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	02/26/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen.1. The facility failed to ensure the stand-by freezer food items were sealed and labeled. 2. The facility failed to ensure the stand-by refrigerator food items were dated, labeled, and sealed.3. The facility failed to ensure the dry storage food items were sealed.4. The facility failed to ensure that canned good food items were free of dents.5. The facility failed to ensure that serving utensils were used when handling food items.6. The facility failed to ensure staff personal items were not in the food preparation area.These failures could place residents at risk for foodborne illness and foodborne intoxication. Findings included:Observation on 02/24/2026 at 8:40 A.M. of the facility's only kitchen revealed:In the stand-by freezer:large tub of ice cream with the lid not sealed on the containeran unlabeled frozen dinner boxIn the stand-by refrigerator:an unsealed bag of sliced cheese, with no label or datean unsealed bag of deli meata used bag of shredded cheese, with no label or dateIn the dry storage closet:a dented can of chopped tomatoesa dented can of banana puddingan unsealed bag of cerealA backpack under the food preparation table. During an interview on 02/24/2026 at 8:40 A.M. with [NAME] E revealed the backpack was a personal item, and she removed it from under the food preparation counter. She indicated space for staff items was limited but was able to store it outside of food preparation area where staff personal items were kept. [NAME] E said the risk of a dented can was air can get into it and can become contaminated. She said it was important to ensure food was sealed so nothing can get into the food item and to stay fresh. She indicated contamination was a risk to residents because it can cause a foodborne illness. Observation on 02/25/2026 at 11:20 A.M. of the steam tray line revealed [NAME] E used her gloved hands to handle the bread rolls. Interview on 02/25/2026 at 11:30 A.M with the DM revealed [NAME] E should have used tongs to handle the bread rolls because of the risk of cross contamination. The DM said she had seen the frozen dinner in the freezer and threw it away. The DM indicated dented cans and unsealed food items were a risk because of contamination of food items and it was important to keep residents safe. Record review of the facility's Food Storage policy, dated 2023, reflected: Policy:Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Purpose.7. All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods.b. Food should be dated as it is placed on the shelves if required by state regulation.c. Date marking should be visible on all high risk food to indicate the date by which a ready-to-eat TCS food should be consumed, sold or discarded.d. Food will be stored and handled to maintain the integrity of the packaging until ready for use. Food stored in bins may be removed from its original packaging. 13. Refrigerated and storage:.f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded. 14. Frozen Foods:.c. All foods should be covered, labeled and dated. All foods will be checked to assure (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	thatfoods will be consumed by their use by dates or discarded. Record review of the facility's General Food Preparation and Handling policy, dated 2023, reflected: Policy:Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and keep free of harmful organisms and substances. Procedure:.h. Bare hands should never touch ready to eat raw food directly. Disposable gloves are a single use item and should be discarded after each use. Employees should wash their hands prior to putting gloves on and after removing gloves.i. Food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas or other suitable implements to avoid manual contact of prepared foods. Any utensil or serving dish must be thoroughly cleaned and sanitized prior to use.

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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 - Many	Provide and implement an infection prevention and control program. Based on interviews and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections in 1 of 1 facility reviewed for water management. The facility failed to implement a water management program including: 1.) An assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread; and2.) to implement measures to prevent the growth of opportunistic waterborne pathogens (control measures), and how to monitor them. This failure could place residents at risk of waterborne illness. Findings included: In an interview on 2/25/2026 at 11:53 a.m., the Maintenance Director stated that the document titled, Water Management Program was the water management plan. The Maintenance Director was not aware of any type of water management binder and could not state any interventions which were currently being utilized in a water management plan. He could not provide any facility risk assessment related to the water management plan. In an interview on 2/25/26 at 11:55 a.m., The DON stated she was the Infection Control Nurse for the facility, and she had no information or involvement in any facility water plan. She stated that she could not provide any information about the facility's water management plan that it is handled by the ADM. In an interview and record review on 2/25/2026 at 4:39 p.m., the ADM provided a binder as evidence of a water management program which included a policy titled, Water Management Program with date implemented written in as 2/25/26. The binder also contained a document titled, Developing a Water management Program to Reduce Legionella Growth and Spread in Buildings dated 6/4/2021 by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention. The binder included a facility water flow diagram. There was no diagram or other indication that the facility had completed a facility risk assessment of where Legionella and other water-pathogens grow and spread. The binder did not include measures to be implemented as part of the water management program. The ADM was unable to provide this assessment, identified measures, or any documentation of activities related to a water management program. The ADM stated that, We don't need a plan. We don't have Legionella. The ADM stated there were no rooms closed or unused at the facility, and no residents had experienced Legionella infection this past year.Record review of a Policy titled, Water Management Program (undated) stated that, A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. The policy stated, A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic water pathogens could grow and spread in the facility's water system and Control measures will be applied to address potential hazards at each control point. The policy stated, Documentation of all the activities related to the water management program shall be maintained with the water management program binder for a minimum of three years.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions and ongoing monitoring were provided for 1 of 1 resident (Resident #2) reviewed for dialysis services.The facility failed to obtain physician orders for fluid restriction.The facility failed to monitor his fluid intake. This failure could result in fluid overload in the body and residents not being able to maintain the highest practicable level of well-being. Findings included:Record review of Resident #2's face sheet, dated 02/26/2026 revealed a [AGE] year-old male. He was admitted on [DATE] with a principal diagnosis of end stage renal disease (final stage of renal disease, kidneys cannot function adequately to sustain life without treatment). Other pertinent diagnoses included dependence on renal dialysis, cognitive communication deficit (cognitive impairment), altered mental status, hypertension (high blood pressure), and need for assistance with personal care. Resident #2's care providers included NP D. Record review of Resident #2's orders reflected: PATIENT GOES TO [Dialysis facility] DIALYSIS MONDAY, WEDNESDAY, FRIDAY. Order date: 10/09/2025. Orders did not include monitoring or restricting fluid intake. Record review of Resident #2's care plan revealed Resident # 2 had impaired renal function; he receives dialysis (treatment machine removes waste product and excess fluids from the body due to kidneys being unable to) three times per week. He was at risk for increased shortness of breath, chest pains, blood pressure, itchy skin, nausea and vomiting, impaired cognition, infection to shunt site (permanent access created surgically to facilitate blood flow for dialysis), and decreased urine output. Interventions included to administer medications per order, monitor labs, to assess his shunt site, ensure Resident #2 was aware of dietary recommendations/restrictions related to disease process, to monitor compliance with fluid restriction per MD order, and monitoring resident conditions pre and post dialysis, report abnormalities to MD. Record review of Resident #2's progress note dated 02/23/2026 reflected:- Effective Date 02/09/2026: Pt. out of facility per transportation in route to [sic] dialyis. Pt.'s dialysis center called and stated pt. has a scheduled treatment for tomorrow at 11:40 am and completion time between 4:30pm and 4:45pm. [sic]- Effective Date 02/23/2026: Dialysis center called and informed this nurse that resident is to return to dialysis tomorrow 2/24/2026 at 12:00 pm because he has a lot of fluids. Adon notified.Progress notes revealed Resident #2 received additional dialysis treatments on Tuesday 02/10/2026 and Tuesday 02/24/2026. Progress notes did not reflect the dialysis communication forms notes for fluid restrictions or notifying the MD or NP of dialysis recommendations. Record review of Resident #2's dialysis communication notes revealed 13 of 36 dialysis notes under Dialysis Center to Complete for Facility. Recommendations indicated Resident #2 needed to restrict fluids. Notes reflected: 12/1/2025 - control fluid intake; very high fluid intake, limit fluid12/12/2025 - fluid intake restriction 32 ounces per day12/17/2025 - fluid restriction12/19/2025 - restrict fluid intake12/23/2025 - fluid restriction12/28/2025 - fluid restriction01/05/2026 - fluid restriction01/9/2026 - fluid restriction01/12/2026 - fluid restriction01/30/2026 - fluid restriction reinforced02/10/2026 - fluid restriction reinforced to the pt02/20/2026 - fluid intake restriction02/24/2026 - fluid restriction reinforced During observation and interview on 02/25/2026 at 6:31 P.M. with Resident #2, he said he felt great after dialysis. He indicated he went to dialysis on Monday, Wednesday, and Fridays. He said this week he had gone on Tuesday because of the extra fluid in his body. Resident #2 did not confirm nor deny that he had been educated to restrict fluids; he said he used to work out and ride his bike and would sweat out fluids. Resident #2 indicated it was hard to go 2 days (Saturday and Sunday) without dialysis due to swelling (fluid retention) in his ankles. Observation of Resident #2 revealed minimal swelling in ankles. During an interview on 02/25/2026 at 6:44 P.M. with RN A, she said Resident #2 returns from dialysis with paperwork and that was how they communicate with dialysis. She said she reviews (the communication form), charts and checks Resident #2's vitals. RN A said she had seen dietary restrictions but Resident #2 was noncompliant and they have to remind him (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about fluid restrictions. She indicated she did not upload everything into PCC because Resident #2 had a dialysis binder that was utilized. RN A said nurses report what was on the dialysis communication form by giving reports every time nurses take a shift, they tell them about changes in a resident and to remind Resident #2 to watch how many cups of fluids he drinks. She indicated Resident #2's fluid restrictions were put into the 24-hour report in case a nurse forgets he was on a fluid restriction. During an interview on 02/26/2026 at 11:40 A.M. with LVN B, she said Resident #2 sometimes goes to dialysis an extra day a week because he had more fluid in his body than what dialysis could pull off, so he goes back to get more taken off. She said she had not seen fluid restrictions for Resident #2, and no one had discussed him being on fluid restrictions. LVN B said if Resident #2 came back from dialysis with anything on the communication form, it should be on the 24-hour report and documented in the progress notes. LVN B said if Resident #2's fluids were restricted, an order would be put in, direct care staff would monitor, nursing and dietary staff would give the resident a certain amount of fluid, and the MAR would reflect how much the resident was allowed to receive/restrict. LVN B indicated the importance of the dialysis communication form was it was how the dialysis center communicated with the facility and there may be orders the dialysis center wanted the facility to carry out; it was for the resident's care at the facility and at dialysis. The state surveyor requested records of 24-hour reports on 02/26/2026 at 11:58 A.M. The RNC said those were in-house documents that were not given to state surveyors. During an interview on 02/26/2026 at 1:33 P.M. with NP D revealed she provided direct care for Resident #2. She said she was not aware of Resident #2's recommendation from dialysis regarding a fluid restriction. NP D said the nurses did not communicate the fluid restriction recommendations with her. NP D said when dialysis writes notes in the communication form, nurses can put an order in or let her or the MD know about what dialysis recommends if they were not comfortable putting in an order. She said fluids can be monitored by a log of how much fluid was consumed. She indicated fluid and food management was important for Resident #2 because if he did not go to dialysis, there would be swelling (fluid retention), overload on the heart, and all complications that come with it (end stage renal disease). During an interview on 02/26/2026 at 1:52 P.M. with the RD she revealed she was now the RD for Resident #2 and had not seen him yet. She indicated she had not been notified of issues regarding Resident #2's food and fluid intake but (nutrition) education can be provided for him. The RD stated it would be difficult for her to monitor fluid intake and indicated facility staff would monitor fluid intake. During an interview on 02/26/2026 at 2:39 P.M. with the ADON, she said Resident #2 goes to dialysis on Monday, Wednesday, and Fridays, but went to dialysis on Tuesday due to fluid overload. The ADON indicated there was communication form for Resident #2 to take with him to dialysis and the form included assessments of his dialysis shunt and vital signs (i.e. blood pressure). She said the form was put into his dialysis binder (when returning from dialysis). The ADON indicated if there were changes on orders, the nurse would put the orders in, report it to the oncoming nurse, and put it in Resident #2's progress notes. The ADON said she had not seen fluid restrictions on the communication forms, but he was on fluid restrictions and if it was an order, it should be in Resident #2's orders. During an interview on 02/26/2026 at 2:49 P.M. with the DON revealed Resident #2 was not on a fluid restriction and the communication form was for head-to-toe assessment on the resident pre and post dialysis. The DON said she had not seen anything about fluid restrictions on Resident #2's dialysis communication notes and she reviewed the notes. She said there was not an MD order for fluid restrictions and had not received an MD order for fluid restrictions. The DON said the dialysis communication form was for pre and post resident assessments and even if dialysis made a recommendation, it was not an MD order. She then said the MD and NP were aware of the fluid restriction, but NP D was not Resident #2's NP. The DON said if there was no crackling (in lungs), no edema (fluid retention), nothing different with Resident's BP, then nurses do not feel like the Resident had fluid overload. She stated Resident #2 did go to dialysis on Tuesday due to a fluid overload.The DON said the facility communicates with dialysis through the communication forms. She said for any (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dire situation, they call, but if it was not dire then the dialysis center writes on the form. She said the form was pertinent to Resident #2's well-being. The DON indicated if dialysis made recommendations on the communication form, nurses reach out to the MD and the MD will decide on implementing the recommendations. She said she had not heard of nurses reaching out to the MD. The DON said that if a recommendation was not conveyed it could delay care if Resident #2 did need it (what dialysis recommended). Record review of the facility's Long Term Care Facility Outpatient Dialysis Services Care Coordination Agreement, dated 02/26/2026, reflected: This Agreement is made by and between [Nursing Facility] (Operator) and [Dialysis Company] (Company), expressly for the purpose of care coordination as provided in 42 C.F.R S 483.70(f), and is effective upon the date of last signature (Effective Date) .Operator and Company agree as follows:A. Definition of Renal Dialysis Services.a. includes items and services, such as drugs, biological and laboratory services, for the treatment of end stage renal disease which are ordered by, or in coordination with , the physician or non-physician practitioner responsible for managing the Resident's nephrology care; andb. does not include services that are not essential for the delivery of maintenance dialysis, such as respiratory therapy and monitoring, similar specialized services, sitter services, and transportation of Residents to and from Dialysis Facility. B. Obligations of Operator's Long Term Care Facility1. Information Sharing. For the purpose of care coordination, in advance of each Resident's dialysis treatment, Long Term Care Facility shall furnish all information and documentation necessary for Dialysis Facility to provide safe and appropriate care, including any and all information reasonably requested by Dialysis Facility.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for (1 (Wheelchair #1) of 5 wheelchairs observed for safe operating condition.The facility failed to maintain a working brake on the left wheel of Resident #1's wheelchair.This failure could place residents using wheelchairs at risk of falls and injuries.The findings were: Review of Resident #1's Face Sheet reflected he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses in part including cerebral infarction (stroke), difficulty in walking, unsteadiness on feet, other lack of coordination, and cognitive communication deficit (impairment in communication).Review of Resident #1's Quarterly MDS dated [DATE] reflected Resident #1 had functional limitations in range of motion of his lower extremities and normally used a wheelchair. His BIMS was not assessed because he was never/rarely understood. In an interview and observation on 2/24/2026 at 12:00 p.m., Resident #1 used gestures to indicate that the left wheelchair brake of the wheelchair he was sitting in was broken. The right brake was observed working, but the left brake did not stop the movement of the tire. He indicated that he had told staff (unknown name) in the nursing department but that he had not told the therapy department. He indicated the brake had been broken for about one week. Resident #1 denied he had experienced any injury or fall related to the broken wheelchair brake. In an interview on 2/24/2026 at 01:00 p.m., ST A stated she had completed Resident #1's evaluation for therapy on 12/19/25 and that while he could self-wheel a wheelchair he could not ambulate or transfer independently. She stated she was not aware that Resident #1's wheelchair brake was not working until he had told her this morning (2/24/2026). She stated she had informed the DOR. She stated that a broken brake on a wheelchair could place a resident at risk for falls. She stated she was not aware of any injuries or falls related to Resident #1's broken wheelchair brake.In an interview on 2/24/26 at 01:10 p.m., the DOR stated that Resident #1 has tremors and pushes down too hard on his wheelchair brakes and this is the second time in the past one to two weeks that they will have replaced his wheelchair brake. She stated that any direct care staff who noted a broken wheelchair brake could notify their supervisor and put in an electronic work order to the maintenance department. She stated that the risk to a resident of a wheelchair with a broken brake would be a risk for falls. She stated she did not believe that Resident #1 had ever had an injury or fall due to the broken brake. She stated that Resident #1 had a history of falls, and she related this to him being very impulsive and not wanting to wait for assistance. In an interview and observation on 2/24/2026 at 01:20 p.m., Resident #1 was observed sitting in the dining room in his wheelchair while the Maintenance Director completed the repair on his wheelchair brake. He stated that he had just replaced a brake on Resident #1's chair about a week ago. The Maintenance Director stated that any staff who noted a broken wheelchair brake were responsible for reporting it and could put in an electronic work order for maintenance. He stated that he can sometimes repair the chair and at other times the chair will be switched out and the administrator notified. In an interview on 2/25/2026 at 09:31 a.m., the DON stated that on 2/24/26 at approximately 08:00 a.m., Resident #1 had gestured to her that his wheelchair brake was broken, and she had notified the DOR at that time. In an interview and observation on 2/25/26 at 09:39 a.m., the Maintenance Director showed the surveyor the electronic maintenance record on his laptop stating he could not print it. The record reflected that an electronic work for resident's wheelchair brake was created on 02 /24/2026 at 01:40 p.m. by the DOR. The Maintenance Director stated that he first became aware of the broken brake on Resident #1's wheelchair at approximately 01:00 p.m. on 02/24/26 when he was told verbally by the DOR. He stated this was approximately 20 minutes prior to receiving the notification in the electronic maintenance log. He stated he is responsible for monitoring facility equipment including wheelchairs for needed repairs and that he does this monthly. He also stated that the therapy department also monitors equipment for needed repairs when working with (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. He stated that if a resident's wheelchair brake was broken, the resident could be at risk for falls. In an interview on 2/25/26 at 10:00 a.m., the ADM reported that when a staff member noticed an issue or damaged equipment such as wheelchairs, they were to place an electronic maintenance request (work order). He stated that any staff that noticed broken equipment was to place a work order. He stated that maintenance was responsible for monitoring broken equipment and that the maintenance department typically responded the same day.Review of facility policy titled, Accommodation of Needs revised March 2021 stated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. The facility did not provide a policy on equipment maintenance or repair when requested.