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	12/05/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for two of five residents (Resident #7 and Resident #25) reviewed for pre-admission screening and resident review (PASARR) assessments. 1. Resident #7's PASRR Level I indicated he did not have a diagnosis of mental illness despite having a diagnosis of mental illness and the facility failed to ensure Resident #7 received a PASRR Level II Screening. 2. Resident #25's PASRR Level I indicated he did not have a diagnosis of mental illness despite having a diagnosis of mental illness and the facility failed to ensure Resident #25received a PASRR Level II Screening. This could place residents at risk of not receiving necessary specialized services to meet their individual needs.Findings included: 1. Record review of Resident #7's MDS assessment dated [DATE], reflected a [AGE] year-old male, , admitted to the facility on [DATE], with a BIMS score of 7 which indicated moderate cognitive impairment and diagnoses that included: Bipolar Disorder (mood swings between high also referred to as manic and low, depressive), Schizoaffective Disorder Bipolar Type ((a serious mental illness blending symptoms of schizophrenia - psychosis like hallucinations/delusions, with mood disorders like depression or bipolar mania involving extreme mood swings, disorganized thinking, and disrupted reality perception.), and Unspecified Dementia without behavioral disturbance (memory loss and thinking problems caused by another medical condition, like Parkinson's or Huntington's, rather than Alzheimer's itself). Record review of Resident #7's Care Plan dated 11/29/2025, reflected Resident 7 received anti-psychotic medications to treat symptoms of Schizophrenia. Record review of Resident 7's PASRR Level 1 Screening dated 06/01/2020 reflected the resident had evidence of a mental illness. Record Review of Resident 7's Consumer Choice of Reduced Services from Recommended Level of Care dated 01/11/2021 reflected the resident qualified for medication management and rehabilitative services through the local mental health authority. The form stated services were pending post-Covid. Record Review of Resident 7's PASRR Level 1 Screening dated 08/11/2023, completed by the facility, reflected the resident did not have any evidence or indicators of mental illness. During an interview on 12/04/2025 at 1:30 PM, the MDS Nurse reported she reviewed Resident 7's PASRR Level 1 Screenings. She reported she was unaware of why Resident 7 did not start PASRR services after Covid restrictions. She reported some services were paused during that time. She reported the resident had another PASRR Level 1 completed after Covid which reflected he was negative. The MDS Nurse agreed the PASRR Level 1 dated 08/11/2023 was inaccurate due to the form indicating no mental illness. She reported the Resident's last PASRR level 1 was completed by a hospital upon their admission. She reported she would check for accuracy on the forms upon a resident's admission by reviewing hospital records, any psychiatric notes, and diagnoses. She reported if a resident was PASRR positive and not accurately identified, they might not receive special services. During an interview on 12/05/2025 at 11:37 AM, the Administrator reported she would help the MDS Nurse with PASRR questions and problems as needed. She reported she would sit in on PASRR meetings with the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	local mental health authority. She reported Resident # 7 was not PASRR positive. The Administrator was not aware that his PASRR Level 1 was not accurate. She reported if a resident was PASRR positive and not accurately identified; she was not sure of the harm it could have on the resident and would not want to speculate. She reported that the facility provided all services that PASRR provided to residents like laundry, meals, socialization, and therapies. 2. Record review of Resident #25's quarterly MDS dated [DATE] reflected an [AGE] year-old male resident who was admitted to the facility on [DATE] with diagnoses of Schizophrenia Disorder with Bipolar, Heart Disease, and Diabetes Type II. The MDS reflected he had a BIMS of 7 which indicated severe cognitive impairment. He required total assistance with toileting and showers and maximum assist with dressing. He used a wheelchair to ambulate. He was frequently incontinent of bladder and had an ostomy.Review of Resident #25's Comprehensive Care Plan dated 04/01/2023, revised on 03/25/2025 reflected Resident #25 had focus area to address the effects of schizoaffective disorder with a goal to remain at current level of cognitive function. Interventions included engaging in simple structured activities, and to monitor/report any changes in cognitive function to the Medical Doctor. Record Review of the most current PL 1 for Resident #25 was completed on 08/10/2023 and it was negative. In an interview on 12/5/2025 at 10:10 AM with the MDS nurse revealed she was not aware that Resident # 25 had a diagnosis of Schizophrenia and that a new PL 1 was needed to be completed, she stated she would do that immediately. Record Review of the facility's PASRR Policy dated 07/29/2025, reflected in part the following: The PASRR program aims to ensure that individuals with mental illness or intellectual disabilities receive appropriate care and services. It assesses whether the nursing home is the most suitable setting for the individual's needs. Preadmission happens when a person is coming from the community (psychiatric hospital, home, group home, jail, assisted living, etc.). This includes anywhere other than a medical acute care hospital or another nursing facility. The person, coming from the community with a PASRR Level 1 that indicates suspicion of IDD, and/or mental illness must also have a completed PASRR Evaluation submitted before they can be admitted to a nursing facility. This process must be followed to ensure people coming from a community setting can receive education about other placement alternatives before nursing facility admission. Negative indicates the person has a negative PL1 screening, and is not suspected of having an intellectual disability, developmental disability and/or mental illness. Level I Screening: This initial screening determines if the individual may have a mental illness or intellectual disability. It is generally completed by the nursing facility before admission. Level II Evaluation: If the Level I screening indicates potential mental illness or intellectual disability, a Level II evaluation is conducted. This comprehensive assessment is performed by a qualified mental health professional and evaluates the individual's needs and whether nursing home placement is appropriate. Compliance: Nursing homes must comply with all federal and state regulations regarding PASRR. Failure to do so can result in penalties or loss of funding. The facility follows HHS PASRR For Nursing Facility guidelines.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the facility's only kitchen. The Dietary Aide failed to wear a beard restraint while working in the kitchen. This failure could affect the residents who receive their meals from the facility's only kitchen by placing them at risk for food contamination. Observation on 12/03/2025 at 11:12 AM revealed the dietary aide was not wearing a beard restraint while working in the kitchen. Observation and interview on 12/04/2025 at 11:01 AM revealed the dietary aide was wearing a beard restraint, but it was underneath his chin and not covering his beard and mustache. The dietary aide stated he was wearing a beard restraint yesterday (12/03/25), but he must have forgotten to put it back at some point. The dietary aide stated today (12/04/25), he pulled the beard restraint down around his chin and forgot to put it back up. He stated the risk to the residents would be that hair could get into their food. In an interview on 12/05/2025 at 10:22 AM with the dietary manager revealed she expected all of her staff to wear hair restraints when they were in the kitchen. She stated the risk to residents would be they could possibly get hair in their food. In an interview on 12/05/2025 at 11:26 AM with the administrator revealed she expected the dietary staff to follow their policy regarding beard restraints. She stated the risk to the residents is they could shed into the food. Record review of the Healthcare Services Group, Inc. dated 05/2014, revised 1/2025 reflected, All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained.

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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 resident call light system was maintained within reach for 2 of 5 residents (Resident #7, and Resident #28) reviewed for call light system access. The facility failed to maintain Resident #7 and #28's call light system in working order. The call light in their shared room had detached completely from the wall, rendering it unusable. This failure could place residents at risk for delayed assistance and an inability to request help when needed. Findings included:Record review of Resident #7's MDS assessment dated [DATE], reflected a [AGE] year-old male, admitted to the facility on [DATE], with a BIMS score of 7 which indicated moderate cognitive impairment, with diagnoses that included: Bipolar Disorder (mood swings between high also referred to as manic and low, depressive), Schizoaffective Disorder Bipolar Type ((a serious mental illness blending symptoms of schizophrenia - psychosis like hallucinations/delusions, with mood disorders like depression or bipolar mania involving extreme mood swings, disorganized thinking, and disrupted reality perception.), and Unspecified Dementia without behavioral disturbance (memory loss and thinking problems caused by another medical condition, like Parkinson's or Huntington's, rather than Alzheimer's itself), Acute and Chronic Respiratory Failure (the body does not receive enough oxygen) and repeated falls. Record review of Resident #7's Comprehensive Care plan dated 02/23/2025 reflected resident #7 had a communication problem and cognitive deficits. The plan intervention included ensure/provide a safe environment: Call light in reach. The Care Plan also reflected resident #7 had an ADL Self Care Performance Deficit. The plan intervention included Encourage the resident to use bell to call for assistance. The plan reflected Resident #7 was a high risk for falls. The plan intervention included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #28 MDS assessment dated [DATE], reflected a [AGE] year-old male, admitted to the facility on [DATE]. The BIMS score portion of the MDS was not completed as it stated resident was never/rarely understood. Resident #28 had diagnoses that included: Cerebral infarction due to thrombosis of right posterior cerebral artery (a stroke due to a blood clot in the back right part of the brain) and Unspecified dementia (memory loss and thinking problems caused by another medical condition, like Parkinson's or Huntington's, rather than Alzheimer's itself). Record Review of Resident #28's Comprehensive Care plan dated 11/10/2025 reflected Resident #28 had a communication problem and cognitive deficits/dementia, post stroke with impaired ability to make self-understood and understanding others. The plan intervention included ensure/provide a safe environment: Call light in reach. The Care Plan also reflected Resident #28 had an ADL Self Care Performance Deficit. The plan intervention included Encourage the resident to use bell to call for assistance. The plan reflected Resident #28 was a fall risk due to muscle weakness and impaired mobility. The plan intervention included be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During an interview and observation on 12/03/2025 at 11:05 AM, Resident #7 was observed sitting in his room and appeared to be well-groomed and dressed appropriately for the weather conditions. He reported his call light had been broken for 4-5 months, and he would holler if he needed help. Resident #7 said he was not sure how the call light system came out of the wall. The call light box was observed to have been pulled out of the wall and dangling behind Resident #7's bed. The resident had not been given an alternative means to call for assistance if needed. During an interview and observation on 12/03/2025 at 11:15 AM, Resident #28 was observed lying in his bed. He was awake and alert. He appeared to be well-groomed. His body was covered by a blanket. His call light button was observed underneath his bed. Resident #28 said he did not know why it was there. He was unable to explain how he called the staff if he needed help. During an interview on 12/03/2025 at 1:10 PM, CNA A reported the call light system in Resident #7 and #28's room was broken. She reported she noticed it broken yesterday (12/02/2025) during her 6am-2pm shift. She stated she (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported the broken call system to the DON yesterday after she saw it was broken. She reported she conducted rounds on each resident every 2 hours or more. She reported Residents #7 and #28 will yell or scream if they needed help. She reported the risk of a resident not having access to a call light was that the resident would not be able to call if they needed help. During an interview on 12/03/2025 at 1:16 PM, the Maintenance director reported he was on his way to fix the call light system in Resident #7 and #28's room. He stated he was just now made aware that it was broken. He stated a maintenance request was never submitted to him as he was just now learning it was broken. During an interview on 12/03/2025 at 1:21 PM, the DON reported the whole call light system came out of the wall in Resident #7 and #28's room. He stated the maintenance was fixing it now. He denied that a staff member told him it was broken yesterday, he said he just learned it was broken today. He reported it had only been broken since Tuesday. The DON reported Resident #7 was given a bell to ding if he needed help. During a follow up observation on 12/03/2025 at 1:30 PM, Resident #7 was observed in his room. A bell was observed on his bed side table. The resident stated he was given the bell about 15 minutes ago and had never used it before. During a follow up interview with the DON on 12/05/2025 at 11:25 AM, he reported the call light being broken was discovered on Tuesday. He stated it was reported to maintenance but not put in the maintenance log. He stated a CNA told him she reported it to the maintenance director on Tuesday. The DON stated he was not sure why it was not fixed on that same day it was reported. He stated the Department Heads were responsible for checking each room every morning to ensure the call light systems were working. He was unsure which department head was assigned to Resident #7 and #28's room. He was unable to describe the harm that could be placed on residents without access to a call light system. During an interview with the Administrator on 12/05/2025 at 11:47 AM, she reported she was made aware of the broken call system on Wednesday, 12/3/2025 by the maintenance director. She reported she was unaware of how long it had been broken. She reported the maintenance director was made aware that it was broken on 12/03/2025. She reported any maintenance request was put into their TELs System (the building maintenance and compliance tracking system used to schedule, document, and manage equipment in a facility) where the maintenance director is immediately notified of a request. She reported any staff member can put in the request. Record review of facility maintenance request log for the past (6 months) reflected there had not been any requests for services for Resident #7 or #28's call light system. Record review of the facility's Call System Policy dated January 2025 reflected in part: The resident's call system remains functional at all times.