Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675374	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Irving	619 N Britain Rd Irving, TX 75061

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 assures the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for one (Resident #1) of four residents reviewed for medication administration. The facility failed to ensure Resident #1 had received her medications as scheduled and as ordered by her physician. This failure placed residents at risk for decreased quality of life, unrelieved pain and misappropriation or property. Findings included: Review of Resident #1's admission MDS, dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE], with the diagnoses that included cirrhosis of the liver (severe scarring of the liver), metabolic encephalopathy (change in how your brain works due to an underlying condition), chronic hepatitis (long-term inflammation of the liver) and depression (serious mood disorder causing persistent sadness and loss of interest). The MDS assessment reflected Resident #1's BIMs was an 8 indicating moderately impaired cognition. The MDS assessment revealed Resident #1 received antidepressant medication. The MDS assessment revealed Resident #1 received scheduled pain medication. The MDS assessment revealed when Resident #1 was asked Have you had pain or hurting at any time in the last 5 days the answer was no. The MDS assessment revealed resident had experienced PTSD. Review of Resident #1's January 2026 Physician Orders reflected the following: Hydrocodone-Acetaminophen Oral Tablet 7.5-325 MG. Give one tablet by mouth three times a day for pain. Ordered by LVN C on 01/10/26. Review of Resident #1's January 2026 Physician Orders reflected the following: Sertraline HCL Oral Tablet 50 MG. Give one tablet by mouth at bedtime for depression. Ordered by LVN C on 01/09/26. Review of Resident #1's Medication Administration Records for January 2026 documented by MA A and MA B revealed the resident had missed her Hydrocodone-Acetaminophen (pain medication) dose on the following dates:01/12/26 at 2PM and 8PM01/13/26 at 8AM, 2PM and 8PM01/14/26 at 8AM, 2PM and 8PM01/15/26 at 8AM, 2PM and 8PM Review of Resident #1's Medication Administration Records for January 2026 documented by MA B revealed the resident had missed her Sertraline (antidepressant medication) on the following dates:01/12/26 at 8PM01/13/26 at 8PM01/14/26 at 8PM01/15/26 at 8PM Review of Resident #1's Medication Administration Records for January 2026 revealed a pain level of zero for 01/10/26-01/16/26. Review of Resident #1's nursing progress notes dated 01/11/26 - 01/16/26 revealed no indicators of pain or discomfort. Review of Resident #1's Pain Interview dated 01/12/26 revealed Resident #1 was experiencing pain as rarely or not at all. Review of Resident #1's care plan dated 01/08/26 revealed the resident had the following problems addressed: 1) liver disease related to hepatitis with intervention give medications as ordered. Monitor/document effectiveness and side effects. 2) uses antidepressant medication with intervention administer antidepressant medications as ordered by physician. Interview and record review on 01/16/26 at 12:30 PM with the DON of Resident #1's January 2026 physician orders and medication administration records. The DON acknowledged that Resident #1 had an (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: 675374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Irving	619 N Britain Rd Irving, TX 75061

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order as of 01/10/26 for Hydrocodone-Acetaminophen oral tablet 7.5-325 MG, TID for pain. The DON stated that the medication administration times for a medication with an order of TID were 8AM, 2PM and 8PM. The DON reviewed Resident #1's medication administration records and acknowledged that Resident #1 did not receive her Hydrocodone-Acetaminophen as ordered on the following days and times: 01/12/26 at 2PM and 8PM, 01/13/26 at 8AM, 2PM and 8PM, 01/14/26 at 8AM, 2PM and 8PM and 01/15/26 at 8AM, 2PM and 8PM. The DON acknowledged that Resident #1 had an order as of 01/09/26 for Sertraline HCL 50 MG at bedtime. The DON stated that the medication administration time for medication with an order of HS was at 8PM. The DON reviewed Resident #1's medication administration records and acknowledged that Resident #1 did not receive her Sertraline on the following days: 01/12/26 at 8PM, 01/13/26 at 8PM, 01/14/26 at 8PM and 01/15/26 at 8PM. The DON stated that if a medication was administered it would have been signed as given by the MA or nurse on the medication administration record. The DON stated that the expectation is for medications to be given according to physician orders. The DON stated the risk of not following physician orders could result in a drug diversion. The DON stated she did not have any knowledge of Resident #1 not receiving her medications as ordered, therefore she did not know why they were not given as ordered. Observation on 01/16/26 at 12:45 PM with the DON and MA A of Resident #1's medications on MA A's medication cart revealed the DON reconciled Resident #1's number of Hydrocodone-Acetaminophen tablets on hand which confirmed that Resident #1 had not been given her Hydrocodone-Acetaminophen as ordered. The DON reconciled Resident #1's number of Sertraline HCL tablets on hand which confirmed that Resident #1 had not been given her Sertraline HCL tablets as ordered. Interview on 01/16/26 at 1:50 PM with Resident #1 revealed resident was alert and able to answer questions. Resident #1 stated she had just returned from a luncheon/shopping outing with other residents and the Activity Director. Resident #1 stated she had a good time on the outing and was not in any pain. Resident #1 stated she was getting rest and was without pain. Resident #1 stated she was not aware of missing her medications. Resident #1 had no concerns regarding her care. Interview on 01/16/26 at 2:04 PM with MA B revealed she was responsible for Resident #1's medications on the 2PM-10PM shift Monday-Friday. MA B stated she did not know Resident #1's Hydrocodone-Acetaminophen and Sertraline HCL were not given as ordered. MA B stated that when a medication is given it is documented on the medication administration record, and if it is blank then the medication was not given. MA B stated she had seen Resident #1 all week and she did not report any issues with pain or discomfort. MA B stated medications are given according to physician orders. MA B stated the risk of not giving medications as ordered could result in a resident not feeling good. Interview on 01/16/26 at 2:13 PM with MA A revealed she was responsible for Resident #1's medication on the 6AM-2PM shift Monday-Friday. MA A stated she did not know Resident #1's Hydrocodone-Acetaminophen was not given as ordered. MA A stated if a medication is administered then it is documented on the medication administration record, and if there is a blank on medication administration record then it was not given. MA A stated it is her responsibility to give medications according to physician orders. MA A stated the risk of not providing medications as ordered is not meeting the residents' needs. Interview on 01/16/26 at 2:30 PM with the Activity Director revealed Resident #1 did attend an offsite luncheon/shopping trip today. The Activity Director stated Resident #1 did not complain of pain or discomfort while on the outing. The Activity Director stated that Resident #1 enjoyed herself on the outing. Interview on 01/16/26 at 3:25 PM with the DON revealed she just did not understand how MA A and MA B would have missed administering Resident #1's Hydrocodone-Acetaminophen and Sertraline HCL unless there was glitch in the electronic medical record even though no other missed medications had been discovered. Interview on 01/16/26 at 3:30 PM with the ADM revealed he was not aware of Resident #1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675374	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Irving	619 N Britain Rd Irving, TX 75061

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not receiving her medications as ordered. The ADM stated that the expectation was for residents to receive their medications as ordered. The ADM stated that the risk of residents not receiving medications as ordered could result in illness or sickness. Review of facility policy titled Documentation of Medication Administration dated November 2022 revealed A medication administration record is used to document all medications administered. Review of facility policy titled Physician Orders dated November 2014 revealed Purpose: The Purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure resident receives the necessary care and services. 5. Physician orders are essential for the comprehensive care of the residents.