

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Avir at Keller		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Whitley Road Keller, TX 76248	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 6 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1's biliary drain (thin plastic tube used to clear blocked bile ducts) was flushed per the physician's order for seven days. This failure could place residents at risk for worsening of condition which could lead to serious harm. Findings included: Record review of Resident #1's Discharge MDS Assessment, dated 07/15/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on 07/15/26. Section C-Cognitive Patterns reflected Resident #1's BIMS score was a 15, which indicated his cognition was intact. Section GG-Functional Abilities reflected Resident #1 required moderate assistance with most self-care ADLs. Resident #1 was dependent on staff for most mobility functions and used a manual wheelchair. Section I-Active Diagnoses reflected Resident #1's active diagnoses included: cerebral infarction (stroke), secondary malignant neoplasm of liver and intrahepatic bile duct (liver cancer), reduced mobility, and ileostomy status (surgical procedure that allows waste to bypass the colon and empty through an opening in the stomach). Record review of Resident #1's Baseline Care Plan, dated 07/02/26, reflected the document did not indicate Resident #1 required any special treatments or procedures. Record review of Resident #1's discharge hospital records, dated 07/02/26, reflected in part the following: .A biliary drain catheter is placed to drain bile from your liver. Your doctor who requested this procedure will discuss with you how long it will be placed and/or when you need exchanged of this catheter if necessary. Physician discharge instructions-Flush the tube with sterile saline daily as directed given by the Interventional Radiology team. Record review of Resident #1's progress notes, dated 07/02/26 at 10:46 p.m., by LVN E, reflected in part the following: .Other Observations:[Resident #1] arrived via [transportation company] at 3:30 pm. Accompanied by [Resident #1's family]. [Resident #1] is on skilled services for colon cancer. [Resident #1] has a colostomy. Empty the colostomy (surgical procedure that allows waste to bypass the colon and empty through an opening in the stomach) x 2. Has a drain to left side of abdominal area. Has med port to left upper chest. Redness to coccyx. Has a skin tear to left elbow. Very thin gentleman. Skin is very dry due to chemo. Has psoriasis (chronic autoimmune disease that causes rashes and scaly patches on skin) of scalp, face and neck. Can turn from side to side with assist. Can feed self in room. Fair appetite. [MD] is aware of new resident. [Resident #1] Denies any pain or discomfort noted at this time. Record review of Resident #1's progress notes, dated 07/04/26 at 3:57 p.m., by RN C, reflected in part the following: . Other observations:[Resident #1] on skilled services for weakness r/t colon cancer. [Resident #1] no s/s of distress, PRN Norco (prescription pain relief drug) given for back pain, effective. Tx to skin issues provided. Emptied (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	colostomy x2. A drain tube to left side of abdominal area not used. Med port to left upper chest intact. Scheduled meds taken, tolerated. Fair appetite. Participated PT/OT. Keep monitoring. Record review of Resident #1's progress notes, dated 07/04/26 at 8:50 p.m., by the NP, reflected in part the following: . [Resident #1] is a [AGE] year-old male who is seen in the skilled nursing facility for a new admission, day two follow-up evaluation. [Resident #1] was recently hospitalized at [local hospital] history is significant for stage IV colon adenocarcinoma (colon cancer) with hepatic (relating to liver) and bilateral adrenal metastases (cancer spread from one part of body to adrenal glands), status post subtotal colectomy (surgical procedure to remove part of the colon) with ileostomy. Additional medical history includes hypercholesterolemia (high blood cholesterol), hypertension (high blood pressure), and cerebrovascular accident (CVA/stroke). [Resident #1] is currently clinically stable. Continue current treatment plan, monitor chronic conditions, and provide supportive care. Record review of Resident #1's consolidated physician orders, dated 07/29/26, reflected in part the following:-Flush IR drain to LUQ with 10 ml normal saline once daily. Start date: 07/09/26. Discontinued. In an interview on 07/29/26 at 9:25 a.m., Resident #1's family stated upon the resident's admission to the facility, there was a care plan meeting held with the DON and other clinical staff. Resident #1's family stated during the meeting she notified the facility that Resident #1 had a biliary drain that had to be flushed daily. She stated the facility claimed not to have instructions or orders to do so. Resident #1's family stated the biliary drain was newly placed while Resident #1 was at the hospital and the doctor informed them that it was important to flush it daily. Resident #1's family stated the resident was at the facility for about a week without getting his biliary drain flushed, and the facility did not start flushing it until she brought in an order to prove that it was required. Resident #1's family stated there were no obvious issues from the delay in care, but she filed a grievance with the facility and discharged Resident #1 before any harm could occur. In an interview on 07/29/26 at 12:58 p.m., the DON stated Resident #1 was admitted to the facility for almost two weeks, and the resident admitted after a stay in the hospital. The DON stated Resident #1 had an ileostomy and biliary drain, and his care needs were discussed during the care plan meeting with family. The DON could not recall if care for the biliary drain was addressed or if Resident #1 admitted with a physician order for biliary care. The DON stated a biliary drain was uncommon for residents at the nursing facility; however, the nurses would be educated on appropriate care if needed. The DON stated the biliary drain was used to drain and fluid leaving the body and not providing appropriate care could place the resident at risk of complications and infection. The DON stated she would check Resident #1's hospital records to see if he was admitted with an order for biliary care. In an interview on 07/29/26 at 1:17 p.m., RN C stated she worked weekends at the facility and worked with Resident #1. RN C stated Resident #1 required ileostomy care, and he also had a biliary drain that was not used. RN C stated the biliary drain was capped with no drainage or signs of infection, and she would only ensure the site was clean. RN C stated there were no orders in the medical chart for her to flush the biliary drain or provide any additional care. RN C stated Resident #1's family had concerns about the biliary drain not being flushed and she explained to them she could not do anything without an order. RN C stated as a nurse, if there were any concerns raised by the resident or family it was her responsibility to notify the MD for clarity. RN C stated she did not notify the MD that Resident #1's family had concerns regarding the resident's biliary drain as she should have. In an interview on 07/29/26 at 2:15 p.m., RN D stated she worked weekdays at the facility and worked with Resident #1. RN D stated Resident #1 had a lot of co-morbidities and was a high maintenance resident who required a lot of assistance. RN D stated Resident #1's family was very involved in his care and seemed to have different expectations than Resident #1. RN D described (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 as pleasant and easygoing but Resident #1's family had concerns regarding care for the biliary drain. RN D stated Resident #1's family stated she wanted the resident's biliary drain flushed; however, there were no orders to do so. RN D stated the biliary drain was capped off with no drainage. RN D stated Resident #1's family provided an order the following day that was clarified with the MD and implemented. RN D stated when a resident was admitted to the facility from a hospital, the admitting nurse was responsible for assessing the resident and reviewing the discharge report to check for any orders and instructions. RN D stated she was not the nurse when Resident #1 was admitted ; however, ADON B was assigned to Resident #1 and would have confirmed the resident's orders. In an interview on 07/29/26 at 2:45 p.m., Interim ADON A stated ADON B was on vacation, and she was covering for her. Interim ADON A stated she did not review Resident #1's orders because he had already been admitted when she took over the caseload. Interim ADON A stated when a resident was admitted to the facility, the ADONs were responsible for double checking all documents from the discharging facility or hospital to ensure all medication orders, procedures, upcoming appointments, or other care needs were confirmed and entered into the system for clinical staff to be aware. In an interview on 07/29/26 at 3:28 p.m., the MD stated when a resident admitted to the facility, his expectation was for the nurses to notify him to clarify all orders and carry them out accordingly. The MD stated a biliary drain was placed to drain fluid and prevent bile ducts from being blocked. The MD stated it was important to flush the drain to prevent any clogs, although flushing could also introduce bacteria to the abdomen. The MD stated there were no reported issues with Resident #1's biliary drain; however, the facility was still expected to follow any physician orders for care. In an interview on 07/29/26 at 4:25 p.m. with the Administrator and DON, the DON stated it was her expectation for the charge nurses to review and confirm all orders with the MD. The DON stated the ADONs were responsible for reviewing the orders after the charge nurses to ensure no orders were missed. The DON stated an order for Resident #1's biliary drain was in the discharge hospital records and should have been acknowledged and implemented by the facility when the resident admitted . The DON stated Resident #1's discharge documents were extensive which was probably how it was missed; however, the nurses were still expected to look at each document. The DON stated not following all physician orders could place the residents at risk of not receiving all care needs. Record review of the facility's policy titled Physician Orders, revised February 2025, reflected in part the following: PurposeThe purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services. Supervision by a Physician.Physician orders are essential for the comprehensive care of the residents. These orders encompass various aspects, including leave of absence, evaluations, medication and treatment regimen, and therapy for physical therapy (PT), speech therapy (ST), and occupational therapy (OT); consultations with other physicians; dietary plans; activity instructions; X-rays; laboratory work; transfers; discharges; and any other orders as needed. Therapy orders must be renewed every 30 days and can be documented in the therapy notes.		