

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Avir at Richland Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 7146 Baker Blvd Richland Hills, TX 76118	
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 0584 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, comfortable, and homelike environment, for daily living for three (Resident#1 room, Resident#2 room and Resident# 3 room) of sixteen resident rooms reviewed for environmental concerns. The facility failed to maintain Resident#1, Resident#2 and Resident#3 room at temperatures levels ranging of 71 F to 81 F. This failure could put residents at potential risk associated with temperature extremes, like hypothermia or overheating. Findings included: Resident #1 Record review of Resident #1's admission record dated [DATE] revealed, he was a [AGE] year-old male, initially admitted on [DATE] and readmitted on [DATE] with diagnoses, which included but were not limited to: Parkinson's disease without Dyskinesia (the condition where individuals experience the symptoms of Parkinson's but do not exhibit the involuntary movements often associated with long-term treatment, particularly with levodopa), without mention of fluctuations, chronic pain syndrome (long-term condition characterized by persistent pain that lasts for months or years, significantly affecting daily life.), and legal blindness, as defined in USA. Record Review of Resident#1 MDS dated [DATE] revealed, he had a BIMS of 13 indicates cognitively intact. Resident #2 Record review of Resident #2's admission record dated [DATE] revealed, he was a [AGE] year-old male, admitted on [DATE] with diagnoses, which included but were not limited to schizoaffective disorder (hallucinations and delusions, and mood disorder symptoms), unspecified, chronic pain syndrome (long-term condition characterized by persistent pain that lasts for months or years, significantly affecting daily life.), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest.), recurrent, moderate and bipolar disorder (mental health condition characterized by extreme mood swings that include emotional highs (mania or hypomania) and lows (depression), current episode manic serve with psychotic features. Record Review of Resident#2's MDS dated [DATE] revealed, he had a BIMS of 12 indicates moderate cognitive impairment. Resident #3 Record review of Resident #3's admission record dated [DATE] revealed, she was a [AGE] year-old female, admitted on [DATE] with diagnoses, which included but were not limited to Type 2 Diabetes Mellitus with Ketoacidosis without coma (characterized by high ketone levels and symptoms like excessive thirst and frequent urination), adjustment disorder with depressed mood, adjustment disorder with depressed mood (short-term symptoms that affect your thoughts, behaviors and emotions) and Personal history of Transient Ischemic Attack (TIA)- (a short period of symptoms similar to those of a stroke. It's caused by a brief blockage of blood flow to the brain), and cerebral infraction without residual deficits. Record Review of Resident#3's MDS dated [DATE] revealed, she had a BIMS of 13 indicates cognitively intact. Record review of maintenance logs dated, [DATE] to [DATE] reflected no documentation of room temperature checks or AC unit concerns. Observation of Initial Walk through of facility on [DATE] at 9:45 am revealed rm# 119, rm# 205, rm# 206, rm# 216, rm#223, rm# 229 had portable fans in rooms. Observed rm# 221 had window units in the room. Observed floor fan at the entrance of the facility and at the two nurse's station. Observation revealed playmates at both nursing station were full of ice. Interview and observation on [DATE] at 11:30 am with the MD revealed the facility had AC unit issues for the last 3 weeks. The MD stated he did not have an exact date. The MD and surveyor completed a walkthrough of the facility and checked the temperatures. The MD read the temperature for Resident#3 room at 86.3F. The MD read the temperature in Resident#1 room at 92 F on A side and 89 F for Resident#2 room on B side. Interview and observation on [DATE] at 12:00 pm, Resident #1 stated he was miserable, and his roommate was miserable. Observed both residents had portable fans facing them. Observed Resident#2 with no t-shirt on and sweating. Resident#2 stated he was hot. Resident#1 stated he was asked if he wanted to move rooms, and he told staff no. Resident#1 stated he did not want to be separated from Resident#2. Resident#1 stated he was not asked about a window unit. Interview on [DATE] at 1:56 pm, the AC/HT Technician stated he had to wait on the facility to get the curb order in. The AC/HT Technician stated he was due to return to the facility on Wednesday on [DATE] to complete the repairs. The AC/HT Technician stated it should take a full day to complete. Interviews on [DATE] between 2:00 pm to 3:00 pm, LVN A, LVN B, LVN C, CNA D, CNA E, CNA F, and CNA G stated residents on 200 hall south have complained of being hot and staff reported to the MD. The Staff reported the facility did get hot sometimes, but the floor fans help combat the heat. Staff stated Residents are offered more hydration throughout the day. Observation and interview on [DATE] at 3:30 pm with the MD revealed Resident#3 room temperature read 82.9. Observation revealed the facility added a window unit to</p>		