt off [sic] aggressively and continued the verbal abuse saying Your [sic] being a fucking whore showing your fucking tits off this is a place of business not a whore house. [CNA C] and I witnessed that and [RN A] saw our face of concern and surprise and stated maybe I went a little overboard, I know that was verbal abuse, but you know how [Resident #1] is. [CNA C], [RN A], and I (LVN B) walked outside to the front where we sat for a few minutes while [RN A] smoked. While talking we see in the window [Resident #1] was again without her shirt and her breast exposed. [RN A] put her cig out and said Oh fuck no, I'm done got up and I followed. She pushed [Resident (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1] to her room really fast and aggressively leaning to [Resident #1's] ear and told her you're a fucking whore showing your fucking tits acting like a slut, this is why your husband left you here because he doesn't want a whore she then at full force pushed her into her room and let go of the wheelchair like threw her in the wheelchair to roll into the room at full force. I heard [Resident #1] scream and heard a loud thud and ran into the room. I thought [Resident #1] crashed and fell into the floor but it was her wheelchair that slammed into her bed from [RN A] throwing her into the room. [RN A] ripped off the shirt off her contracted arm and [Resident #1] stated stop that hurts you bitch [RN A] aggressively and forcefully ripped off the sweater and put on her other shirt she had on prior and continued the verbal abuse calling [Resident #1] a slut and whore. [RN A] just looked at me and didn't say anything, left [Resident #1] in her room, walked out and slammed the door shut behind her. Record request for the facility's investigation report of the incident that occurred on 10/4/25 revealed one was not completed for this incident. Record review of Resident #1's nursing progress note, dated 10/4/25, at 5:47 a.m. stated Resident hitting and kicking CNA. Nurse and another CNA there to assist and witness. Resident changed into clean clothes and yelling at staff. Resident came out of room naked with breasts showing because she took off her clean shirt. Resident instructed to keep clothes on, Resident is now wearing clothes at this time. Written by LVN B. Record review of Resident #1's nursing progress note, dated 10/4/25, at 8:36 a.m. stated digging on trays taken from rooms after those residents have eaten. Written by RN A. Record review of Resident #1's nursing progress note, dated 10/5/25, at 8:04 a.m. stated res seen taking large amt of sugar packets from coffee cart and putting them in her shirt. when told not to do that she said it is paid for by her so she can do what she wants with it. When told it is for everyone to use and she is not even using it she says to hell with them it is hers to take. Written by RN A. Record review of Resident #1's skin assessment, dated 9/30/25, revealed no alteration in skin integrity noted. The assessment was completed by RN A. Record review of Resident #1's skin assessment, dated 10/7/25, revealed the resident had no new or unusual markings or bruises to any part of her body. The assessment was completed by LVN D. Record review of the nursing staff schedule from 10/4/25 revealed RN A worked the 6 a.m. shift to 6 p.m. shift on the A hallway where Resident #1 resided on 10/4/25. Record review of the nursing staff schedule from 10/5/25 revealed RN A worked the 6 a.m. shift to 6 p.m. shift on the A hallway where Resident #1 resided on 10/5/25. Record review of RN A's employee file revealed she was rehired on 7/1/23, her last day worked was on 10/5/25, and she was terminated on 10/8/25 without being eligible for rehire. Record review of document titled Safe Survey-Abuse dated 10/7/25, revealed 2 Residents were interviewed and stated they felt safe. One resident stated they heard loud voices on 10/4/25 but did not know what they were saying. During an interview on 1/7/26 at 10:06 a.m. LVN B confirmed the events in her statement are what she witnessed on the morning of 10/4/25. LVN B stated she checked the resident for injuries after the incident, and none were found but she forgot to document it in a nursing note or assessment. LVN B stated she had training and knew she was supposed to report the incident to the Administrator but she was in shock and had to sit with what happened. She stated she also wanted to follow her chain of command and decided to try to reach the DON first. LVN B stated she thought the incident occurred on 10/5/25. LVN B stated she called the DON on the morning of 10/5/25 but the DON had not return her call. LVN B stated she was not sure but she thought she informed the DON later that evening on 10/5/25 when she returned for her 6 p.m. shift. LVN B stated after she spoke to the DON she informed the Administrator after her shift on 10/6/25 in the morning (10/7/25). LVN B stated after the incident she had not had any one-on-one coaching or training but did receive an in service on 10/7/25 over abuse and neglect reporting. She stated she also had annual abuse (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	training in December of 2025. LVN B stated not reporting the abuse immediately meant the resident could be abused again. During an interview on 1/7/25 at 3:05 p.m. the Administrator stated the incident was reported to him the morning of 10/7/25 by LVN B. The Administrator confirmed The alleged perpetrator explained that the resident was not cooperative the morning of the incident and kept taking off their shirt. The administrator then asked the alleged perpetrator (RN A) did you call the resident [Resident #1] a Whore? The alleged perpetrator responded that she told the resident that 'she was acting like a whore,' but insisted she did not call the resident a whore. The administrator then asked if the alleged perpetrator shoved the resident in their wheelchair into their room. The alleged perpetrator stated she didn't push the resident hard, but she did push the resident into their room without controlling the wheelchair. Following the conversation with the alleged perpetrator the administrator terminated the employee, due to them confirming the allegations of abuse. The Administrator stated staff were expected to immediately report incidents like this to him. The Administrator stated after the incident they completed an in-service on reporting abuse and neglect, and all staff also completed annual abuse and neglect training in December of 2025. The Administrator stated he made all staff aware they could contact him at anytime for abuse and neglect concerns. The Administrator stated by delaying reporting the incident the resident was at risk of something potentially happening. During an interview on 1/7/25 at 6:03 p.m. CNA C stated on the morning of 10/4/25 Resident #1 was combative and agitated. She stated she saw RN A get aggressive with Resident #1 by pushing her into her room, calling her a slut, and shutting her door. CNA C stated she had checked on Resident #1, and she stated RN A always treated her like that and was a bitch to her. CNA C stated her and LVN B agreed LVN B would report the incident. CNA C stated she received an in-service after the incident on 10/4/25 over reporting abuse and neglect and had annual training for abuse and neglect in December of 2025. CNA C stated the Administrator was the abuse coordinator and all abuse concerns should immediately be reported to him. CNA C stated however she felt she had done her part by talking with the charge nurse LVN B and agreed LVN B would report the abuse. LVN B stated she did not know what could have happened in the few days RN A continued to work with Resident #1. During an interview on 1/9/26 at 10:20 a.m. The DON stated she was informed of the incident late on 10/6/25 and was not given all the details of the incident until 10/7/25. The DON stated this incident occurred over the weekend and she had not worked that weekend. The DON stated she could not recall what the resident stated happened but that she was not affected by the incident because she was seen as she normally would. The DON stated this incident could have mentally affected the resident. During an interview on 1/9/25 at 4:17 p.m. Resident #3 stated on 10/4/25 she was woken up to RN A yelling at an unknown resident. She stated she heard RN A calling someone a whore and a slut. Resident #3 stated later she asked RN A who she was yelling at, and she stated she was talking to Resident #1 because she was naked. Resident #3 stated RN A was never abusive to her, but she was vulgar with other residents. Resident #3 stated the Administrator had interviewed her about the incident but she had not disclosed to him the exact details of what she heard at that time. Record review of the facility's policy, titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, dated 9/22, stated Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation. Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be (continued on next page)

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	676301	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Schertz	3301 Fm 3009 Schertz, TX 78154

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines.3. Immediately is defined as:a. within two hours of an allegation involving abuse or result in serious bodily injury; or . This noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 10/4/25 and ended on 10/8/25. The facility had corrected the noncompliance before the investigation began. The facility took the following actions to correct the non-compliance: -10/7/25 Incident reported to HHSC. -10/13/25 3613-A report was sent to HHSC with the investigation findings. -10/7/25 Inservice over abuse and neglect of all staff was started. -10/7/25 Head to toe Assessment completed by nursing for Resident #1. -10/7/25 RP of Resident #1 was notified of incident. -10/7/25 Resident safe interviews were conducted. -10/8/25 RN A was terminated on. -10/16/25 Resident #1 was evaluated by a mental health professional. During interviews with the staff, from various shifts, 2 LVNs, 1 RN and 2 CNAs on 1/6/26-1/9/26 all staff stated they were in-serviced on abuse and neglect, they were able to define the types of abuse, they stated they would immediately report any abuse, neglect, or exploitation to the abuse coordinator, the Administrator. Review of Resident #1's Administration notes revealed a note, dated 10/7/25, The administrator spoke with the family of the resident to speak with them about an incident that occurred with the resident. The administrator told the family of the reported issue that occurred, and notified them of the active investigation and the outcome. Record review of an Inservice dated, 10/7/25, revealed the topic was Abuse and Neglect presented by the DON. The in-service was signed by 42 of 43 staff (LVN B and CNA C signed the in-service). One housekeeper did not sign the in-service. Record review of Resident #1's skin assessment, dated 10/7/25, revealed the resident had no new or unusual markings or bruises to any part of her body. The assessment was completed by LVN D. Record review of RN A's employee file revealed she was rehired on 7/1/23, her last day worked was on 10/5/25, and she was terminated on 10/8/25 without being eligible for rehire. Record review of document titled Safe Survey-Abuse dated 10/7/25, revealed 2 Residents were interviewed and stated they felt safe. One resident stated they heard loud voices on 10/4/25 but did not know what they were saying. Review of Resident #1's progress notes date range 10/07/25 to 11/07/25 revealed the resident was seen for a psychiatric periodic evaluation on 10/16/25 and noted patient is not in acute danger to self or others. An Immediate Jeopardy (IJ) existed from 10/4/2025 - 10/08/2025. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 residents (Resident #6) reviewed for care plans: The facility failed to ensure Resident #6's Care Plan reflected a code status of DNR. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. Record review of Resident #6's admission Record dated [DATE] revealed a [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (progressive or persistent loss of intellectual functioning) depression (mental health disease of high and low mood swings), epilepsy (chronic brain disorder characterized by recurrent seizures), paranoid schizophrenia (form of psychosis characterized by intense distrust, suspiciousness, and delusions of persecution), and Alzheimer's Disease (a progressive brain disorder that slowly destroys memory, thinking and reasoning skills). Under the heading, Advance Directive, the code status was listed as Full Code (meaning resident would have CPR initiated upon loss of breathing and heartbeat).Record review of Resident #6's latest MDS assessment dated [DATE] revealed a BIMS score of 4 indicating severe cognitive impairment.Record review of Resident #6's care plan with the latest revision date of [DATE] documented a code status of Full Code.Record review of Resident #6's electronic medical record under Miscellaneous documents revealed a DNR form signed by her Responsible Party dated [DATE].Record review of Resident #6's active orders as of [DATE] revealed a Code Status of Full Code.Record review of hospice binder revealed a report from an interdisciplinary group meeting that was held with facility on [DATE]. Under the heading Prep Notes, the code status was DNR. During an interview on [DATE] at 12:08 pm with the Social Worker, the Social Worker stated, We will start addressing code status in the care plan meetings. The Social Worker also stated that she was told the MDS Nurse would update the care plan when a DNR was written. During an interview with the DON on [DATE] at 1:40 pm, the DON stated she downloaded DNR information into the resident's file and also kept hard copies. The DON stated that either she or the MDS Nurse would put the code status in the Care Plan. The DON stated she did not know why Resident #6's code status was not updated.During an interview on [DATE] at 11:31 am, the MDS Nurse stated no one communicated with him the fact that the code status had changed for Resident #6. The MDS Nurse stated, I guess hospice didn't write an order for a DNR or didn't give the information to the charge nurse. The MDS Nurse stated he had only been in this position for 2 months and prior to his taking this position, no care plan meetings had been held. The MDS Nurse stated that care plan meetings were important to keep everyone up to date.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 2 nurse medication cart (B hall nursing medication cart) reviewed for storage of drugs. 1. The facility failed to ensure the B hall nursing medication cart was locked. 2. The facility failed to ensure B hall nursing medication cart did not contain a narcotic blister pack with a broken seal for one of the pills and all narcotics were logged on the narcotic count sheets. This deficient practice could place residents at risk of medication misuse and diversion.The findings were: 1. Observation and interview on 1/7/26 at 4:22 p.m. revealed the B hall nurse medication cart was on the on the side of the nursing station facing the hallway and unlocked. LVN E was sitting at the nurses station and not in view of the nurse medication cart. LVN E stated the cart was unlocked and should not be left unlocked. 2. Record review of Resident #4's face sheet, dated 1/7/25, revealed a [AGE] year old male resident who was admitted on [DATE] with diagnoses of congenital and developmental myasthenia (inherited conditions that usually develop at birth or in early childhood that cause muscle weakness that gets worse with physical activity.), chest pain, and pain in left wrist. Record review of Resident #4's MAR, dated 1/7/26, revealed an order for hydrocodone/acetaminophen 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for pain related to pain with a start date of 11/6/25 and no end date. The MAR revealed the hydrocodone/acetaminophen was last administered on 1/7/26 at 2:24 p.m. by LVN E. During an observation, interview, and record review on 1/7/26 at 6:21 p.m. LVN E and RN F counted the narcotic medication in the B hallway nurse medication cart. Resident #4's narcotic count sheet for hydrocodone/acetaminophen 7.5-325 mg showed he had 17 left in the package. The package of Resident #4's hydrocodone/acetaminophen contained 16 pills. The narcotic log for the medication showed LVN E last signed out the medication on 1/6/26. LVN E stated he had actually administered the medication that day 1/7/26, and forgot to log it on the narcotic sheet. Another blister package of Resident #5's hydrocodone/acetaminophen 5-325 mg had a broken seal over pill #13. Pill #13 was still in the package. RN F asked LVN E if they could put tape over the package. LVN E stated they should discard the pill. Both decided to discard the pill. RN F then dispensed a pill from an unknown different residents blister pack of an unknown medication to discard. This surveyor then pointed out that patient and medication were different than the one observed. RN F and LVN E then found and discarded Resident #5's pill from the broken blister pack. During a follow up interview on 1/7/26 at 7:00 p.m. LVN E stated his medication cart should not be unlocked because anyone could access it and potentially take the medications. LVN E stated he should have logged narcotics in the narcotic count sheet as soon as he dispensed the medication. LVN E stated he gave the hydrocodone/acetaminophen 7.5-325 mg to Resident #5 around 2 p.m. that day and forgot to write it down. LVN E stated the narcotic log needed to be filled out to show who dispensed the medication. LVN E stated any blisters packs that had a hole and the medication was still inside should be discarded because it could have been tampered with, and may not be the right medication. LVN E stated residents could be at risk of taking medication that had been tampered with or damaged. During an interview on 1/9/25 at 9:59 a.m., the DON stated she had spoken with staff about locking their carts many times. The DON stated it was important that staff locked their carts to ensure residents do not have access to the cart, or other staff that was not responsible for that cart. The DON stated staff should sign the narcotic log immediately as they dispensed the medication. The DON stated a medication error could occur if staff did (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not sign the medication out on the narcotic log. The DON stated if any blister packs were broken, the medication should be wasted and witnessed by 2 staff. Record review of the facility's policy titled Medication Labeling and Storage, dated 2/23, stated: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.7. Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Record review of the facility's policy titled Controlled Substances, dated 11/22, stated: Policy Statement The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Policy Interpretation and Implementation Handling Controlled Substances 1. Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II controlled substances maintained on premises.Dispensing and Reconciling Controlled Substances 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #6) reviewed for administration, in that:Resident #6's OOH-DNR was signed and listed under Miscellaneous documents in the electronic medical record while her face sheet and care plan were listed as Full Code.This deficient practice could place the resident at risk of receiving care inconsistent with their wishes.Record review of Resident #6's admission Record dated [DATE] revealed a [AGE] year old female who was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (progressive or persistent loss of intellectual functioning) depression (mental health disease of high and low mood swings), epilepsy (chronic brain disorder characterized by recurrent seizures), paranoid schizophrenia (form of psychosis characterized by intense distrust, suspiciousness, and delusions of persecution), and Alzheimer's Disease (a progressive brain disorder that slowly destroys memory, thinking and reasoning skills). Under the heading, Advance Directive, the code status was listed as Full Code (meaning resident would have CPR initiated upon loss of breathing and heartbeat).Record review of Resident #6's latest MDS dated [DATE] revealed a BIMS score of 4 indicating severe cognitive impairment.Record review of Resident #6's care plan with the latest revision date of [DATE] documented a code status of Full Code.Review of Resident #6's electronic medical record's opening page that included special instructions indicated a code status of Full Code.Record review of Resident #6's electronic medical record under Miscellaneous documents revealed an OOH DNR form signed by her Responsible Party dated [DATE].Record review of Resident #6's active orders as of [DATE] documented a Code Status of Full Code.Record review of hospice binder revealed a report from an interdisciplinary group meeting that was held with facility on [DATE]. Under the heading Prep Notes, the code status was DNR. During an interview on [DATE] at 12:08 pm with the Social Worker, the Social Worker stated, We will start addressing code status in the care plan meetings. The Social Worker also stated that she was told the MDS Nurse would update the care plan when a DNR was written. During an interview with the DON on [DATE] at 1:40 pm, the DON stated she downloaded DNR information into the resident's file and also kept hard copies. The DON stated that either she or the MDS Nurse would put the code status in the Care Plan. The DON stated she did not know why Resident #6's code status was not updated in the Care Plan and did not know why physician's orders were not obtained.During an interview on [DATE] at 11:31 am, the MDS Nurse stated no one communicated with him the fact that the code status had changed for Resident #4. The MDS Nurse stated I guess hospice didn't write an order for a DNR or didn't give the information to the charge nurse to have the orders updated.