STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675270	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kennedale	413 E Mansfield Cardinal Kennedale, TX 76060

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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
	675270	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Kennedale	413 E Mansfield Cardinal Kennedale, TX 76060

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 4 resident (Resident #1) reviewed for pressure ulcers.The facility failed to ensure Resident #1 received wound care according to physician orders on 11/05/25, 11/21/25, 11/24/25 and 11/27/25.The failure placed residents at risk for pressure ulcer deterioration and infection.Findings included:Record review of Resident #1's face sheet, dated 12/15/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE], readmitted on [DATE] and discharged on 12/02/25. Record review of Resident #1's admission MDS assessment, dated 11/06/25, reflected his diagnoses included chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), essential hypertension (high blood pressure), hyperlipidemia (high cholesterol), and type 1 diabetes mellitus (blood glucose, or blood sugar, levels are too high). Resident #1's BIMS score was 10 which indicated moderate cognitive impairment. The MDS further revealed Section M - Skin Conditions indicated Resident #1 had 1 unstageable pressure injuries presenting as deep tissue injury that were present upon admission/entry to the facility, surgical wound and skin tear(s). Record review of Resident #1's care plan, undated, reflected Resident #1 had pressure ulcers or the potential for pressure ulcer development. The care plan interventions included: Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection wound size, state. The resident requires the bed as flat as possible to reduce shear. The resident prefers to be repositioned with (2 people, lifter, slider). Follow facility policies/protocols for the preventions/treatment of skin breakdown. The resident requires (Specify: Pressure relieving/reducing device) on (Specify: bed/chair). Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort.Record review of Resident #1's physician orders, dated 10/31/25 reflected: cleanse with NS, pat dry, paint with betadine and leave open to air every evening shift. right lower leg(front): cleanse with NS, pat dry, apply Xeroform and cover with dry DRSG every evening shiftRecord review of Resident #1's Initial Wound Evaluation & Management Summary, dated 11/12/25, reflected the following Treatment Plan/Orders: (Site 1) Non-Pressure wound of the right, distal shin partial thickness: Sodium hypochlorite gel (Anasept) apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days; Collagen powder apply once daily and as needed: if saturated, soiled, or dislodged. (Site 2) Unstageable DTI of the right heel undetermined thickness: Betadine apply once daily and as needed: if saturated, soiled, or dislodged. (Site 3) Non- Pressure wound of the right, anterior, medial ankle: Betadine apply once daily and as needed: if saturated, soiled or dislodged.Record review of Resident #1's TAR for November 2025 reflected there was no documentation showing that wound care was provided on 11/05/25, 11/21/25, 11/24/25 and 11/27/25.Interview on 12/15/25 at 3:01 PM, ADON A revealed the charge nurses were responsible for providing daily wound care to the nurses. She stated it was her responsibility to ensure wound care was being provided. ADON A reviewed Resident #1's TAR and stated the TAR had some days that were not documented. She stated she was not aware, and it was unknown if the wound care was provided or if the nurse forgot to sign the TAR. She stated she could not recall being told Resident #1 refuse any wound care treatment. ADON A stated the expectation for the nurses were for them to follow the physician orders, provide the wound care and document that the wound care was provided. She stated the potential risk of not providing wound care would be wound getting worse or infected. She stated the potential risk of not documenting correctly would be staff not knowing if the wound care was provided. ADON A stated LVN B was the assigned nurse for Resident #1 on 11/05/25, 11/21/25, 11/24/25 and 11/27/25.An attempt was made to interview LVN B on 12/15/25 at 3:15 PM by phone; however, call was unsuccessful. Interview on 12/15/25 at 4:25 PM, the Wound Care Doctor revealed treatment should be followed. He stated he could not say what could happen if a treatment was missed, he stated it would all depend on the type of wound the resident had.Interview on 12/15/25 at 5:05 PM, the DON revealed she was not aware wound care was not provided to Resident #1. She stated nurses were responsible for performing wound care on Resident #1. The DON stated wound care might have been provided and the nurse failed to document. She stated she could not recall being told Resident #1 refuse any wound care treatment. She stated she expects her staff to follow the treatment orders. She stated ADON A was responsible for ensuring wound care was provided and ensure it was documented. She stated the potential risk could result in the wounds worsening and getting