STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675840	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Richland Hills	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two (Resident #12 and Resident #13) of ten residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #12 and Resident #13's rooms were in a position that was accessible to the residents on 02/03/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #12 Record review of Resident #2's Face Sheet, dated 02/03/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with history of falling and fracture (broken bone) of the rib.Record review of Resident #12's Quarterly MDS Assessment (tool used to assess health status), dated 01/30/2026, reflected the resident had a severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS (tool used to assess cognitive status) score of 00. The Staff Assessment for Mental Status denoted the resident was severely impaired in decisions regarding tasks of daily living. The Quarterly MDS Assessment indicated the resident needed assistance for transfer, bed mobility, toileting hygiene, shower, dressing, and personal hygiene.Record review of Resident #12's Comprehensive Care Plan, dated 01/30/2026, reflected the resident was at risk for falls and had a communication problem. One of the interventions for both focus was to be sure the resident's call light was within reach.During an observation and interview on 02/03/2026 at 9:23 AM, revealed Resident #12 was sitting in his wheelchair, awake. It was observed that the resident's call light was on top of his bed. It was also observed that the cord of the call light was between the resident and his roommate's bed frame. When asked where his call light was, the resident shook his head. During an observation and interview on 02/03/2026 at 9:35 AM, CNA C stated call lights should always be within reach of the residents because that was how they called the staff if they needed something. She said without the call lights, the residents might be upset or might fall if they tried to do things by themselves. She went inside Resident's #12's room and saw the call light was not on top of the resident's bed and the cord was between the two beds. She pulled the call light and put it where the resident could reach it. She said, maybe, the call light fell when she fixed the resident's bed. She said she should have made sure the call light was with the resident before leaving the resident's room. She said the call lights were for all residents, dependent or independent. She said dependent residents might be having a distress and would not be able to call the staff. She said she was responsible in making sure the call lights were within reach for the residents assigned to her.Resident #13 Record review of Resident #13's Face Sheet, dated 02/03/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with epilepsy (brain disorder caused by abnormal electrical signals in the brain), muscle weakness, lack of coordination, repeated falls, and difficulty in walking.Record review of Resident #13's Quarterly MDS Assessment, dated 01/28/2026, (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected the resident had a severe impairment in cognition with a BIMS score of 00. The Staff Assessment for Mental Status denoted the resident was severely impaired in decisions regarding tasks of daily living. The Quarterly MDS Assessment indicated the resident needed assistance for transfer, bed mobility, toileting hygiene, shower, dressing, and personal hygiene.Record review of Resident #13's Comprehensive Care Plan, dated 01/12/2026, reflected the resident was at risk for falls and one of the interventions was to be sure that the call light was within reach.Observation and interview on 02/03/2026 at 9:53 AM revealed Resident #13 was in her bed, awake. It was observed that the resident's call light was on the floor. When asked where her call light was, the resident just shrugged her shoulders.Observation and interview on 02/03/2026 at 9:56 AM, the DON stated call lights were important for the residents because the residents used them to call the staff when they needed something or needed assistance. He said the residents might fall trying to get the call light or trying to do some activities that needed assistance. He said the nurses and the CNAs were responsible in making sure the call lights were within reach. He went inside Resident #13's room and saw the call light on the floor. He picked it up and put it where the resident could reach it. He then said the resident was sleeping and might not need the call light and the resident was alert and able to communicate well so he did not see the problem if her call light was on the floor. He said he would still do an in-service about call lights.In an interview on 02/03/2026 at 4:48 PM, the Administrator stated call lights should be within the reach of the residents at all times in case they need help. She said sometimes the residents would knock them down when they move so the staff should make sure the call lights were secured that even the residents moved, they would not fall. She said the call lights were for the dependent residents more than the independent residents because the independent residents could yell or go to the nurse's station. She said the call lights should be monitored throughout the day by the CNAs and the nurses. She said she would start an in-service after the interview.Policy for call lights within reach requested on 02/03/2026 at 12:32 PM via email to the Administrator and verbally requested on 02/03/2026 at 4:48 PM from the Administrator. the Administrator said they do not have a policy regarding the call light within reach.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of hazards as was possible for one (Resident #9) of ten residents and one (LVN A) of three LVNs reviewed for accident hazard. The facility failed to ensure Resident #9 did not have a can of Off insect spray on his bedside table on 02/03/2026. The facility failed to ensure LVN A did not leave a container of germicidal wipes (cleaning wipes designed to eliminate bacteria, viruses, and fungi) on top of her cart on 02/03/2026.These failures could prevent the residents from having an environment that was free from toxic chemicals. Findings included:Resident #9Record review of Resident #9's Face Sheet, dated 02/03/2026, reflected a [AGE] year-old male who admitted on [DATE]. The resident was diagnosed with dementia (decline in cognitive function that interferes with daily life).Record review of Resident #9's Comprehensive MDS Assessment, dated 11/26/2025, reflected severe cognitive impairment with a BIMS score of 06. Section GG (Functional Abilities) indicated the resident was independent with mobility, eating, dressing himself, and toileting. He required assistance with showers and personal hygiene. Record review of Resident #9's Comprehensive Care Plan, dated 01/03/2026, reflected the resident had a communication problem related to cognitive deficit, developmental and intellectual impairment as evidenced by impaired ability to make himself understood or understanding others. An intervention was to Request clarification from the resident to ensure understanding. Turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate. Use simple, simple, brief, consistent words/cues.During an observation on 02/03/2026 at 10:29 AM, Resident #9 was not in his room. The bedside table was placed against the wall. There were several personal items on the bedside table. A can of insect repellant was also on the bedside table. During an interview on 02/03/2026 at 11:23 AM, the DON stated most residents on the hall were alert and oriented and bought things for themselves or family did. He stated all residents were assessed on admission and if a resident started to wander from room to room, they were moved to the memory care unit. The DON was shown a picture of the insect repellant on the bedside table and entered Resident #9's room with the surveyor. Resident #9 was not in his room. The insect repellant had been removed from the bedside table. When asked about the insect repellant, the DON stated the resident had the right to have a home like environment. During an interview on 02/03/2026 at 5:10 PM, the Administrator stated in the past staff had removed items the resident's family member brought to his room. When asked if the resident should have insect repellant in his room, she stated the facility paid a lot of money for pest control and the resident did not need insect repellant. She stated the facility did not have a policy related to the resident having it in his room. LVN AAn observation on 02/03/2026 at 11:47 AM revealed LVN A was about to change a resident's colostomy bag. She went inside the room and closed the door. It was observed that a container of germicidal wipes was on top of a cart when LVN A closed the door and left her cart unattended. When she was about to start, she realized that there was no gown inside the resident's room. She went out of the room and went to get a gown. She left the germicidal wipes unattended on top of the cart she was using as she returned to the room. During an observation and interview on 02/03/2026 at 11:59 AM, LVN A stated she should have secured the germicidal wipes before leaving the cart unattended because residents might think they were ordinary wipes and use them to clean their eyes, nose, ears, skin, and perineal area (area between the legs). She said it might cause irritation and toxicity. She said anything that indicated Keep out of reach of children. should be considered harmful because the facility had confused residents that may not know the outcome if the germicidal wipes were used. She took the container of germicidal wipes and put it inside (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the cart.In an interview on 01/08/2026 at 12:09 PM, the DON stated that the containers of germicidal wipes should not be placed or left on top of the cart because they have chemicals that could cause adverse effects if consumed or had contact with the skin, eyes, and mouth. He said the container of germicidal wipes was closed but somebody could open it and pull some wipes with their bare hand. She said the wipes were handled with gloves on because they had chemicals on them to eliminate germs on surfaces. He said the containers should be inside the carts. He said he would start an in-service about not leaving any germicidal wipes on top of the carts for resident safety.In an interview on 02/03/2026 at 4:48 PM, the Administrator stated the germicidal wipes with purple tops were used to clean some items that were used from one resident to another. She said she was not aware of the harm it could cause and did not want to speculate.Policy for storage of germicidal/disinfectant wipes requested on requested on 02/03/2026 at 12:32 PM via email to the Administrator and verbally requested on 02/03/2026 at 4:48 PM from the Administrator. The Administrator said they do not have a policy regarding storage of germicidal/disinfectant wipes.Record review of Safety Data Sheet on 01/21/2026 reflected Safety Data Sheet (SDS) Medline Micro-Kill Two Germicidal Wipes . Section 2. Hazards Identification . Classification . acute toxicity - oral . eye irritant . flammable liquids . Hazard Statements: Causes serious eye irritation . Flammable liquid and vapor . May cause drowsiness or dizziness . Storage: Keep out of the reach of children.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #4) of eight residents reviewed for respiratory care.The facility failed to ensure Resident #4's BiPAP (noninvasive ventilation that helps you breathe) face mask and oxygen tubing were stored in a bag when not in use on 02/03/2026. This failure could place residents at risk for respiratory infection and not having their respiratory needs met.Findings include:Record review of Resident #4's face sheet, dated 02/03/2026, reflected a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE]. She had diagnoses which included mild persistent asthma (airway becomes narrow and makes it difficult to breathe) and respiratory disorder (affects how well the lungs work and the ability to breathe). Record review of Resident #4's Quarterly MDS Assessment, dated 12/02/2025, reflected intact cognition with a BIMS score of 15. Section O (Special Treatments, Procedures, and Programs) reflected the use of oxygen therapy and a non-invasive mechanical ventilator.Record review of Resident #4's Comprehensive Care Plan, dated 11/26/2025, reflected the following:*resident required the use of BiPAP related to sleep apnea (interruptions in breathing during sleep). An intervention was to administer the BiPAP face mask at bedtime and as needed during naps. *resident was at risk of breathing difficulties/complications related to asthma with shortness of breath and allergies. An intervention was to administer oxygen at 2-3 liters via nasal cannula continuously. Record review of Resident #4's Physician's Orders, dated 05/10/2021, reflected to administer oxygen at 2-3 liters via nasal cannula continuously every shift. Record review of Resident #4's Physician's Orders, dated 07/13/2024, reflected noninvasive ventilation was to be administered via face mask at bedtime every night shift and as needed during naps for shortness of breath. During an observation and interview on 02/03/2026 at 10:01 AM, Resident #4 was sitting in her wheelchair in her room asleep. Resident #4 was receiving oxygen via the portable oxygen tank on the back of her wheelchair. The oxygen tubing, connected to her oxygen concentrator, was on the floor unbagged. The resident's BiPAP mask was on the nightstand unbagged. LVN A entered Resident #4's room and stated the BiPAP should have been in a bag. She stated the resident used it at night and removed the BiPAP mask herself. She stated the resident did not use the oxygen concentrator very often, but the oxygen tubing should have been in a bag. LVN A picked up the oxygen tubing from the floor and stated she was going to throw it aways and get new tubing. She stated it was important to keep the items covered in a bag for infection control. During an interview on 02/03/2026 at 11:23 AM, the DON stated the nurses were responsible for ensuring the respiratory items were stored in a bag when not in use. He stated it was to prevent infection. During an interview on 02/03/2026 at 11:29 AM, the ADON stated the respiratory items should have been bagged when not in use. She stated the resident removed the respiratory items. She stated the nursing staff must ensure the items were placed in a bag. She stated anyone who sees respiratory items unbagged should tell the nurse. She stated it was important to keep them from getting dirty and causing infection.During an interview on 02/03/2026 at 5:10 PM, the Administrator stated it was the nurse or aides responsibility to ensure the items were bagged. The Administrator stated she had contacted the regional office and they did not have a policy about storing respiratory items when not in use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for two (Residents #11 and Resident #14) of ten residents reviewed for medication storage. 1. The facility failed to ensure that Resident #11's pain relieving spray was not on top of the resident's drawer on 02/03/2026.2. The facility failed to ensure that Resident #14's pain reliving roll-on was not on top of the resident's overbed table on 02/023/2026.These failures could place the residents at risk of misuse of medications and possible adverse reactionsFindings included: 1. Record review of Resident #11's Face Sheet, dated 02/03/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with chronic pain, gout (form of inflammatory arthritis [inflammation of the joints] commonly affecting the big toe), and depressive disorder (persistent feeling of sadness or loss of interest).Record review of Resident #11's Comprehensive MDS (tool used to assess health status) Assessment, dated 12/17/2025, reflected the resident had a severe impairment in cognition with a BIMS (tool used to assess cognitive status) score of 00. The Comprehensive MDS Assessment indicated the resident had chronic pain, gout, and depressive disorder, and would frequently experience pain at any time.Record review of Resident #11's Comprehensive Care Plan, dated 01/20/2026, reflected that the resident was on pain medication and one of the interventions was to administer analgesia. The resident had no care plan for self-administration of medications.Record review of Resident #11's Physician Order on 02/03/2026 reflected the resident did not have an order for pain relieving spray.Record review of Resident #11's Clinical Assessment Notes on 02/03/2026 reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications.An observation on 02/03/2026 at 9:46 AM, revealed Resident #11 was not inside his room. It was observed that there was a container of a pain-relieving spray on top of the resident's drawer and was on plain view. The drawer was just few steps from the door, and the pain-relieving spray was visible from the hallway.In an interview on 02/03/2026 at 3:16 PM, Resident #11 stated he used the pain-relieving spray for sometimes pain to his back. He said he would always put it on top of his drawer. He said he was not sure if the nurses knew about it but it had always been inside his room.2. Record review of Resident #14's Face Sheet, dated 02/03/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with osteoarthritis (a type of arthritis that happens when the cartilage that lines your joints is worn down and your bones rub against each other) and fracture of the right hip.Record review of Resident #14's Comprehensive MDS Assessment, dated 12/02/2025, reflected the resident was cognitively intact with a BIMS. The Comprehensive MDS Assessment indicated the resident osteoarthritis and fracture of the right hip and would frequently experience pain at any time.Record review of Resident #14's Comprehensive Care Plan, dated 01/20/2026, reflected that the resident was on pain medication and one of the interventions was to administer analgesia. The resident had no care plan for self-administration of medications.Record review of Resident #14's Physician Order on 02/03/2026 reflected the resident did not have an order for pain relieving spray.Record review of Resident #14's Clinical Assessment Notes on 02/03/2026 reflected no assessment for self-administration of medications or an assessment that the resident was competent to manage their own medications.During an observation and interview on 02/03/2026 at 10:02 AM, revealed Resident #14 was in her bed, awake. It was observed that a pain reliving (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	roll-on was on top of her overbed table that was at her bedside. The resident said she would sometimes use the pain reliever on her arthritic knees. She said the staff knew she had a pain reliever with her.During an observation and interview on 02/03/2026 at 10:38 AM, LVN B stated the pain reliever spray and roll-on should not be inside residents' rooms and should be inside the nurses' carts because the nurses were supposed to be the ones administering them. She said it was the first time she heard about the pain relivers inside Resident #11 and Resident #14's rooms. She said she did not notice them when she would check on the residents. She said the residents might use them more than the recommended and could result in skin redness or dryness. She said confused residents might consume them as well that could result to upset stomach and nausea. LVN C said she would go to the residents' rooms, talk to them, and would get the medications.In an interview on 01/08/2026 at 12:09 PM, the DON stated medications should not be stored inside the residents' rooms because residents might use them inappropriately that could result in adverse reactions. He said the pain relievers should be inside the carts and the staff should be administering them he said he would start an in-service about medication storage. He said he would start an in-service.In an interview on 02/02/2026 at 4:48 PM, the Administrator stated she was not aware of the harm of storing the pain reliever inside the residents' rooms could cause and did not want to speculate. Record review of the facility's policy, Self-Administration of Medications 2001 MED-PASS, Inc., revised February 2021, reflected Policy heading: Residents have the right to self-administer medications if the interdisciplinary team has determined that it 1s clinically appropriate and safe for the resident to do so . Policy Interpretation and implementation . 3. If it is deemed sate and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan . 4. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the nurse call system was assessable for one (Resident #7) of twelve residents reviewed for resident call system.The facility failed to ensure the call light system in Resident #7's room was functioning on 02/03/2026.This failure could place the residents at risk of not being able to directly contact the staff to obtain assistance for activities of daily living or help in an event of an emergency.Findings include:Record review of Resident #7's face sheet, dated 02/03/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE]. He was diagnosed with limitation of activities due to a disability. Record review of Resident #12's Quarterly MDS Assessment, dated 12/18/2025, reflected severely impaired cognition with a BIMS score of 5. Section GG (Functional Abilities) indicated Resident #7 required staff assistance for mobility and self-care needs. Record review of Resident #7's Comprehensive Care Plan, dated 12/29/2025, reflected the resident was at risk for falls related to impaired mobility/balance, hemiparesis (muscle weakness on one side of the body), and cognitive deficits. An intervention was to ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed. During an observation and interview on 02/03/2026 at 10: 32 AM, Resident #7 was lying in bed. The bedside table was placed next to his bed. A call bell was observed on the bedside table. Resident #7 stated staff did not always come when he rang the bell. He stated his call light did not work, and he was unsure how long it had not worked. Resident #7's call light was connected to the wall and placed at the foot of the bed. LVN A was in the hall and entered the room. She stated she was unaware Resident #7's call light did not work. She checked the resident's call light, and it did not light up in the hall outside his door. She stated it was important for him to be able to call staff when he needed something. She stated she would let maintenance know.During an observation and interview on 02/03/2026 at 10:41 AM, the Maintenance Director was observed outside Resident #7's room. The Maintenance Director stated no there was not a work order for the resident's call light. He stated the nurse had just told him the call light was not working. He checked the call light, left the resident's room, and returned with another corded call light. He replaced the resident's call light and it lit up in the hall when he pulled it. He stated it was important for the residents to have a call light to reach staff if they needed help. During an interview on 02/03/2026 at 10:43 AM, CNA D stated she was unsure when Resident #7's call light quit working. She stated when the call light broke, the resident was given a call bell. She stated when you hear the bell, you know to go to the resident's room. She stated the bell was loud. She stated it was important for the resident to reach staff if he needed something. She stated he might need water or something that he could not reach himself. During an interview on 02/03/2026 at 11:23 AM, the DON stated he was unaware Resident #7's call light did not work. He stated the resident was alert, oriented, verbal, and able to communicate his needs. He stated the call light was important for the resident's safety. During an interview on 02/03/2026 at 11:29 AM, the ADON stated it was important for the resident to have a call light so he could let staff know if he needed help with anything. During an interview on 02/03/20256 at 5:10 PM, the Administrator stated they knew there was a problem and Resident #7 had a bell in his room. She stated the Maintenance Director found another call light to put in his room. She stated it was important for the resident to have a call light to notify staff if he needed assistance. Record review of the facility's policy Call System, Residents, updated January 2025, reflected Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation.The resident call system remains functional at all times. If audible (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional.