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	06/11/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record review, the facility failed to adequately equip residents the ability to call for staff assistance through a communication system, which relays the call directly to a staff member or to a centralized staff work area, from the bedroom of 3 of (Resident #1, Resident #2 and Resident #3) 7 resident rooms reviewed for resident call systems. The facility failed to ensure the call light in the room and bathroom were operable for Resident #1, Resident #2 and Resident #3. This failure could place residents at risk of being unable to have a means of directly contacting caregivers which could place them at risk for injuries and unmet needs. Findings included: Record review of Resident #1's face sheet, dated 06/09/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: acute respiratory failure (a life-threatening medical emergency where the lungs cannot adequately supply oxygen to the blood or remove excess carbon dioxide), lack of coordination (a symptom of nervous system dysfunction characterized by clumsy, uncoordinated, or jerky movements), muscle weakness, malignant neoplasm (an abnormal mass of tissue that grows uncontrollably, invades nearby healthy tissues), type 2 diabetes mellitus (chronic metabolic disorder where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels), encephalopathy (a broad, clinical term for any diffuse disease or damage that alters your brain's function or structure), hereditary optic atrophy (a group of genetic disorders that cause the degeneration of retinal ganglion cells and their axons, leading to progressive, permanent vision loss), chronic obstructive pulmonary disease (a progressive, incurable lung disease that restricts airflow and makes breathing difficult), chronic kidney disease (a long-term condition where the kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood), dry eye syndrome of bilateral lacrimal glands (a condition where the main tear glands above both eyes fail to produce enough of the watery (aqueous) layer of the tear film), pruritus (an uncomfortable, irritating sensation on the skin that creates an urge to scratch), Parkinson's disease (a progressive neurological disorder characterized by the death of dopamine-producing neurons in the brain), chronic pain syndrome (a condition where persistent pain lasts beyond the expected healing time (typically 3 to 6 months and causes secondary physical and emotional symptoms), insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and being unable to get back to sleep), cataract in diseases (the clouding of the eye's natural lens), glaucoma (glaucoma), legal blindness, gastro-esophageal reflux disease (chronic digestive condition where stomach acid or bile repeatedly flows back into the esophagus) and acute kidney failure (sudden and rapid loss of your kidneys' ability to filter waste products, balance fluids, and regulate electrolytes). Record review of Resident #1's Quarterly MDS assessment, dated 04/30/26, reflected a BIMS score of 14, which indicated cognition intact. The MDS assessment under Section GG-Functional Abilities, (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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected Resident #1 needed setup or clean-up assistance with eating, oral hygiene, showering/bathing self. Section GG-Functional Abilities also reflected Resident #1 was independent with toileting hygiene, upper/lower body dressing, putting on/taking off footwear, rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to stand, chair/bed-to-chair transfer and toilet transfer. Record review of Resident #1's care plan, revised 07/10/23, reflected Resident #1 had an ADL self-care performance deficit related to blindness. Intervention included: encouraging the resident to use bell to call for assistance. Resident #1 also had a communication problem related to hearing/visual deficit. One of the interventions included was ensuring/providing a safe environment to include call light in reach, Resident #1's care plan also revealed he was at risks for falls related to vision/hearing problems. One of the interventions included reminding the resident to use call light when needed assistance and ensuring the resident's call light was within reach and encouraging the resident to use it for assistance as needed. It further reflected the resident needed prompt response to all requests for assistance. Record review of Resident #2's face sheet, dated 06/09/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: chronic obstructive pulmonary disease (a progressive, incurable lung disease that restricts airflow and makes breathing difficult), drug induced subacute dyskinesia (a medication-induced movement disorder characterized by involuntary, repetitive muscle movements (chorea, tics, or spasms) that develop over a period of days to weeks), muscle weakness, unsteadiness on feet, myopathy (any disease that affects the skeletal muscles), chronic pain syndrome (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and being unable to get back to sleep), hyperlipidemia (high levels of lipids (fats), such as cholesterol and triglycerides, circulating in the blood), schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia (like hallucinations or delusions) with a mood disorder (like depression or bipolar disorder), bipolar disorder (a lifelong mental health condition that causes extreme, cyclical shifts in mood, energy, and activity levels), major depressive disorder (a severe, recurring mood disorder characterized by pervasive sadness, loss of interest in activities, and low energy), extrapyramidal and movement disorder (drug-induced movement disorders that primarily affect muscle tone, posture, and involuntary movement), obstructive sleep apnea (a chronic disorder where the airway repeatedly collapses during sleep, blocking airflow and causing breathing to stop and start) and type 2 diabetes mellitus (chronic metabolic disorder where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). Record review of Resident #2's Quarterly MDS assessment, dated 03/16/26, reflected a BIMS score of 15, which indicated cognition intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #2 needed setup or clean-up assistance with toileting hygiene. Resident#2 was independent with eating, oral hygiene, showering/bathing self. Section GG-Functional Abilities also reflected Resident #1 was independent with toileting hygiene, upper/lower body dressing, putting on/taking off footwear, rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to stand, chair/bed-to-chair transfer, toilet transfer, walking 50 feet with two turns and walking 150 feet. Record review of Resident #2's care plan, revised 07/12/23, reflected Resident #2 had had an ADL self-care performance deficit related to impaired balance and gait with tremors. One of the inventions included encouraging the resident to use bell to call for assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's face sheet, dated 06/09/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: cellulitis (a common, potentially serious bacterial infection of the skin and the deep underlying tissues beneath it), megaloblastic anemia (the bone marrow produces abnormally large, immature, and dysfunctional red blood cells), morbid obesity, hyperosmolality (a condition where bodily fluids—most commonly blood plasma—have an abnormally high concentration of solutes, such as sodium, glucose, or urea) and hypernatremia (an electrolyte imbalance defined as a serum sodium concentration greater than 145 mEq/L), hypokalemia (abnormally low levels of potassium in the blood, typically falling below 3.5 mmol/L), bipolar disorder (a lifelong mental health condition that causes extreme, cyclical shifts in mood, energy, and activity levels), depression (a common and serious mood disorder that causes a persistent feeling of sadness, emptiness, and a loss of interest in activities), major depressive disorder (a severe, recurring mood disorder characterized by pervasive sadness, loss of interest in activities, and low energy), extrapyramidal and movement disorder (drug-induced movement disorders that primarily affect muscle tone, posture, and involuntary movement), obstructive sleep apnea (a chronic disorder where the airway repeatedly collapses during sleep, blocking airflow and causing breathing to stop and start), polyneuropathy (simultaneous malfunction or damage of many peripheral nerves throughout the body), muscular dystrophy (a group of over 30 genetic disorders characterized by progressive muscle weakness and degeneration), toxic encephalopathy (a neurological disorder caused by brain damage or malfunction from exposure to external poisons (toxins) or internal metabolic imbalances), hemiplegia (paralysis that affects only one side of the body, caused by brain or spinal cord damage) and hemiparesis (weakness or partial loss of movement on one entire side of the body)following cerebral infarction (stroke) affecting right dominant side, pulmonary fibrosis (a lung disease in which tissue becomes damaged and scarred), acute and chronic respiratory failure (when the respiratory system cannot adequately transfer oxygen into the blood or remove carbon dioxide from it), gastro-esophageal reflux disease (chronic digestive condition where stomach acid or bile repeatedly flows back into the esophagus.), umbilical hernia (occurs when part of the intestine or abdominal fat pushes through a weak spot or hole in the abdominal muscles near the belly button), pain in left and right knee, plantar fascial fibromatosis (plantar fascial fibromatosis), acute osteomyelitis (a sudden, localized bone infection), acute kidney failure (sudden and rapid loss of your kidneys' ability to filter waste products, balance fluids, and regulate electrolytes), ataxia (a neurological sign referring to a lack of voluntary muscle coordination, resulting in clumsy, unsteady movements), slurred speech, hyperglycemia (when there is too much glucose in the bloodstream), personal history of pulmonary embolism (a sudden, life-threatening blockage in one of the pulmonary arteries in your lungs). Record review of Resident #3's admission MDS assessment, dated 06/04/26, reflected a BIMS score of 13, which indicated cognition intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 needed supervision or touching assistance with lower body dressing, putting on/taking off footwear, rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to stand, chair/bed-to-chair transfer, toilet transfer, car transfer, walking 50 feet with two turns and walking 150 feet. Section GG-Functional Abilities also reflected Resident #3 needed partial assistance with showering/bathing self and walking 50 feet with two turns, setup or clean-up assistance with personal hygiene and independent with oral hygiene and upper body dressing. Record review of Resident #3's care plan, revised 06/04/26, reflected Resident #3 had potential communication related to hearing deficit in right ear, slurred speech and history of CVA (stroke). One of the interventions included ensuring/providing a safe environment to include call light in reach. The care plan also revealed Resident #3 risked falls related to gait/balance problems. One of the interventions was to ensure the resident's call light was within reach and encourage the resident to (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use it for assistance as needed. Resident #3 needed prompt response to all requests for assistance. During an observation with the DON on 06/11/26 at 10:35, revealed Resident #1, Resident #2 and Resident #3's call light in their rooms did not light up when the button was used. Resident #1, Resident # 2 and Resident #3's call light did not light up on the outside of the room when the DON pressed the button. The DON witnessed that when the call light was used it did not light up outside of the residents' rooms. Resident #1, Resident #2 and Resident #3 shared the same restroom and the call light in the restroom was observed not working. The DON stated although it did not light up on the system on the door, it should at the nurse's station on the centralized box. Upon further observation, the DON and Investigator went to the nurse's station, and the rooms did not show on the centralized work station box. The centralized call system box was observed inoperable. The DON stated he did not know what was going on with the system, but he would reach out to maintenance. During an interview on 06/11/26 at 11:20 AM, Resident #1 stated the call light in their room had not been working for approximately six or seven weeks. Resident #1 stated he had to holler, beat on the wall or his roommate went to get assistance. Resident #1 stated he did not know what was going on with the call light, but it did not light when he pressed the button. Resident #1 also stated his restroom call light was not working. Resident #1 stated the staff knew that it did not work. During an interview on 06/11/26 at 11:29 AM, Resident #2 stated his room and restroom call light had not worked for approximately one month. Resident #2 stated he walked to the nurse's station for assistance for him or his roommate. During an interview on 06/11/26 at 1:02 PM, the Maintenance Director stated he worked in the building Monday-Friday 7:00am-3:30pm and was on call on the weekends. He stated he was informed this morning that one of the call lights was stuck and when the reset button was pressed, it did not reset. He stated it caused a malfunction by shortening rooms [ROOM NUMBERS]. He stated it was either room [ROOM NUMBER] or 205 call light that was stuck with the light on. The Maintenance Director stated he was not aware of the call light not working in the room prior to 06/11/26. The Maintenance Director stated the facility may have minor issues such as pressing the button too hard would push it inside the unit itself, causing the light to set on not register the reset. The Maintenance Director stated the risk of the call light not working was staff not knowing the resident needed assistance. During an interview on 06/11/26 at 3:58 PM, Resident #3 stated he was admitted into the facility less than a week ago. Resident #3 stated his call light had not worked since he admitted . Resident #3 also stated the one day during the week he attempted to press his call light and found that it did not work. Resident #3 stated he had to wait for staff to pass or go to the nurse's station for assistance. Resident #3 stated he informed the staff and they stated that someone would come to fix it. During an interview on 06/11/2 a4:12 PM, the DON stated no one informed him that the call light was not working. He stated he found out today with State being in the building. The DON stated the risk of an inoperable call light was that the resident was unable to call if there was any injuries and staff not knowing the resident needed assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/11/26 at 4:20 PM, the Administrator stated she was unaware that the call lights were not properly working on 06/11/26. The Administrator stated she found it on 06/11/26 while State was in the building. She stated the risks of the call light not properly functioning were the residents not being able to call for assistance. Record review if the facility's policy titled, Call System, Residents, revised 10/15/22, updated January 2025, reflected the following: Policy Statement: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. Call system communication may be audible or visual. The system may be wired or wireless. 3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remained functional. 4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan. 5. The resident call system is routinely maintained and tested by the maintenance department. 6. Calls for assistance are answered timely.