STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675035	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Burkburnett	406 E Seventh St Burkburnett, TX 76354

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, for 1 of 1 kitchen as evidence by: The facility failed to ensure:A. Kitchen Aide F wore a hair restraint for his moustache and goatee/beard. B. The shelves throughout the kitchen were clean and not soiled.C. The stove and oven were clean and not soiled with working knobs and all parts working. D. The grease fryer was clean and not soiled with grease buildup.E. The vent hood was clean and free of dust.F. The food cart that drinks were being prepared on was clean and not soiled.G. The food disposal was free of food.H. The food thicker was in a sealed container. These failures could place residents at risk for foodborne illness, compromised nutritional health status, and being served food items that may not be fresh, taste stale, or be contaminated.The findings included:In an observation on 02/17/26 at 9:15 AM, during the initial tour of kitchen, Kitchen Aide F's mustache and goatee/beard was not covered with a hair net. He was preparing drinks for the residents and placing them on a cart that that was soiled with food crumbs on the top of the cart. The shelves throughout the kitchen, including the shelves that held the dishes, pots and pans, were soiled with food crumbs and dust. The bowl attached to the mixer had food crumbs in the bottom of the bowl. The grease fryer had some pieces of fried okra in the basket from the day before and the top of the grease fryer was covered with grease. The stove was missing 3 knobs to turn the burners on, and the stove and oven were soiled with food crumbs and dried food. The vent a hood was covered with a layer of dust. The food disposal had standing food in it. The container that contained food thickener located near the blender was not sealed properly as it had a piece of foil covering the top for the lid. In an interview on 02/19/26 at 2:49 pm, the Dietary Manager said when he came to work yesterday, he noted that Kitchen Aide F did not have his facial hair covered. He said it was his expectation that all facial hair to be covered. The findings concerning the food crumbs and dirt on the shelves and appliances were observed with the Dietary Manager and said he would get it cleaned and fix the issues. The Dietary Manager said the food disposal should be run when food was placed in it. The Dietary Manager said all of his staff are new and they are in the process of training them. The Dietary Manager said the stove was missing some knobs and the griddle portion of the stove top was not working but it had not been a big issue. The Dietary Manager said potential negative outcomes of not keeping crumbs, food, and dirt/dust could attract pests, bad smells, hair in food, and infection control issues. In an interview on 02/19/2026 at 4:15 pm, the Administrator was made aware of findings in kitchen. She said there has been a lot of staff turnovers in the kitchen. It was her expectation for the kitchen to be cleaned after each meal. She was made aware the stove was missing some knobs, and the griddle portion of the stovetop was not working. She said a possible negative outcomes could be pests and infection control. Record review of the facility policy Sanitization, dated as revised November 2022, revealed the following [in part]:Policy Statement: The food service is maintained in a clean and sanitary Manner. Policy Interpretation and Implementation: 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. 2. All utensils, counters, shelves and equipment are kept clean, maintained in food repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #33 and Resident #23) of sixteen residents reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light was in reach and accessible for Resident #33 on 02/17/2026 and 2/19/2026. The facility failed to ensure the call light was in reach and accessible for Resident #23 on 02/17/2026. This failure could place the residents at risk of being unable to obtain assistance when needed, obtain help in the event of an emergency, and result in an increased risk of falls. Findings included: Resident #33 Review of Resident #33's Face Sheet, dated 5/22/2025, reflected a [AGE] year-old male, admitted on [DATE]. Resident #33 had diagnoses of cerebral infarction (stroke), contracture to left hand (a condition of shortening and hardening of muscles thereby limiting joint mobility), muscle wasting (loss of muscle mass), and left side hemiparesis (weakness or paralysis on one side of the body, often caused by stroke, traumatic, brain injury or tumors, which may affects the arms legs and face). Review of Resident #33's Quarterly MDS Assessment, dated 12/29/2025, reflected that Resident #33 had a BIMS score of 11, indicating moderate cognitive impairment. The Quarterly MDS Assessment also indicated the resident required assistance for toileting, dressing, personal hygiene and transferring. Review of Resident #33's Comprehensive Care Plan, dated 12/13/2025, reflected Resident #33 was a fall risk, and one of the interventions was a reachable call light and to respond quickly to all calls for assistance. Observation and interview on 02/17/2026 from 9:30 a.m. to 9:38 a.m. revealed Resident #33 lying in bed. The call light was observed hanging down at the foot of his bed between the wall and the bed. Resident #33 stated sometimes staff leave the call light where he can't reach it, but stated when he was able to reach it, it usually doesn't take them long to answer him. He stated he can't use his left arm, but he could pull the call light with his right arm to call for help if he could reach it. He stated that if he cannot reach the call light, he just hollers out for someone to come to help him. He then stated he would like his fingernails to be trimmed and asked the surveyor to call for help. Observation on 02/17/2026 at 9:43 AM CNA D answered Resident #33's call light and turned it off at the wall. She asked Resident # 33 what he needed. He stated he wanted LVN A to cut his nails. CNA D stated she would tell LVN A and left the room without making sure the residents' call light was in reach of the resident. The call light remained out of reach and was hanging between Resident #33's bed and wall. Observation on 02/17/2026 at 9:47 AM MA C entered Resident #33's room. She talked with Resident #33, and he told her he was waiting for LVN A to cut his nails because he was diabetic and the aides weren't allowed to cut his nails. MA C repositioned the resident's left arm and adjusted his pillow, so his left arm and hand were elevated. The call light remained out of reach for the resident remaining between the bed and the wall on the left side of the bed. Observation on 02/17/26 at 9:51 AM LVN A entered room to cut Resident #33's fingernails. The call light was between the bed and wall out of Resident #33's reach. Observation on 02/17/2026 at 9:58 AM LVN A moved Resident #33's bed out from the wall to be able to get to residents #33's left hand on the left side of the bed. LVN A continued to file Resident #33's fingernails. LVN A noticed the call light was not in the resident's reach and placed the call light on the resident's bed in reach of Resident #33's right hand before she left the room. Interview on 02/17/2026 at 9:59 AM LVN A stated it was everyone's responsibility to monitor call lights. She stated her expectation was that call lights always remain in reach of the resident. She stated all staff should check to see that the residents' call light was in reach before they left the resident's room. She stated she did not know why 2 other people had entered the room and left and did not make sure the call light was in reach. LVN A stated a negative outcome for the residents would be that the residents would not be able to receive needed care in a timely manner. She stated a call light not in reach of a resident could lead to a fall. Observation for 02/19/26 at 9:15 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m. Resident #33's call light was not in reach. The call light was hanging between the bed and the wall. Resident stated he did not know how long it had been there. Resident #23 Review of Resident #23's Face Sheet dated 02/19/26 reflected a [AGE] year-old female, admitted [DATE]. Resident #23 had diagnoses of Dementia (decline in cognitive abilities), Alzheimer's Disease (a type of dementia that affects memory, thinking and behavior and slowly destroys a person's memory and thinking skills.), and muscle weakness. Review of Resident #23's Significant Change 1/20/2026 MDS Assessment, dated 3/18/2025 reflected that Resident #23 had a BIMS score of 3, indicating severe cognitive impairment. The Significant Change MDS Assessment indicated that Resident #23 needed supervision or touch assistance with transferring and toileting. She was continent of bowel and bladder. Review of Resident #23's Comprehensive Care Plan dated 01/15/2026 reflected that Resident #23 was a fall risk, and to instruct resident to call for help before getting out of bed and always keep call light visible to resident and in reach. Observation on 02/17/2026 at 10:28 a.m. Resident #23 was in the recliner in her room sleeping and the room was dark. A fall mat by her bed on the opposite side of the room and her call light was laying on a freshly made bed and was not in reach of the resident. Observation on 02/17/2026 in dining room at 12:10 p.m. Resident #23 was still sleepy during lunch. Staff were attempting to feed this resident. Resident did not respond to attempts to interview her. Interview with the DON on 02/19/2026 at 10:30 AM she stated it was her expectation that all staff monitor to ensure that residents call lights were in reach. She stated it was everybody's responsibility to answer call lights and to ensure residents could reach them. She stated she was preparing an in-service on answering call lights and staff should always make sure call lights were in reach of each resident before they left the room. She stated a call light not being in reach of a resident that needed help could result in an injury or a resident not receiving needed care and services. Review of the policy titled Call system, Residents dated revised January 2025 stated in part: Residents are provided with a means to call staff for assistance through communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff for assistance from his/her bed, from toileting bathing facilities and from the floor. Calls for assistance are answered timely. If a resident has a disability that prevents him or her from making use of the call system, an alternate means of communication that is usable for the resident is provided and documented in the care plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 3 (Residents #2, #7, and #38) of 5 residents reviewed for treatment administration. The facility failed to ensure staff accurately documented Resident's 2, #7, and #38's Medication Administration Record (MAR) the administration of controlled substance. The facility failed to ensure staff followed up with Resident's #2, #7 and #38 after narcotic pain medication administration for monitoring results and or complaints/symptoms for which the drug was administered, per facility policy. These failures could put residents at risk for medication errors and errors in care.Findings included: Resident #2 Review of Resident #2's face sheet, dated 2/19/2026, revealed the resident was a [AGE] year-old female who originally admitted to the facility on [DATE], with readmission date of 12/18/2023. Her diagnoses included Type 2 Diabetes, non-pressure chronic ulcer of the right foot, and chronic pain syndrome (long term pain). Review of Resident #2's Quarterly MDS, dated [DATE], reflected a pain presence of yes, frequency was occasionally, and it occasionally affects her sleep and day to day activities. Review of Resident #2's care plan, dated 12/05/2025, reflected the following: Insomnia/sleep pattern disturbance . Assess for pain and administer pain meds as ordered. Monitor for effectiveness I am on pain medication therapy related to diagnosis of chronic pain syndrome. Assess/record/report to MD as needed signs/symptoms of distress or pain unrelieved by ordered treatments. Administer analgesic medications as ordered by physician. Monitor for side effects/effectiveness. Review of Resident #2's physician's orders, dated 2/10/2026, revealed the following order:Acetaminophen-Codeine Oral Tablet 300-60 MG Give 1 tablet by mouth every 4 hours as needed for pain -Start Date- 02/10/2026 1000 Review of Resident #2's MAR dated 02/19/2026 verses her Controlled Medication log dated most recently 02/19/2026, revealed the following dates: 2/11/2026 x1 dose, 2/12/2026 x4 doses, 2/13/2026 x2 doses, 2/14/2026 x1dose, 2/15/2026 x3 dose, 2/16/2026 x2 doses, 2/17/2026 x4 doses, 2/18/2026 x3 doses, and 2/19/2026 x1 dose, was not documented in the MAR to show the medication, Acetaminophen-Codiene Oral Tablet 300-60mg, was administered but was only documented as administered on the Controlled Medication log. The log and medication count were correct as of this day, 02/19/2026. Review of Resident #2's Progress Notes dated 2/19/2026 at 15:03pm, with date range of 1/1/2026 thru 2/19/2026, revealed no nursing note or documentation for follow up of effectiveness for Resident #2's pain medication administration. Observation and interview on 2/18/2026 at 9:51am with Resident #2, she was lying in bed watching television, she stated she received her medications on time and if she needed a pain pill the nurses were good about getting it to her. Resident #7 Review of Resident #7's face sheet dated 02/19/2026 reflected she was an [AGE] year-old female originally admitted on [DATE] and readmitted [DATE]. Her diagnoses included Bipolar disorder (a mental health condition), Chronic pain (long term pain), and Anxiety. Review of Resident #7's Quarterly MDS, dated [DATE], reflected the following:Section I0020 Active Diagnoses marked for anxiety disorder.Section J0100 Pain Management - received scheduled pain medication marked yes.Section N0415 High Risk Drug Classes marked for taking Antianxiety and Opioid medications. Review of Resident #7's care plan with revision date 02/03/2026 reflected the following: I am at risk for alteration in comfort/risk for pain presence R/T disease process. I am on pain medication therapy r/t other chronic pain. Administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT. I use anti-anxiety medication r/t DX of anxiety disorder. Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Review of Resident #7's physician orders dated 2/19/2026 revealed the following orders:Acetaminophen-Codeine Oral Tablet 300-30 MG Give 1 tablet by mouth every 6 hours as needed for moderate pain related to Chronic pain. Start date (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/18/2025Hydrocodone-Acetaminophen Oral Tablet 5-325MG Give 1 tablet by mouth every 6 hours as needed for moderate pain related to Chronic pain. Start date 11/19/2025Lorazepam Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth in the evening related to Anxiety. Start date 1/26/2026. Review of Resident #7's MAR dated 02/19/2026 verses her Controlled Medication log dated revealed the following:There was no documentation in Resident #7's MAR of the administration of her Lorazepam Oral Tablet 1mg on the following days for the month of February; 02/04/2026, 02/05/2026, 02/06/2026, 02/07/2026, 02/08/2026, 02/09/2026, 02/10/2026, 02/11/2026, 02/12/2026, 02/13/2026, 02/14/2026, 02/15/2026, 02/16/2026, 02/17/2026, and 02/18/2026. These dates were marked and initialed as administered on Resident #7's Controlled Medication Log. Log and medication count were correct as of this day, 02/19/2026. There was no documentation in Resident #7's MAR of the administration of her Hydrocodone-Acetaminophen Oral Tablet 5-325MG on the following days for the month of February; 02/17/2026 x1 dose. This date was marked and initialed as administered on Resident #7's Controlled Medication Log. The log and medication count were correct as of this day, 02/19/2026. There was no documentation in Resident #7's MAR of the administration of her Acetaminophen-Codeine Oral Tablet 300-30 MG on the following days for the month of February; 02/09/2026 x2 doses, 02/10/2026 x3 doses, 02/11/2026 x3 doses, 02/12/2026 x3 doses, 02/13/2026 x3 doses, 02/14/2026 x3 doses, 02/15/2026 x3 doses, 02/16/2026 x3 doses, 02/17/2026 x3 doses, 02/18/2026 x3 doses, and 02/19/2026 x2 doses. These dates were marked and initialed as administered on Resident #7's Controlled Medication Log. The log and medication count were correct as of this day, 02/19/2026. Review of Resident #7's Progress Notes dated 2/19/2026 at 15:03pm, with date range of 1/1/2026 thru 2/19/2026, revealed no nursing note or documentation for follow up of effectiveness for Resident #7's pain or anxiety medication administration. Observation and interview on 02/18/2026 at 9:51am with Resident #7, she was lying in bed resting in low position, hydration on bedside table, call light within reach. Resident stated she was doing ok, that she had a procedure on her eye yesterday and it was a long day. She stated she had no concerns at this time. She stated she receives her medication on time from what she can tell, that she's never had an issue with receiving her medications. She stated if she needed something for pain the nurse was good at getting it for her. Resident #38 Review of Resident #38's face sheet dated 02/18/2026 revealed he was a [AGE] year-old male admitted on [DATE]. His diagnoses included heart disease, cancer of left ear, and chronic pain (long term pain). Review of Resident #38's MDS dated [DATE], reflected it had not been completed as of 02/19/2026. Review of Resident #38's care plan dated 02/16/2026 reflected the following. I am at risk for alteration in comfort/risk for pain presence related to disease process and diagnosis other chronic pain . Administer pain medications as ordered by physician and assess effectiveness. My physician ordered the opioid medication Hydromorphone related to diagnosis of chronic pain . Administer medication as ordered. Review of Resident #38's physician orders dated 2/19/2026 revealed the following orders:Hydromorphone extended release 15mg capsule Give 1 capsule orally/rectally every 8 hours as needed for Moderate pain related to chronic pain. Start date 02/12/2026. Hydromorphone hydrochloride Oral Tablet 4mg Give 1 tablet by mouth every 4 hours as needed for moderate pain related to chronic pain: malignant melanoma of left ear and external auricular canal. Start date 02/12/2026. Review of Resident #38's MAR dated 02/18/2026 verses his Controlled Medication log dated revealed the following:There was no documentation in Resident #38's MAR of the administration of his Hydromorphone hydrochloride Oral Tablet 4 MG on the following days for the month of February; 02/12/2026 x1 dose, 02/13/2026 x2 doses, 02/14/2026 x1 dose, 02/15/2026 x3 doses, 02/16/2026 x4 doses, 02/17/2026 x3 doses, and 02/18/2026. These dates were marked and initialed as administered on Resident #38's Controlled Medication Log. Log and medication count were correct as of this day, 02/19/2026. There was no documentation in Resident #38's MAR of the administration of his Hydromorphone extended release 15mg capsule Give 1 capsule on the following days for the month of February; 02/13/2026 x1 dose, 02/16/2026 x1 dose, 02/17/2026 x1 dose, and 02/18/2026 x1dose. These dates were marked and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initialed as administered on Resident #38's Controlled Medication Log. Log and medication count were correct as of this day, 02/19/2026. Review of Resident #38's Progress Notes dated 2/19/2026 at 15:03pm, with date range of 2/12/2026 through 2/19/2026, revealed no nursing note or documentation for follow up of effectiveness for Resident #38's pain medication administration. Observation and interview on 02/18/2026 at 11:09am, Resident #38 was standing independently in his room, bed made in low position, call light within reach, hydration on bedside table. He stated he was there for rehab and get his medications back on track. He said he only has 15% use of his heart and messed up his medications. He stated he has been with Hospice a while, and that he has ear cancer too. He stated he receives his medications on time but sometimes his pain would be more than the medication would help but Hospice was trying to adjust them best they could for what he needed. In an interview on 02/18/2026 at 3:01 PM with LVN G, she stated she has worked there for almost 3 years. She stated she was fully trained when she was hired and feels competent in her position. She further stated for hospice residents, if the resident came to her a couple hours later after giving him or her pain medication and said it's not working can I have the stronger medication that as long as it was ordered and available to be given at that time she would give it. She said a negative outcome for the residents if not given as ordered would be unnecessary pain and suffering. She also stated when she administers a narcotic pain medication she must log and initial it on the residents narcotic sheet to make sure the count was correct and then document in the residents MAR to show it was given. She stated that was the expectation and a negative outcome could be a medication error. In an interview on 02/19/2026 at 10:15am with LVN A, she stated with all controlled medication administration there was a separate log the nurses and medication aides must complete, date and initial when administering and then they must document in the residents MAR their pain scale and the administration. She further stated they were to follow up with the resident to make sure the effectiveness of the pain meds or any adverse effects. She stated a negative outcome could be a medication error. When asked about the MAR's and logs not correlating for all 3 residents, she stated the only thing she could say about it not being documented in one or the other could just be laziness and not taking the time to document both or forgetting to go back to mark in the MAR. In an interview on 02/19/2026 at 11:00am with the DON, she stated the controlled medication logs were to be filled out when medications were administered and documented in the residents MAR. She stated an adverse outcome could be a drug diversion or medication error. Review of facility provided policy titled Administering Medications dated revised April 2019 revealed [in part]:22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; f. Any results achieved and when those results were observed;

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 (Resident #22) of 5 residents reviewed for infection control. The facility failed to ensure staff followed infection control practices of washing hands before performing patient care, performing hand hygiene with an alcohol-based hand sanitizer after glove use, and following proper steps for performing peri-care on a male resident (Resident # 22) during incontinent care. These failures could place residents at risk for infection due to improper care practices. Findings included: Record review of Resident #22's face sheet dated 2/19/26, revealed a [AGE] year-old male, with an initial admission date of 08/01/2024, and a most recent admission date of 07/24/25. Resident #22's diagnoses included: retention of urine (failure of the bladder to empty completely), abnormal gait and mobility, pressure area of the sacrum, and diarrhea. Record review of Resident #22's quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 indicating severe cognitive impairment. Review of Section GG - revealed Resident #22 was dependent on staff for all activities of daily living which included toileting hygiene. Review of Section H revealed Resident #22 was also incontinent of bowel and bladder. Record review of Resident #22's care plan dated revised 1/16/26 revealed the following: Focus: I have the potential for skin breakdown/pressure ulcer development related to incontinence, impaired mobility, and disease process. Interventions: Check often for incontinence. Wash, rinse, and dry soiled areas. Change clothing PRN after incontinence episodes. Observe for signs and symptoms of urinary tract infection including frequency, burning, urgency, foul-smelling urine, cloudy urine, blood in urine, fever, and chills. Provide with adult briefs/pull ups/pads and change as needed During an observation on 02/17/2026 at 10:45 a.m. CNA B and MA C entered Resident # 22's Room. CNA B ran his hand through his hair and then donned gloves without performing hand hygiene. MA C used hand sanitizer which was in her pocket and then donned her gloves. CNA B unfastened Resident #22's urine soiled brief and began to perform incontinent care while leaving the soiled brief laying underneath Resident # 22's buttocks. CNA B cleansed the penis and perineal area by cleaning from the rectal area and up the shaft of the penis to the penis head using only one wipe. MA C used another wipe and cleansed the shaft of Resident #22's penis. She changed her gloves and used alcohol-based hand sanitizer before she donned new gloves. CNA B changed gloves and did not use hand sanitizer before turning Resident #22 to his left side to clean the buttocks and the rectal area. CNA B changed gloves again to apply the clean brief to Resident #22 and then disposed of the soiled brief. CNA B gathered the trash into a bag and removed his gloves and placed them in the bag. MA C removed her gloves, placed them in the trash, and used alcohol-based hand sanitizer to perform hand hygiene before leaving the room. CNA B did not perform hand hygiene before leaving the room. During an interview on 02/17/2026 at 10:55a.m, MA C stated that she knew that CNA B did not perform the incontinent care correctly on Resident #22. She stated he did not use hand sanitizer between glove changes, and he cleaned the Resident #22's perineum while wiping from a dirty to a clean area. She stated a negative outcome resulting from not performing incontinent care and proper hand hygiene correctly would be increasing the risk of infection for the resident. During an interview on 02/17/2026 at 11:00 a.m., CNA B stated that he should have washed his hands before patient contact and should have used hand sanitizer between glove changes. He stated that failure to use proper hand hygiene could cause the spread of germs and infection. He stated he did not have any hand sanitizer available when he did the incontinent care. He stated he did not normally carry hand sanitizer in his pocket. He stated there were hand sanitizer dispensers in the hallways. During an interview on 02/19/2026 at 10:55 a.m., the DON said staff were previously trained on hand hygiene including the need to wash hands before and after glove use. She stated it was her expectation that staff follow this training when providing patient care. She stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675035	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Burkburnett	406 E Seventh St Burkburnett, TX 76354

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff were competency checked annually. The DON said the risk of not performing hand hygiene between glove use was infection control. Review of facility provided policy titled Perineal Care dated 2021, stated in part: Take the wipe in one hand and gently grasp the penis shaft. If the resident is uncircumcised gently pull the foreskin aback and wipe the head of the penis beginning at the urethral opening working outward and away from the penis head (circular motion). Use a new wipe with each stroke. After cleaning is complete gently move the foreskin back to its natural position if uncircumcised. Cleanse the penis shaft with wipe from the top of the shaft towards the rectum, including the scrotum. Using a new wipe with each stroke cleans from the upper part of the leg to the hip. Repeat to the other side and then once from the hip bone to hip bone. Turn the resident over and repeat on the back side. Take off gloves, put them into the trash bag with the soiled brief and wipes, then wash and sanitize your hands. Review of the facility policy titled Handwashing/Hand Hygiene dated 2001, stated in part: The facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene is indicated immediately before touching a resident. After contact with blood body fluid, or contaminated surfaces, after touching a resident, after touching the resident's environment, before moving from work on a soiled body site t a clean body site on the same resident; and immediately after glove removal.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 31(East Hall room [ROOM NUMBER]) provided a minimum of 80 square feet of floor space per resident, in that: East hall room [ROOM NUMBER] was included in the facility's licensed capacity as a three-bed resident room and did not provide the minimum floor space required per resident. This failure could place residents at risk for restricted movement and limit the amount of resident use equipment and personal effects that could be accommodated in the room.The findings included: Review of the Bed Classifications Form 3740, signed and dated by the facility Administrator on 2/17/2026, revealed resident room [ROOM NUMBER], located on the East Hall, was licensed for three beds and was categorized as Title 18 (Medicare). In an interview on 2/17/2026 at 2:47 PM, the Administrator stated East Hall room [ROOM NUMBER] is considered under licensure as a 3-bed ward but was used for therapy. She stated she wanted to continue the room size waiver that was in effect for the room. Observation on 2/18/2026 at 3:20 PM, accompanied by Life Safety Code surveyor and the facility's Maintenance Director, revealed Room #E15, was used by the therapy department and contained therapy equipment and a desk. Room #E15 was licensed as a 3-bed ward. The room floor space was measured at 221.8 square feet and equaled 73.9 square feet per person.