STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676475	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Madisonville	600 Bacon Street Madisonville, TX 77864

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 treated with respect and dignity for one of five residents (Resident #1) reviewed for dignity. Housekeeper A failed to speak to Resident #1 in a way that promoted her dignity and self-worth. This failure could place residents at risk of a decline in their sense of dignity, level of satisfaction with life, and feeling of self-worth.Findings include: Record review of Resident #1's face sheet, dated 04/15/2026, reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder (a chronic mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday things), major depressive disorder, recurrent severe without psychotic features (a chronic mental health condition with the following symptoms: hopelessness, persistent sadness, and extreme fatigue without any psychotic - a mental state characterized by a severe loss of contact with reality- seeing and hearing things not there and false beliefs), and unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, or mood disturbance (a clinical diagnosis of cognitive decline- memory loss or confusion- where the specific cause is unknown or not yet determined, and the person does not exhibit aggressive, agitated or psychotic symptoms). Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 14 indicating her cognition was intact. Record review of Resident #1's Comprehensive Care Plan, dated 03/27/2026, reflected Resident #1 had potential to be verbally aggressive, disrespectful to staff related to dementia. Interventions: Analyze key times, places, circumstances, and what de-escalates behavior and document. Assess and anticipate Resident #1's needs for food, thirst, toileting needs, comfort level, and pain. Assess Resident 1's understanding of the situation and allow time for Resident #1 express self and feelings toward the situation. Provide Resident #1 psychiatric consult as indicated. Resident #1 had depression. Interventions: Administer medications as ordered. Arrange psych consult and follow up as indicated. Monitor/ document/ report as needed any risk for harm to self: suicidal plan, past attempnt at suicide, intentionally to try and harm self, refusing to eat or drink, refusing medications, sense of hopelessness or helplessness, and impaired judgement or safety awareness. Monitor / document / report to MD as needed risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons. Record review of Resident #1's behavior and mood assessment, dated 03/21/2026, she was not in distressed after an hour of the incident with Housekeeper A. Record review of Resident #1's behavior record reflected Resident #1 did not have any behaviors after the incident on 03/21/2026 approximately 6:00 pm and she was not depressed/ upset within an hour after the incident. Record review of Resident #1's activity participation record in March 2026 and April 2026 reflected Resident activity level/ participation in group activities had not declined. Resident #1 was attending at least 3 activities per week. There was no changes in her socialization with other residents outside of her room. Interview on 04/14/2026 at 9:40 am Resident #1 stated she had an incident with Housekeeper A in March. She did not recall the exact date. She stated it occurred over a weekend. Resident #1 stated she was going to the kitchen when she was (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	finishing her meal to ask for milk. She stated Housekeeper A and Dietary Aide B were talking in the dining room. She stated Dietary Aide B was in the kitchen area and Housekeeper A was standing at the door to the dishwashing room. She stated they kept talking and would not listen to her and she propelled herself to another door to the kitchen and began knocking on that door. She stated Housekeeper A asked her what she wanted and began to talk very rude to her in a loud tone. Resident #1 stated Dietary Aide B came to the door and gave her some milk after she requested it several times. She stated Housekeeper A began talking louder and stated, You are ugly and I am going to beat your ass. Resident #1 stated she began to yell back at Housekeeper A because she was not going to allow anyone to talk to her like this and she felt threatened. Resident #1 stated Houskeeper A stated, Why don't you stand up? You can walk; you don't need that wheelchair. iIf you think you can do something, why don't you stand up? Resident #1 stated she stood up and almost fell. She stated she felt humiliated and embarrassed. Resident #1 stated she became angry and was very upset. She stated she propelled herself to her room and later went to the nurses' desk to ask about smoking. Resident #1 stated LVN C was at the nurses' desk, and she would not listen to her. She stated LVN C continued to say, You are mad and upset but you should not be cussing people. Resident #1 stated she tried to explain what happened and LVN C would not listen to her and this made her mad and she began to yell and cuss LVN C. She stated LVN C would not listen to what she had to say about the incident with Housekeeper A and only heard one side of the story from Housekeeper A. She stated she went to her room, and she did calm down approximately an hour after the incident. She stated it did humiliate her and was embarrassing related to other residents heard what happened to her. She stated she did not feel she was treated with respect from Housekeeper A. Interview on 04/14/2026 at 10:30 am Resident #2 stated he was in the dining room when the incident occurred with Resident #1 and Houskeeper A. He stated Resident #1 was trying to get some milk. She went to one of the doors where Housekeeper A and Dietary Aide B were talking. He stated Resident #1 could not get their attention and she propelled herself to the second door of the kitchen and she did get some milk, and this is when Houskeeper A began to argue with Resident #1. Resident #2 stated Houskeeper A began the argument with Resident #1. He stated he felt sorry for Resident #1 related to the way Housekeeper A was speaking to Resident #1. He stated Houskeeper A made her feel embarrassed and Housekeeper A did talk to her in a loud tone and was almost yelling at Resident #1. He stated Houskeeper A told Resident #1 I am going to beat your ugly ass. You need to go on with your funky ass. Resident #2 stated when Houskeeper A made this statement, Resident #1 yelled back at Houskeeper A and was trying to defend herself. He stated he did not want to say exactly what Resident #1 had stated due to not knowing the exact words and did not want to make a false statement. Resident #2 stated he felt sorry for Resident #1 because she was embarrassed and felt disrespected. Resident #2 stated he did see Resident #1 for approximately 2 hours after the incident, and she was calm and was not upset. He stated Resident #1 was very upset and told him she was not respected by Housekeeper A. Record review of Resident #2's Quarterly MDS Assessment, dated 01/31/2026, reflected Resident #2 had a BIMS score of 15 indicating his cognition was intact. Interview on 04/14/2026 at 11:34 am Housekeeper A stated she was in the kitchen cleaning and was standing near the kitchen door while removing the plates. She stated Dietary Aide B was in the dishwasher room and they were talking. She stated Resident #1 rolled up in her wheelchair and began demanding milk. Houskeeper A stated she asked Resident #1 what did she want and Resident #1 stated, Mind your own business you stinking looking man. She stated she asked Resident #1 why she said this to her. Housekeeper A stated she continued to yell. She stated, I may have raised my voice to Resident #1 and may have been in a rude tone, but I did not cuss her. Houskeeper A stated she exited the dining room and reported to LVN C what occurred with Resident #1. Interview on 04/14/2026 at 2:45 pm Dietary Aide B stated she heard Resident #1 in the dining room talking in a loud tone. She stated she was in the dishwasher room, and it was difficult to hear what is being said in the dining room when in the kitchen. Dietary Aide B stated she asked Housekeeper A what did (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 want and she stated she is wanting some milk. Dietary Aide B stated she gave Resident # 1 some milk from another kitchen door. She stated, I heard Housekeeper Aide A and Resident #1 talking loud tone to one another, however, I did not witness the incident. Interview on 04/14/2026 at 3:30 pm Director of Nurses stated he had in-serviced staff on abuse and neglect, interactions with residents with behaviors, and documentation when residents have any type of incident with another resident or staff. He stated Resident #1 does have behaviors and outbursts with staff and other residents. He stated when this does occur staff is to walk away from Resident #1 or any resident if they believe they can not respond appropriately to the resident. The Director of Nurses stated if Resident #1 felt she was embarrassed , humiliated, or became upset with how Housekeeper A spoke to her there was a possibility Resident #1 may not feel she was respected by staff. He stated there was non-consistent interviews during their investigation. He stated Resident #1's physical or emotional status had not changed since 03/21/2026. She has remained at her baseline. Interview on 04/14/2026 at 5:15 pm Social Worker stated she had interviewed Resident #1 on Monday 03/23/2026 after the incident on 03/21/2026. She stated Resident #1 stated she was embarrassed and felt disrespected by Houskeeper A when the incident occurred on 03/21/2026. Social Worker stated Resident #1 was not upset, depressed, or emotional during her conversation with her on 03/23/2026. She stated Resident #1 was already seeing Psych services and was talking to a different therapist. Social Worker stated Resident #1's mood has been at her baseline. She has denied being depressed or sad. She stated Resident #1 was not isolating herself in her room or from others and did not have a decline in appetite. Social Worker stated she has been monitoring Resident #1 several days after the incident on 03/21/2026 and Resident #1 has been at her baseline. She stated when Resident #1 was upset, depressed or anxious she would move her hands above her head and swing her arms/ hands during conversations with her. Social Worker stated she did not have any signs or symptoms of being sad as evidenced by her facial expression which was relaxed and did not have burrowed eyebrow or a frown on her face. She stated she smiled at times during the conversation when they were discussing the incident with Housekeeper A. Interview on 04/14/2026 at 5:30 pm Maintenance Supervisor stated when he came to work the Monday (03/24/2026) after the incident over the weekend, he entered the dining room and Resident #1 called him over to her table. Maintenance Supervisor stated Resident #1 explained to him of Housekeeper A making a statement to Resident #1 I am going to beat your ass. He stated he immediately reported it to the Administrator (abuse coordinator) and the Director of Nurses. He stated Housekeeper A was not working on the Monday 03/23/2026 and she was contacted and was suspended until further investigation. He stated she turned in her 2 weeks' notice and it was immediately accepted. Maintenance Supervisor stated Housekeeper A was not on schedule to work after the incident on 03/21/2026 and had not been at the facility since she clocked out on 03/21/2026. Interview on 04/14/2026 at 5:55 pm LVN C stated Housekeeper A came to me on a weekend (she did not recall the exact date) in March 2026. She stated Housekeeper A stated, Resident #1 was at the kitchen door observing staff talking (Housekeeper A and Dietary Aide B) and Resident #1 began to yell. Housekeeper A stated Resident #1 called Housekeeper A man looking ass bitch. LVN C stated she did not witness the incident between Housekeeper A and Resident #1. She stated her only interaction with Resident #1 was when Resident #1 came to the nurses' desk yelling and wanting to go smoke. LVN C stated Resident was upset at first with the incident with Housekeeper A and was yelling and cussing. LVN C stated she did not document what Resident #1 was saying and she did not recall what she said after the incident. LVN C stated approximately 1 hour after the incident Resident #1 was calm and was at her baseline. She was not upset, anxious or depressed. Interview on 04/14/2026 at 6:20 pm LVN D stated she was late coming into work the date of the incident between Resident #1 and Housekeeper A. She stated when she arrived at the facility approximately 6:30 pm Resident #1 was calm. She stated LVN C gave her a report of what occurred between Resident #1 and Housekeeper A. LVN C stated she observed Resident #1 the rest of her shift. She stated Resident #1 did not have any behaviors and was calm the remaining of her shift. She (continued on next page)

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