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	05/05/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to report violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property to the State Survey Agency for 1 of 7 residents (Resident #1) reviewed for abuse and neglect. The facility failed to report an injury of unknown source to HHSC when Resident #1 sustained a dislocated left shoulder on 04/19/26.This failure could place the residents at risk of injuries not being thoroughly investigated and potential neglect. Findings included:Record review of Resident #1's quarterly MDS, dated [DATE], revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included emphysema, dementia, and cognitive impairment. Her BIMS score was 1, indicating severe cognitive impairment. Her Functional Ability assessment indicated she used a manual wheelchair for mobility and was reliant on staff for her ADLs; the resident had no impairment of upper extremities (arms). Record review of Resident #1's care plan, dated 03/19/26, revealed she had a history of past collar bone, and shoulder dislocation with loose hardware in the shoulder. Resident #1 had limited physical mobility, was a high fall risk with no history of falls and was a two-person lift assist with a gait belt. Record review of Resident #1's EHR revealed progress notes:04/18/26 by the ADON Resident c/o pain to left shoulder MD notified and X- Ray ordered STAT. PRN pain medication administered resident made comfortable in bed n/o placed on MAR. Awaiting X-Ray. RP notified no concerns. 4/19/26 by LVN-A Upon getting report from night nurse. X-ray of left shoulder results printed, on coming nurse notified MD at 0647 [AM]. Nurse then goes into resident room to assess resident, notice redness and swelling to left shoulder, grimacing noted by resident upon nurse touching site. Administrator, DON, and NP notified. NP recommended resident be sent out to ER for further evaluation. EMT services called report given. EMT arrives at 1145[AM]. [Family members] called no pick up, message left by charge nurse. Charge Nurse called Hospital ER to give report. Report given to ER charge nurse, at [Hospital].Record review of Fire Department's EMS report, dated 04/19/26, revealed Medic XX dispatched to traumatic injury .Medic XX arrived on scene to find PT [patient] laying [sic] in nursing home bed conscious and alert in no apparent distress. PT has obvious swollen left shoulder with deformity. Staff states i just got here and did not know the events leading up to this morning and that she just got orders to transfer the PT to the hospital for a dislocated shoulder. Other staff stated she arrived at work yesterday and sent the in charge nurse a picture of the injury at 658am and was advised to not call 911 that they would do their own imaging, image does show obvious deformity at that time. PT injury is over 24 hours at this point. PT is normal mentation for history of dementia. PT states she does not hurt anywhere and does not have any head injury signs. Pupils are equal and reactive. PT was moved to stretcher via sheet lift, secured with straps and loaded into ambulance without incident. Vitals are assessed. PT remained calm and did not have any complaints during transport.Record review of Resident#1's hospital records, dated 04/19/26 revealed a left shoulder x-ray was performed and the radiologist noted there was hardware from a rotator cuff repair present and the left shoulder was dislocated. During an observation on 05/05/26 at 11:23 AM, revealed Resident #1 was in her bed, wakes to verbal stimuli, and holding her left hand to (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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her chest. Attempted to shake the resident's left hand was met with a grimace and pulled back. The resident did not answer questions and easily fell asleep. Resident #1 had an arm sling that was off to the side of the resident, not under her left arm. During an interview on 05/05/26 at 11:28 AM, LVN-B stated she was notified by CNA-C of Resident #1's shoulder being discolored and swollen. LVN-B contacted the physician and received orders for a portable x-ray. She stated the report came back indicating a left shoulder dislocation. She stated the resident had not fallen that she knew of. The resident was unable to verbalize what happened. During an interview on 05/05/24 at 11:44 AM, LVN-A stated she received report from the night shift nurse and was told about Resident#1's shoulder being dislocated and no further orders from the physician. LVN-A stated she assessed the resident after report and notified the Administrator of the situation; she was told to contact the nurse practitioner for orders. The Nurse Practitioner ordered the resident be sent to the ER. LVN-A stated Resident #1 normally transferred with two people to assist, using a gait belt. Once in her wheelchair she could move around the facility, using her arms to propel herself. LVN-A stated if Resident #1 had fallen without someone seeing it, she would not have been able to get herself off the floor and back to bed without assistance. LVN-A stated the shoulder might have been dislocated during a transfer. During an interview on 05/05/26 at 12:20 PM, CNA-C stated she was getting Resident #1 ready for bed, changing her into her gown, when she noted the left shoulder was discolored and did not look right. She stated she took a photo of the shoulder and took it to LVN-B to show her. LVN-B stated to leave the resident as is and she would call the physician. She stated later the x-ray company showed up and took the x-ray. The resident slept for the rest of the night. During an interview on 05/05/26 at 1:05 PM, the Administrator stated after the Nurse Practitioner ordered the resident sent to the hospital, 911 was called and the resident was transported. She stated Resident #1 was a fall risk, but had not had a fall in a long time. She stated Resident #1 would wheel herself around the facility with no issues and she was not one to get out of her wheelchair and walk around. The Administrator stated she did not report the injury because the resident had a chronically dislocated shoulder and the physician did not think it was an acute injury, and there was no investigation because it was not new. The Administrator stated there was no policy on reporting injuries, they followed CMS guidelines. During an interview on 05/05/26 at 3:10 PM, the Physician stated he was contacted on 04/18/26 about Resident #1's shoulder and when he looked at the x-ray report he did not feel the dislocation was new as she had a known dislocation of that shoulder. The Physician stated if the shoulder had been dislocated since the report in 2023, she would not have been able to use her left arm to move her wheelchair. The Physician stated the resident most likely reduced the dislocation on her own at some point and had recently dislocated it again. The Physician stated the dislocation was most likely acute, not chronic. Record review of left shoulder x-ray report, dated 11/24/23 reflected the resident's left shoulder was dislocated and the bones were thin. Record review of Resident #1's pain management physician assessment, dated 12/28/23 reflected the resident was able to move her arms and legs without pain. Indicating the shoulder dislocation noted on 11/24/23 was not an issue and may have been reduced by then.