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	04/15/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received appropriate treatment and services to prevent complications for 1 of 1 resident (Resident #2) reviewed for feeding tubes.LVN C failed to follow physician orders and added water to Resident #2's g-tube (device inserted through the belly into the stomach to deliver nutrition, fluids, and medications). formula prior to administering her feeding. This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care.Findings included:Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), hyperlipidemia (a condition of high cholesterol), respiratory failure (a condition in which there is not enough oxygen in the tissues in the body), diabetes (a condition that happens when blood sugar is too high), end stage renal disease (the final stage of chronic kidney disease), and pain. The MDS reflected Resident #2's cognition was moderately impaired with a BIMS score of 11. The MDS further reflected that the resident had a g-tube. Record review of Resident #2's care plan revised on 12/02/25 reflected she required tube feeding related to dysphagia (swallowing problem). Interventions included to assist with administration of tube feeding per MD order. Record review of Resident #2's monthly physician's orders for April 2026 reflected the resident was on enteral feeding three times a day Bolus 237mL one carton of Glucerna 1.5 at 8:00 AM and two cartons at both 12:00 PM and 4:00 PM feeding.During an observation on 04/15/26 at 10:43 AM, revealed LVN C was at the medication cart about to prepare Resident #2's g-tube feeding. Once in the room, LVN C poured an undisclosed amount of tap water into each of the cups that contained the g-tube formula. LVN C put on her gloves and poured the formula that was in the cups into the syringe that was attached to the g-tube and let it flow to gravity and there were no concerns with the pour or the g-tube. After the formula had all been poured into the syringe attached to the g-tube, LVN C flushed with water. During an interview on 04/15/26 at 1:38 PM, LVN C revealed she poured water into the cups of formula but did not recall how much it was. LVN C said she poured the water into the formula so she could dilute it because it would take the formula a long time to go down the tube if she did not add water. LVN C said she was told by the ADON she could dilute the formula with water but would get with management again to verify that. During an interview on 04/15/26 at 3:09 PM, the ADON revealed she was not aware LVN C would dilute Resident #2's g-tube formula with water and never told her to do that. The ADON said they could only dilute the g-tube formula with water if they had a physician's order to do it. The ADON said the risks of adding water to the g-tube formula included overfeeding the resident, which would give the resident a sense of feeling full. During an interview on 04/15/26 at 4:09 PM, the DON revealed Resident #2's formula should not have been diluted with water without a physician order. The DON said the formula should not be diluted with water because it could affect the concentration of formula or the resident could cause overload and put the resident at risk of aspiration (accidental breathing of [NAME], liquid, or stomach contents into the airway and lungs instead of the esophagus). Record review of the facility's Enteral Nutrition policy, revised January (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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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2014, reflected the following: Adequate nutritional support through enteral feeding will be provided as ordered.4. Enteral nutrition will be ordered by the Physician based on the recommendations of the Dietitian.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the service of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 13 of 60 days reviewed during a look back period from 02/07/26 to 04/05/26 for weekend coverage. The facility failed to have RN coverage in the facility for eight consecutive hours on 02/08/26, 02/14/26, 02/15/26, 02/21/26, 02/22/26, 02/29/26, 03/07/26, 03/08/26, 03/14/26, 03/15/26, 03/22/26, 03/28/26, 03/29/26.This failure could place residents at risk of not having their nursing and medical needs met and improper care.Findings included: Record review of the facility's Detailed Hours report, printed on 04/15/26, reflected there was no RN coverage on the weekends for the following dates:02/08/26, 02/14/26, 02/15/26, 02/21/26, 02/22/26, 02/29/26, 03/07/26, 03/08/26, 03/14/26, 03/15/26, 03/22/26, 03/28/26, and 03/29/26.During an interview on 04/15/26 at 3:09 PM, the ADON revealed the facility was having a hard time finding and keeping an RN for weekend RN coverage and they had been without one for quite a while. The ADON said the facility should have an RN on the weekends to cover in case something happened that was out of the scope of an LVN. During an interview on 04/15/26 at 4:09 PM, the DON revealed she had only been at the facility for three days and said she had been told they had recently lost their weekend RN and did not realize there were so many days without one. The DON said it was important to have an RN for 8 consecutive hours Monday through Sunday because it was a state regulation. During an interview on 04/15/26 at 4:18 PM, the Administrator revealed the facility did not have a weekend RN for quite a while and would try to hire one soon. The Administrator said it was important to have an RN seven days a week for eight hours in case there was something that needed to be done that was out of the scope of practice of an LVN and for better oversight. Record review of the facility's Staffing, Sufficient, and Competent Nursing policy, revised August 2022, reflected the following: .Sufficient Staff.3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) day a week.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 4 resident (Resident #2) reviewed for pharmaceutical services.LVN C failed to follow the facility policy when she mixed and crushed Resident #2's medications and administered them via g-tube (device inserted through the belly into the stomach to deliver nutrition, fluids, and medications).This failure placed residents at risk of not receiving the therapeutic dosages of their medications, gastric upset, pain, and symptomatic changes. Findings included:Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), hyperlipidemia (a condition of high cholesterol), respiratory failure (a condition in which there is not enough oxygen in the tissues in the body), diabetes (a condition that happens when blood sugar is too high), end stage renal disease (the final stage of chronic kidney disease), and pain. The MDS reflected Resident #2's cognition was moderately impaired with a BIMS score of 11. The MDS further reflected that the resident had a g-tube. Record review of Resident #2's care plan revised on 12/02/26 reflected that she required tube feeding related to dysphagia (swallowing problem). Interventions included assisting with administration of tube feeding per physician orders. Record review of Resident #2's monthly physician's orders for April 2026 reflected the resident was on the following medications:- Apixaban Oral Tablet 5mg; give 1 tablet via g-tube two times a day related to atrial fibrillation (rapid irregular heartbeat)- Atorvastatin Calcium Oral Tablet 40mg; give 1 tablet via g-tube one time a day related to hyperlipidemia - Acetaminophen-Codeine Oral Tablet 300mg-30mg; give 1 tablet via g-tube every 6 hours as needed for pain- Calcium Carbonate-Vitamin D with Minerals; give 1 tablet via g-tube one time a day related to vitamin deficiency During an observation on 04/15/26 at 9:50 AM, revealed LVN C was at the medication cart and crushing 4 pills in a clear pouch and poured them into a clear cup. Upon entering the room, LVN C filled the crushed medication cup with 110 ml of water per the measurement lines on the cup. LVN C put on gloves and used a stethoscope to check Resident #2's g-tube placement. LVN C flushed the g-tube with water and then poured the medication mixture with the 110 ml of water into the g-tube syringe, and used gravity to administer the medications. The resident did not display any signs of discomfort or distress. LVN C then poured a small amount of water into the empty medication cup to clear some of the residual medications and poured it into the g-tube and finally flushed the g-tube with more water. LVN C proceeded to administer the feeding formula. During an interview on 04/15/26 at 1:38 PM, LVN C revealed she always combined and crushed Resident #2's medications. LVN C said she heard other nurses gave the crushed medications one by one but that would take too long, so she would give them all together. LVN C said no one told her she was not supposed to cocktail (mix) them together. LVN C further stated she did not realize she had poured so much water into the cup with crushed medications and usually only poured them in 30 cc of water. LVN C said risks of cocktailing could possibly affect the effectiveness of the medications. During an interview on 04/15/26 at 3:09 PM, the ADON revealed she was not aware LVN C was cocktailing Resident #2's medications. The ADON said g-tube medications should be crushed, put in separate cups, and given one at a time with a water flush in between each medication. The ADON said cocktailed medication could be unsafe. During an interview on 04/15/26 at 4:09 PM, the DON revealed she was not aware LVN C was cocktailing Resident #2's medication and should only be given that way with an order. The DON said the medications should be given one at a time diluted with a small amount of water, 15ml to 30ml and with a water flush at the beginning of, in between each medication and at the end of the medication administration. The DON said the medication should not be cocktailed because there could (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be contraindications and/or medication interactions, or it could be too hard on the resident's digestive system. Record review of the facility's Administering Medications through an Enteral Tube policy, revised March 2015, reflected the following: PurposeThe purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube.3. Do not mix medications together prior to administering through an enteral tube. Administer each medication separately unless resident has physician's orders to mix (cocktail) medication.23. Dilute the crushed or split medication with 15-30 mL room temperature tap water (or prescribed amount).26. If administering more than one medication, flush with 15 mL (or prescribed amount) room temperature tap water between medications.

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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 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, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #1) reviewed for infection control practices. CNA A failed to perform hand hygiene and glove changes while providing Resident #1 with incontinence care and a shower.These failures could place residents at risk of cross-contamination and infections. Findings included: Record review of Resident #1's Face Sheet, dated 04/15/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE].Record review of Resident #1's Quarterly MDS, dated [DATE], reflected the resident's diagnoses included: hemiplegia following cerebral infarction (one-sided paralysis caused by brain tissue damage), non-Alzheimer's dementia (cognitive disorders caused by diseases other than Alzheimer's), and aphasia (language disorder caused by brain damage). The MDS reflected Resident #1 had moderate cognitive impairment with a BIMS score of 8. The MDS reflected she was incontinent of bowel and bladder and was dependent on staff for all care. Record review of Resident #1's Care Plan, revised 04/01/26, reflected the resident was incontinent with interventions for staff to use mild cleansers for perineal care (the cleaning or washing of the genitals and anal area) and that the resident request staff assistance to turn and reposition. During an observation on 04/15/26 at 9:30 AM revealed CNA A and CNA B preparing to take Resident #1 to the shower. After CNA A informed Resident #1, CNA A put on clean gloves, closed the door to the room, and pulled the privacy curtain. The Hoyer lift (a mechanical device designed to safely transfer patients with limited mobility) and shower chair were observed in the resident's room. CNA A prepared the incontinence care supplies on a clean barrier. She then opened Resident #1's brief and began to clean the resident's perineal area. On the last wipe of Resident #1's perineal care, CNA A got brown fecal matter on her gloves. Next, CNA A and CNA B assisted Resident #1 to turn onto her left side. CNA A was observed to reach over Resident #1 and brown fecal matter residue was left on Resident #1's left leg and on the bed pad. CNA A then used new wipes to clean Resident #1's buttocks. Resident #1 had a soft bowel movement (the feces discharged in an act of defecation). Once Resident #1's buttocks were cleaned, CNA A rolled the soiled brief within itself and discarded the brief into the trash. CNA A still had brown fecal matter on her gloves. Without performing hand hygiene or changing her gloves, CNA A obtained a clean brief and placed it under Resident #1's buttocks. CNA A then retrieved the Hoyer sling (specialized fabric used with a Hoyer lift to transfer) and placed it underneath the clean brief. Next, CNA A and CNA B turned Resident #1 and secured her clean brief. While still wearing the same soiled gloves, CNA A retrieved the Hoyer lift, and CNA A and CNA B transferred Resident #1 safely into the shower chair. Without performing hand hygiene or a glove change, CNA A pushed Resident #1 out into the hallway and then into the shower room. CNA A was observed to give Resident #1 a shower while wearing the same gloves she wore while providing the resident with incontinence care. Once Resident #1 was washed and rinsed, CNA A removed her gloves and began to dry Resident #1. CNA did not perform hand hygiene prior to or after providing incontinence care or a shower. CNA A also did not change her gloves or perform hand hygiene when soiled during incontinence care. During an interview on 04/15/26 at 12:24 PM, CNA B revealed he had been working at the facility for one month. CNA B stated gloves should be changed and hands washed when they were visibly dirty. He stated he was not aware that CNA A had fecal matter on her gloves when they were providing Resident #1 with incontinence care. CNA B stated he was trying to keep Resident #1 calm and was not paying attention. CNA B stated if hand hygiene was not performed and gloves were not changed appropriately, that it could cause an infection, cause fungal issues or worsen the resident's condition. During an interview on 04/15/26 at 2:09 PM, CNA A revealed she had worked at the facility for eight years. CNA A stated hand hygiene should be performed before putting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on gloves and when changing or removing gloves. She stated she changed her gloves when going from dirty to clean during incontinence care of if her gloves became soiled. She stated she was supposed to wash her hands when entering or exiting a room. CNA A stated she did not recall seeing bowel movement on her gloves during incontinence care. CNA A stated she forgot to change gloves or wash her hands because Resident #1 was fighting with her and tried to grab her. CNA A stated she was just trying to get things done quickly. She stated not changing her gloves when they were soiled or performing hand hygiene could cause an infection. CNA A stated she has had training on incontinence care. During an interview on 04/15/26 at 3:26 PM, the ADON revealed she expected staff to perform hand hygiene when entering or leaving the room. She stated with any incontinence care, hand hygiene should be performed with any glove changes. The ADON stated gloves should be changed when soiled or when going from dirty to clean. The ADON stated not performing hand hygiene and glove changes appropriately could cause cross contamination, spread germs, and cause infections. She stated there had been recent in-services on incontinence care and infection prevention. The ADON stated the nurse managers were responsible for ensuring incontinence care and infection control measures were followed. The ADON stated she usually did spot checks with the CNAs, but recently she had needed to work the floor, so she had not been able to do the spot checks. The ADON stated she would start back doing the spot checks and continue in-service training with the CNAs. During an interview on 04/15/26 at 4:17 PM, the DON stated she had been working at the facility for three days. She stated her expectation was that staff change their gloves when in contact with any bodily fluids or when going form dirty to clean. The DON stated she expected staff to perform hand hygiene when entering or leaving the room, and with any glove changes. The DON stated she, the ADON, and nurses were responsible for ensuring incontinence care and infection control were done properly. The DON stated it was unacceptable for staff to not change gloves when they were visibly dirty with stool (feces) or when leaving the room. She stated there was a risk for infection if hand hygiene was not performed and gloves were not being changed properly. During an interview on 04/15/26 at 4:48 PM, the Administrator stated she would expect staff to change gloves if they were soiled. She stated hand hygiene was also expected to be performed when entering and exiting a resident's room. The Administrator stated not changing gloves or performing hand hygiene was an infection control and dignity issue. Record review of the facility's Perineal Care policy, revised February 2018, reflected the following: .If resident is heavily soiled with feces, turn resident on side and clean away feces with tissue, wipes, or incontinent brief. Discard soiled gloves along with the soiled brief and/or wipes in trash bag. Cover the resident, provide safety measures and wash hands with soap and water.4. Discard soiled gloves, sanitize hands. Re-glove prior to touching clean linens / adult brief.Record review of the facility's Standard Precautions policy, revised September 2022, reflected the following: .Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care. Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one). Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to other residents or environments.