

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Avir at Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 12 of 74 days (01/12/25, 01/25/25, 01/26/25, 02/22/25, 02/23/25, 03/01/25, 03/02/25, 03/08/25, 03/09/25, 03/15/25, 03/16/25, and 05/18/25) reviewed during a look back period from 01/01/25 to 09/14/25 for weekend coverage. The facility failed to have RN coverage in the facility for eight consecutive hours on 01/12/25, 01/25/25, 01/26/25, 02/22/25, 02/23/25, 03/01/25, 03/02/25, 03/08/25, 03/09/25, 03/15/25, 03/16/25, and 05/18/25. This failure could place residents at risk of not having their nursing and medical needs met and improper care. Findings included: Record review of facility RN Coverage, period from 01/04/25 to 09/14/25, reflected the following: - Sunday 01/12/25 - No RN - Saturday 01/25/25 - Time in 18:00 (6:00 PM) - Out Time 23:00 (11:00 PM); Time in 23:30 (11:30 PM) - Out time 6:15 AM (01/26/25 Sunday). 5 hours and 30 minutes were worked on 01/25/25 Saturday. - Sunday 01/26/25 - Time in 18:00 (6:00 PM) - Out Time 23:00 (11:00 PM); Time in 23:30 (11:30 PM) - Out time 6:30 AM (01/27/25 Monday). 5 hours and 30 minutes were worked on 01/26/25 Sunday. - Saturday 02/22/25 - Time in 18:00 (6:00 PM) - Out Time 23:00 (11:00 PM); Time in 23:30 (11:30 PM) - Out time 6:45 AM (02/23/25 Sunday). 5 hours and 30 minutes were worked on 02/22/25 Saturday. - Sunday 02/23/25 - Time in 18:15 (6:15 PM) - Out Time 23:15 (11:15 PM); Time in 23:45 (11:35 PM) - Out time 6:30 AM (02/24/25 Monday). 5 hours and 30 minutes were worked on 02/23/25 Sunday. - Saturday 03/01/25 - Time in 18:00 (6:00 PM) - Out Time 23:00 (11:00 PM); Time in 23:30 (11:30 PM) - Out time 6:45 AM (03/02/25 Sunday). 5 hours and 30 minutes were worked on 03/01/25 Saturday. - Sunday 03/02/25 - Time in 18:00 (6:00 PM) - Out Time 23:15 (11:15 PM); Time in 23:45 (11:35 PM) - Out time 7:30 AM (03/03/25 Monday). 5 hours and 30 minutes were worked on 03/02/25 Sunday. - Saturday 03/08/25 - No RN- Sunday 03/09/25 - Time in 5:53 PM - Out Time 10:00 PM; Time in 10:30 PM - Out time 6:32 AM (03/10/25 Monday). 5 hours and 37 minutes were worked on 03/09/25 Sunday. - Saturday 03/15/25 - Time in 6:07 PM - Out time 6:46 AM (03/16/25 Sunday). 5 hours and 53 minutes were worked on 03/15/25 Saturday. - Sunday 03/16/25 - Time in 6:05 PM - Out time 7:26 AM (03/17/25 Monday). 5 hours and 55 minutes were worked on 03/16/25 Sunday. - Sunday 05/18/25 - Time in 5:27 PM - Out time 6:28 AM (05/19/25 Monday). 6 hours and 33 minutes were worked on 05/18/25 Sunday. Interview on 09/18/25 at 3:17 PM, the Staffing Coordinator revealed she had been employed since April 2025. She stated she was responsible for completing the nursing staffing schedules. She stated when she was hired, she was told the facility did not have a Staffing Coordinator from October 2024 through April 2025. She stated she was not sure who was responsible for completing the nursing schedules prior to her being hired. The Staffing Coordinator stated she was aware there should be an RN for 8 consecutive hours. She stated when she was hired she was never aware of the facility having any issues with RN coverage. She stated the potential risk of not having an RN would be LVNs not able to do things that an RN could do. Interview on 09/18/25 at 3:37 PM, the DON revealed he had been employed for 11 months. He stated the Staffing Coordinator was responsible for completing the nursing schedules. The DON stated he was aware of the 8 consecutive hours; however, he was not aware the facility had no 8 consecutive hours RN coverage for the above (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675905	Facility ID: 675905 If continuation sheet Page 1 of 19

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	days. The DON stated he would review the days that were missing. Follow-up interview on 09/18/25 at 4:22 PM, the DON revealed he reviewed the RN coverage, and he was not aware the facility did not have an RN for 8 consecutive hours on the days provided. He stated the ADONs and himself were responsible for reviewing schedules. The DON stated RNs were able to provide more appropriate care in case of an emergency. Interview on 09/18/25 at 4:28 PM, the Administrator revealed she was aware of the 8 consecutive hours for RN coverage. She stated she had been employed since March 2025. The Administrator stated she was aware of the facility having problems with RN coverage but it was not a consistent issue. The Administrator stated the Staffing Coordinator was responsible for completing the nursing schedules and the ADONs were responsible for reviewing them. The Administrator stated there would always be a potential risk for not having an RN in the facility. Interview on 09/18/25 at 4:36 PM, ADON C revealed the Staffing Coordinator was responsible for completing nursing staffing schedules. She stated the ADONs and DON were responsible for reviewing the schedules once completed. She stated she was aware of the requirement of having an RN for 8 consecutive hours but was not aware of facility having an issue with RN coverage. The ADON C stated there could always be a potential risk of not having an RN for 8 consecutive hours. She stated RN were able to do more things than an LVN could do and responsibilities. Record review of facility Staffing, Sufficient and Competent Nursing policy, revised August 2022, reflected the following: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the medication error rate was not five percent (5%) or greater for two of three staff LVN B and MA E which resulted in a 17.95% medication error rate after 39 opportunities with 7 errors for three of five residents (Residents#4, #10 and #59) observed for medication pass. 1. The facility failed to ensure MA E administered the correct eye drop for Resident #59 at 07:46 AM. 2. The facility failed to ensure MA E administered Dextromethorphan-Guaifenesin Oral Tablet 20-400 MG (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours for cough for Resident #4 at 07:46 AM. 3. LVN B failed to follow the physician orders for flushing Resident #10's gastrostomy tube with 10 mL (or prescribed amount) of water between medications when he administered medication, failed to administer all the medications by gravity, and failed to check gastrostomy tube placement before medication administration at 08:46 AM. These failures could place residents at risk of physical and chemical incompatibility, leading to an altered therapeutic response and put residents who received medications via gastrostomy tube at risk for gastrostomy tube blockage and medication interaction. Findings included:1. Record review of Resident #59's quarterly MDS assessment, dated 06/17/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. The assessment reflected the resident cognition severely impaired with BIMS score of 3. The resident had diagnoses which included Glaucoma (a group of eye diseases that damage the optic nerve, which carries visual information from the eye to the brain). Record review of Resident #59's September 2025 Physician Orders reflected there were orders to administer latanoprost 0.05 MG/ML Ophthalmic Solution 1 drop each eye at bedtime. Observation on 09/17/2025 7:46 AM revealed MA E prepared medications for resident #59. She took latanoprost 0.05 MG/ML Ophthalmic Solution to resident room. She sanitized and put on gloves and explained the procedure to resident#59. She administered 1 drop to each eye and left the resident comfortable. Interview with MA E on 09/17/25 at 8:08 AM revealed she knew resident was supposed to get two different types of eyes drops medications and she did not confirm the eye drops and the medication administration record to confirm the name and time. She stated she knew she was supposed to compare the MAR and the medication on hand, but she did not. She stated she knew she was supposed to follow the five rights for medication administration the right patient, the right drug, the right time, the right dose, and the right route but she was nervous. She stated she only checked the time, and she saw two eye drops were due at 08:00AM and she did not notice she administered latanoprost 0.05 MG/ML Ophthalmic Solution 1 drop each eye which was supposed to be administered at bedtime instead of Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) Instill 1 drop in both eyes two times a day for Glaucoma which was also on hold . She stated failure to check the MAR against the available medication could lead to medication error and administration of the wrong medication at the wrong time. 2. Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included hypertension (high blood pressure) and heart failure (a serious condition but not the same as a heart attack, where blood flow to the heart is suddenly blocked). He had a BIMS score of 13 which indicated his cognition was intact. Record review of Resident #4's September 2025 Physician Orders reflected there were orders for Dextromethorphan-Guaifenesin Oral Tablet 20-400 MG (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours for cough. Observation on 09/17/25 at 07:58 AM revealed MA E did not administer Dextromethorphan-Guaifenesin Oral Tablet 20-400 MG (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours for cough for Resident #4 at 07:46 AM scheduled for 08:00AM. Interview with MA E on 09/17/25 at 08:39 AM revealed she did not administer Dextromethorphan-Guaifenesin Oral Tablet 20-400 MG (Dextromethorphan-Guaifenesin) morning dose because she did not have it in her cart. She stated she (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was previously off work and 09/17/25 was her first day after being off and she could not tell when it ran out and whether it was reordered. She stated she knew she was supposed to notify the nurse, but she did not, she said she forgot. She stated failure to administer medication could lead to a resident not getting the required therapy. She stated she was aware Resident #4's medications came from hospice and her nurse was supposed to call and notify hospice for delivery. Interview with LVN K on 09/17/25 02:50PM revealed he was the charge nurse and stated MA E had not notified him of the missing dose of Dextromethorphan-Guaifenesin Oral Tablet 20-400 MG (Dextromethorphan-Guaifenesin) for Resident #4. He stated failure to be notified so that he can call Hospice for refill could lead to medication error and Resident #4 not getting the needed therapy. He stated he would call Hospice so that it can be delivered for the evening dose. 3. Record review of Resident #10's quarterly MDS assessment, dated 08/07/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. The assessment reflected the resident's cognition status was not documented because (resident is rarely/never understood). The resident had diagnoses which included anemia (condition characterized by a lower-than-normal number of red blood cells, or a deficiency of hemoglobin, which carries oxygen in the blood and dysphagia (difficulty swallowing solids, liquids, or both). The nutritional approaches revealed feeding tube. Record review of Resident #10's September 2025 Physician Orders reflected there were orders for very shift Flush feeding tube with 10 cc water between each medication and 30 cc water before and after med administration. Observation on 09/17/2025 8:47 AM revealed LVN B prepared medications outside resident's room. He sanitized and prepared the following medications: Esomeprazole 40 MG Granules Oral Suspension 1 packet mix with 6-8 OZ water via g-tube for Gerd. Magnesium oxide 400 MG Oral Tablet via g-tube for supplement. Iron Supplement Oral Solution 220 (44 Fe) MG/5ML (Ferrous Sulfate). Give 5 ml via G-Tube one time a day for supplement. Metoclopramide HCl Oral Tablet 5 MG. Give 5 mg via G-Tube two times a day for GERD (a digestive condition where stomach contents flow back up into the esophagus, causing irritation and discomfort). Polyethylene Glycol Powder (Polyethylene Glycol 1450) Give 17 gram via G-Tube in the morning for constipation. Multivitamin Oral Liquid (Multiple Vitamins w/Minerals) Give 15 ml via G-Tube in the morning for supplement. LVN B put the medications in different cups. LVN B crushed the medication and put it in separate cups, mixed with 5 mls water. He washed hands and put on gloves and gown and went to Resident #10's room. LVN B positioned Resident #10 in an upright position. LVN B did not check for the gastrostomy tube placement. He did not flush the gastrostomy tube with 30 ml of water, he administered medication one at a time through plugging, he did not flush the gastrostomy tube with water between each medication. LVN B flushed the gastrostomy tube with 30 ml of water after administering al of the medication, and he left the resident comfortable. He removed the gloves and gown, and he washed hands. Interview with LVN B on 09/17/2025 9:26 AM, revealed he was aware of the order to flush gastrostomy tube between medication, and after medication administration through gastrostomy tube for Resident #10. He said he forgot to flush the gastrostomy tube between medication administration. LVN B stated failure to check orders and flush in between the medication could lead to medication interactions. He stated he was also supposed to administer all the medication by gravity and not plunging. He stated the risk of plunging could lead to rupture of the Balloon (usually at the end of the tube it keeps the tube in place and prevents it from being accidentally pulled out) . He stated he was also supposed to check the gastronomy tube placement before medication administration, and he assumed since he had checked earlier that morning, he was okay to administer medication without checking for residual. He could not tell what time he had checked for gastronomy tube placement. He stated failure to check to for placement could lead to aspiration. He stated he had received training on medication administration via gastrostomy tube. Interview with DON on 09/18/2025 8:52 AM revealed his expectation was nurses are supposed to check the patency and placement before they administer medication. He stated the risk of not checking will be aspiration, nausea and vomiting. He stated he expected his staff to flush the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gastronomy tube before, between medication administration and after medication administration. He stated failure to flush between medication would cause gastronomy tube clogging and possible medication interaction. She stated the risk of not flushing before between and after medication administration would be gastronomy tube being clogged and medication interactions. He stated he also expected his staff to administer medication through gravity not plunging as the best standard practice. He stated the risk of plunging is adding more air to Resident #10's stomach and could risk nausea and vomiting. He stated he was responsible of monitoring the nurses and the MA on medication administration. He stated he had done skill check with LVN B on 06/17/25 on gastronomy medication administration and in-service on MA E on medication administration on 07/02/25. Interview with the DON on 09/18/25 at 09:02AM revealed his expectation was for MA E to notify the charge nurse, when she discovered she did not have the morning dose for Resident #4 for follow up with pharmacy and notify the doctor so that the medication could have been put on hold or discontinued until available. He stated hospice was called and they delivered the evening dose and Residnet#4 only missed the morning medication. He stated the risk of Resident #4 missing the morning medication would be not getting the appropriate therapy. He stated the facility had done in-service, but he could not recall when. Interview with the DON on 09/18/25 at 09:15AM revealed his expectation was for MA E to follow the 5 rights of medication administration for the right patient, right time, right dose, right route and right drug. He stated he expected MA E to administer what is on the medication administration record not what she had on the cart. He stated the risk of not following the orders could lead to wrong medication and adverse effects. Record review of facility in-service dated 07/02/25 titled medication administration revealed Nurses and medication aide should always follow 5 rights of medication patient, medication, dosage, route, time and documentation. When medication is missing to the cart we must replace immediately if it is Over the counter or call pharmacy. If unavailable call the doctor to get an order to hold med until available. Medication should be administered as ordered and in timely manner. LVNB and MA E were in attendance. Record review of the facility training dated 06/17/25 revealed LVN B did skill check on gastrostomy tube management. Record review of the facility Administering Medication through an enteral tube policy dated February 2015 revealed the following: 18. Confirm placement of feeding tube per physician's order. 25. Administer medication by gravity flow. 27. When the last of the medication begins to drain from the tubing, flush the tubing with 15ml of warm room temperature tap water (or prescribed amount).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 3 medication carts (Nurses' medication cart for Hall 200) reviewed for medication storage. The facility failed to ensure the nurses' medication cart for 200 halls did not contain medications that were expired. This failure could place residents at risk of adverse medication reactions. Findings included: Observation on 09/17/2025 11:49 AM, revealed the nurses' medication cart for 200 Hall with LVN K had the following medication that had expired. 1. ^ 1 packet Midodrine 2.5mgs tablets with use by^date of 07/23/25 2. 1 packet Ibuprofen 400mgs tablets with use by date of 09/05/25 3. 1 bottle of nitroglycerin 0.4mgs tablet with expiry date 07/20/25 4. 1 packet Meclizine 25mgs with use by 07/16/25 Interview on 09/17/2025 12:17 PM with LVN K revealed it was the responsibility for all nurses to check carts for expired medications every shift, but he did not check the whole cart that morning. He stated the risk of not checking the carts for expired medication if administered they will not be effective. He stated he had done training on labelling and storage. Interview with ADON on 09/18/2025 2:52 PM^revealed her expectation was all nurses to check their carts every shift for expired medication. She stated it was her and the DON?s responsibility to audit carts, but she has not been auditing, and she had no reason. She stated the risk of not checking and removing expired medication from the cart if administered they might not be effective. Interview with the DON on 09/18/2025 3:41 PM, he stated the nurses were responsible for checking their carts every shift for expired medications. He stated it was the responsibility of nursing management to check and audit the carts after the nurses. The DON stated the last time he checked the carts was 09/16/25 and he missed the expired medications. The DON said the facility had in-serviced staff checking and removal of expired medications, but he could not recall the date and no training was provided. Record review of the Medication Storage and labelling policy dated February 2021 revealed the following: 3. If facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroy these items .		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review the facility failed to provide a private meeting space for the residents' monthly council meetings for 7 of 7 confidential residents reviewed for resident council. The facility failed to provide a private space for resident council meetings. This failure could place residents, who attended resident council meetings, at risk of not being able to voice concerns due to a lack of privacy. Findings included: During a confidential resident group interview with seven residents on 09/17/25 at 1:45 PM, the facility arranged for the meeting to be held in an open dining room located next to the facility kitchen and main entrance hall. There were no doors that could be closed to ensure the residents' privacy during the meeting. There were no signs indicating a resident council meeting was being held. During the meeting, staff were observed walking through the main hall while the meeting was in progress and kitchen staff stepping out of the kitchen to grab the tray carts. The seven residents in attendance all reported that their monthly resident council meetings were held in this open dining room area. The residents stated the monthly meetings were being held in the conference room, but the conference room was too cold for them. Interview on 09/18/25 at 2:21 PM with the Activity Assistant revealed resident council meetings were being held in the conference room, but residents began to complain about the room being cold. She stated the resident council meetings had been held in the dining room since June 2025. The Activity Assistant stated she would post signs or use the dry eraser board to notify facility staff of an active resident council meeting being held. She stated she was not aware of resident council meetings needed to be in a private setting. The Activity Assistant stated there was no risk to the residents if they were not provided with a private setting. Interview on 09/18/25 at 4:31 PM with the Administrator revealed resident council meetings had been held in the dining room area. She stated since the Activity Director left around May or June 2025 the resident council meetings had been in the dining room. The Administrator stated she was aware of the requirement of providing residents with a private area; however, she was not sure why it was not done. She stated a potential risk would be residents not having privacy to talk. Record review of the resident council minutes for May 2025 through August 2025 reflected there were no documented requests for a private meeting area. Record review of the facility's current, undated Statement of Resident Rights the following: .privacy, including privacy during visits and telephone calls. Record review of the facility Activity Programs, revised June 2018, reflected the following: Activity programs are designed to meet the interests of and support the physical, mental, and psychological well-being of each resident 14. Adequate space and equipment are provided to ensure that needed services identified in the resident's plan of care are met. The facility's policy did not address resident council meetings.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 16 residents (Resident #16) reviewed for comprehensive care plans. The facility failed to develop a comprehensive care plan addressing weight loss for Resident #16. This failure could place residents at risk of not having their individual needs met and not receiving necessary care and services. Findings included: Record review of Resident #16's quarterly MDS assessment, dated 06/26/25, reflected the resident was a [AGE] year-old male, who was admitted to the facility on [DATE]. The resident diagnoses included Alzheimer's Disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), malnutrition, hypothyroidism (thyroid gland does not make and release enough hormone into your bloodstream), gastro-esophageal reflux disease without esophagitis (stomach acid flows back up into the esophagus and causes heartburn), dysphagia (difficulty or discomfort in swallowing) and hypertension (high blood pressure). The MDS reflected Resident #16's BIMS was not completed due to resident is rarely/never understood. Resident #1 did not exhibit wandering behaviors. The MDS Section K - Swallowing/Nutritional Status - Weight Loss reflected Resident #16 had loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Record review of Resident #16's care plan, dated 06/06/25, did not reflect Resident #16 being at risk of weight loss. Record review of Resident #16's physician orders, dated 07/01/24, reflected orders for the following: Regular diet, Mechanical Soft texture, Regular Liquids consistency. for all meals diet HOUSE shake 8 oz PO three times a day for risk of malnutrition Supplement dated 09/09/2025. Record review of Resident #16's weight records reflected the following weights: 03/04/25 - 155.8 pounds 08/05/25 - 147.2 pounds 09/03/25 - 143.3 pounds 09/18/25 - 149.0 pounds Between 03/04/25 and 09/18/25, Resident #16 had an 4.46% weight loss in 6 months. From 08/08/25 to 09/18/25, Resident #16 had a 1.22% weight gain. Observation and interview on 09/16/25 at 2:18 PM revealed Resident #16 was in the dining room playing with cards and was smiling when approached. Resident #16 stated he was doing well; however, he was unable to answer further questions. Resident #16 complexion showed no signs of illness or deficiency. Observation of lunch meals on 09/17/25 and 09/18/25 revealed Resident #16 ate about 75% to 100% of his meal. Resident #16 was observed drinking his house shakes as well. Interview on 09/18/25 at 11:36 AM, LVN A revealed she was the nurse assigned to Resident #16. LVN A stated Resident #16 eats about 75% to 100% of his meals and received a house shake with his meals. She stated Resident #16 weights were checked monthly. LVN A reviewed Resident #16's weights and stated resident was slowly losing weight but was not a significant weight loss. She stated Resident #16 was seen by the Dietitian and Nurse Practitioner. LVN A stated Resident #16 does not appear he had lost any weight. LVN A stated Resident #16 was at risk of weight loss and it should be care planned. LVN A reviewed Resident #16's care plan and stated the resident care plan did not address his weight loss or interventions. LVN A stated the ADONs were responsible for reviewing and updating care plans. She stated weight loss should be care planned so that the staff can monitor weights and put interventions in place, so residents do not lose anymore. Observation on 09/18/25 at 11:43 AM revealed Resident #16 was weighed standing up and weighed 149.0 pounds. Interview on 09/18/25 at 11:50 AM, ADON D revealed she was the ADON assigned to the memory care unit. She stated Resident #16 had not been triggered for significant weight loss. ADON D reviewed Resident #16's weights and stated resident was slowly losing weight; however, Resident #16 eats 75% to 100% of his meals and received a health shake for each meal. ADON D stated any resident who was at risk of weight loss should be care plan for it. ADON D (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed Resident #16's care plan and stated the resident care plan did not address any weight loss. She stated she was not aware Resident #16 was not care plan for it. She stated the ADONs and the DON were responsible for care plans. ADON D stated the potential risk for not care planning weight loss would be staff not able to monitor and would not be aware of any interventions for resident not to lose weight. Interview on 09/18/25 at 12:10 PM, the DON revealed the MDS Coordinator was responsible for reviewing and updating care plans. He stated his expectations were for care plans to be completed correctly and updated with the resident plan of care and interventions. He stated it was his responsibility to ensure care plans were completed. He stated if a resident was at risk of weight loss it was expected for it to be care planned. The DON stated he was aware of Resident #16's weight loss and a IDT meeting was held and interventions were put in place. He stated Resident #16 was at risk of weight loss, malnutrition and loss of appetite. The DON stated the potential risk of resident not being care plan for weight loss would be staff not being aware of the interventions. Interview on 09/18/25 at 1:07 PM, the Dietitian revealed Resident #16 had not had a significant weight loss. She stated Resident #16 was receiving 3 house shakes a day for an extra 200 calories. She stated Resident #16 weight was unavoidable due to age related, diagnosis, resident was more of the thinner side and muscle loss of not moving a lot. The Dietitian stated around April and May the facility had issues with the weight scales, and they had the weight scales calibrated. Interview on 09/18/25 at 4:18 PM, MDS Coordinator revealed she had been employed for 3 weeks. She stated she was responsible for care plans and the ADONs and DON were responsible for reviewing them and updating care plans. MDS Coordinator stated residents at risk of weight loss should be care plan for it. She stated she was not aware Resident #16 did not have a are plan for weight loss. She stated the potential risk would be staff not aware of the interventions that were put in place. Record review of facility Care Plans, Comprehensive Person-Centered policy, revised date March 2022, reflected the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise and review the care plan for 1 of 5 residents (Resident #10) reviewed for comprehensive care plans timing and revision. The facility failed to revise and review Resident #10's care plan to include his physician orders to have a 70 ml water flush during his tube feedings. This failure could lead to the residents not receiving appropriate hydration intake. Findings included: Record review of Resident #10's MDS assessment reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #10's MDS assessment, dated 08/07/25, reflected Resident #10's BIMS score of 00 indicating resident was not able to complete the interview. Resident #10's MDS indicated he had parenteral/IV feeding and feeding tube while a resident of the facility. His diagnoses included paraplegia (inability to move or control the legs and lower body), contracture of muscle right and left lower leg (muscles or other tissues tighten or shorten causing deformity), unspecified protein-calorie malnutrition (inadequate intake of protein and calories), dysphagia (difficulty swallowing), gastrostomy status (an opening in the stomach through the abdominal wall, allowing for the placement of a feeding tube) . The MDS reflected Resident #10 was dependent on staff for eating and all activities of daily living skills. Record review of Resident #10's care plan further indicated Resident #10 had an Activity of Daily Living Skills performance deficit. Goal: will maintain or improve current level of function in eating. Interventions included eating: required 1 staff assistance. Resident #10's care plan also noted he required tube feeding related to Dysphagia calorie requirements changed and new order received for 1. Nutren 2.0 at 44mL/hr x 22hr 2. Water flush at 50mL/hr x 22hr. Provides 1936kcal, 968mL formula, 1770ml Total water. Revision on: 04/18/2025 Goal: Resident #10 will remain free of side effects or complications related to tube feeding. Interventions included to clean insertion site daily as ordered, monitoring for signs and symptoms infection or breakdown such as redness, pain, drainage, swelling, and/or ulceration and report to physician if symptoms arise. Discuss with the resident/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications. Monitor/document/report to Physician PRN: Aspiration-fever, Short of Breath, Tube dislodged. Infection at tube site, Self-extubation (patient deliberately removes their own tubing), Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. NPO status Revision on 04/23/2025 1. Nutren 2.0 at 44mL/hr x 22hr 2. Water flush at 50mL/hr x 22hr. Provides 1936kcal, 968mL formula, 1770ml Total water (not counting med flushes). Obtain and monitor lab/diagnostic work as ordered. Report results to Physician and follow up as indicated. Provide local care to G-Tube site as ordered and monitor for signs and symptoms of infection. Registered Dietitian to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. The resident is dependent with tube feeding and water flushes. See physician orders for current feeding orders. The resident needs assistance with tube feeding and water flushes. See physician orders. for current feeding orders. The resident needs the Head of Bed elevated 30 degrees during and thirty minutes after tube feed. Record review of Resident #10's care plan also indicated Resident #10 has alteration in gastrointestinal status (G-Tube) related to Dysphagia; Nutren 2.0 at 44 cc/hr x 22 hours and 100 water flush every hour. Goal: Resident #10 will remain free from discomfort, complications, signs, or symptoms related to gastrointestinal alterations. Interventions included Keep Head of Bed elevated. Give medications as ordered. Monitor/document side effects and effectiveness. Monitor vital signs as ordered/per protocol and record. Notify physician of significant abnormalities (rapid pulse, shallow, rapid, or labored respirations, low blood pressure). Obtain and monitor lab/ diagnostic work as ordered. Report results to physician and follow up as indicated. Revision on: 05/08/2025. Record (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #10's physician's order for feeding revealed one time a day Nutren 2.0 at 44mL/hr via PEG, up at 1200pm until total volume of 968mL has been infused. Provides 1936kcal. FWF 70mL/hr x 22hrs. Total volume= 1540mL fluid. Enteral Feed Active 9/16/2025 12:00 9/16/2025. Observation of Resident #10 on 09/16/25 at 11:18 AM revealed him sitting in the television room. Resident #10 was not connected to his tube feeding machine, it was left in his room. Resident #10's tube feeding machine was currently off, the formula bag was dated 9/15/25 12:30 PM with rate of 44ml, water was dated 09/15/25 12:30 PM rate 70ml. Observation of Resident #10 on 09/16/2025 at 1:12 PM revealed him in the bed with staff checking for tube placement, residual and connecting the tube for his feeding. Observation of Resident #10 on 09/16/2025 at 1:54 PM revealed Resident #10 in bed, observation of feeding machine revealed 44ml 1698, water flush 70 ml. Resident #10's formula bag or water bag did not indicate the date, time, initials, or rate. Observation and Interview on 09/17/2025 at 12:15 PM with LVN B revealed that Resident #10 had been on an alternative formula until the Nutren 2.0 was available, allowing for changes with his feedings and water flushes. LVN B stated any changes with Resident #10's formula or water flow rate should be updated in the care plan by the nursing staff which could include the charge nurse, ADON C or the DON. LVN B stated not doing so could place Resident #10 at risk of receiving the wrong flow rate. Interview on 09/18/25 2:02 PM with ADON C revealed nursing staff were responsible for updating acute changes on the care plan and the MDS Coordinator was responsible for updates during comprehensive reviews. The ADON stated she was not aware that Resident #10's care plan was updated with accurate water flushing. ADON C stated not having the care plan updated could place Resident #10 at risk for not getting the correct amount of hydration. Interview on 09/18/25 at 2:45 PM with the DON revealed Resident #10 had use of tube feeding machine, his expectation was if there was a change in condition or resident status the charge nurse was responsible for updating the care plan. The DON stated when there were any updates or changes, it was brought to the morning meetings and discussed daily. The DON stated a change in formula or water flush rates would be something that he would expect the charge nurse to update on the care plan and the ADON C or himself would review. The DON stated not updating the care plan could place residents at risk of not receiving the personalized care they desire. Interview on 09/18/25 at 4:18 PM with the MDS Coordinator revealed she had been employed for 3 weeks. She stated she was responsible for care plans and the ADONs and DON were responsible for reviewing them and updating care plans. MDS Coordinator stated residents on tube feeding and water flushes should be care planned for it. She stated she was not aware Resident #10's care plan was not updated with the new orders for water flushes. The MDS Coordinator stated, she updated care plans quarterly during the care plan meetings when the resident, family and staff are together to discuss residents' required care. She stated the potential risk would be staff not aware of the interventions that were put in place and dehydration. Record review of facility Care Plans, Comprehensive Person-Centered policy, revised date March 2022, reflected the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services in accordance with subsection (a) of this section for the following activities of daily living, hygiene (grooming) for 1 of 5 residents (Resident #67) reviewed for ADL care. The facility failed to provide Resident #67 assistance with nail care. Resident #67 nails were observed to be about half inch long with black debris under nails on both hands. This failure could place the residents at risk for decreased feelings of self-worth and infection. Findings included: Record review of Resident #67's Quarterly MDS assessment, dated 08/02/25, reflected the resident was a [AGE] year-old male originally admitted to the facility on [DATE], readmitted [DATE]. Resident #67 had cognition intact with a BIMS score of 99 (indicating he was not able to complete interview). Resident #67 was dependent on staff with shower/bathe self, and personal hygiene. Active diagnosis included Non-Alzheimer's Dementia (memory loss), bipolar disorder (mood swings of emotional highs and lows). Record review of Resident #67's current, undated care plan reflected Resident #67 had a self-care performance deficit. The resident required more assistance /cueing with activities of daily living skills. The care plan reflected: Goal: [Resident #67] will maintain current level of function in personal hygiene. Interventions included Bathing/Showering: Check nail length, trim and clean on shower days and as needed. Staff will be aware that resident require more assistance with activities of daily living and provide additional cueing and redirection. Observation and interview on 09/16/25 at 2:06 PM with Resident #67 revealed him in his room sitting in his wheelchair. His nails were at least half inch long with black debris underneath and around the nail bed. Resident #67 stated he was unsure of the last time staff assisted with trimming or cleaning his nails. According to Resident #67 his nails were long and would not mind if someone helped him to cut them down, however he was not bothered by them being dirty. Interview on 09/18/25 at 10:24 AM with the Staffing Coordinator revealed Resident #67's nails were dirty and need to be trimmed. The Staffing Coordinator further stated [Resident #67] is a combative person, however when I care for him I usually will take a towel and clean up under his nails. Nail days are on Sundays, CNAs are responsible for cleaning nails, if residents are not diabetic, on Monday, Wednesday, and Fridays during his shower. The Staffing Coordinator stated not providing nail care to residents could place them at risk for infections, especially someone like Resident #67 because he is a digger, so that is poop underneath his nails. Interview on 09/18/25 at 10:37 AM with CNA F revealed she was not currently working with Resident #67, but resident nail care was to be completed during shower days. She stated she usually paid attention to resident nails daily and would clean or trim them if needed. CNA F revealed it was the responsibility of the aides to complete nail care and grooming for residents on their respective halls and not doing so placed residents at risk of scratching or cutting themselves or others. Interview on 07/24/25 at 1:26 PM with ADON C and the DON revealed they both expected residents to have hand hygiene which included nail care. ADON C stated it was the responsibility of the CNAs to complete nail care if residents were not diagnosed with Diabetes, otherwise the charge nurse would trim and clean resident nails, or resident would be referred to podiatry. According to the DON, previously there was an CNA that was responsible for completing nail care on all residents, that was her specific task, however she has been on maternity leave, so the failure is that no one else has been assigned or has continued that task. Both ADON C and the DON stated not having a plan in place to continue nail care for residents placed them at risk of infections and skin tears. Record review of the facility's Activities of Daily Living (ADL), Supporting policy, updated February 2025, reflected: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene - (bathing, dressing, grooming, and oral care).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, based upon the comprehensive person-centered care plan and the residents' choices for 1 of 3 residents (Residents #52) reviewed for wounds. The facility failed to follow physician orders for the treatment of the surgical wound on Resident #52's left foot, to include failing to properly wrap the foot and ensure the nurses initialed and dated the dressing. This failure could place residents at risk of not receiving the care and services to meet their needs. Findings included: Record review of Resident #52's MDS, dated [DATE], reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #52 had a BIMS score of 14 indicating his cognition was intact. The assessment reflected Resident #52 had a surgical wound with treatments that included pressure reducing device for bed, turning/repositioning program, nutrition, or hydration intervention to manage skin problems, surgical wound care. Diagnoses included Amputation (surgical removal of a limb or body part), encounter for other orthopedic aftercare (used when patients require follow up care after orthopedic procedures or treatments), other chronic osteomyelitis (bone infection that is not completely cured after treatment and can reoccur), right ankle and foot, lack of coordination, acquired absence of other left toes, unsteadiness on feet. Record review of Resident #52's care plan, undated, reflected: Resident has an acquired amputation of Left, forefoot amputation related to gangrene. Measurement 14 X 2 X not measurable cm. Goal: The resident will exhibit adequate coping skills dealing with loss of limb and rehabilitation. The resident will have an acceptable level of comfort and have well-controlled phantom pain. Surgical site will heal with no complications. Interventions included check and document on wound daily for signs and symptoms of infection, drainage, bleeding, any breakdown of skin and impaired circulation (edema or pain). Encourage resident to be an active participant in the rehabilitation process, to set goals that are realistic and achievable. Give analgesics as ordered by physician. Monitor/document for side effects and effectiveness. Physical therapy and occupational therapy to evaluate and treat as ordered. Apply Iodosorb (a gel containing cadexomer iodine use to treat wounds) daily and wrap with gauze roll and apply kerlix. Record review of Resident #52 care plan, undated, reflected Resident has an actual impairment to skin integrity of the left distal foot r/t postsurgical wound. Goal: Resident will have no complications r/t post-surgical wound of the left distal foot. Interventions included: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Follow facility protocols for treatment of injury. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to physician. Record review of Resident #52's care plan, undated, reflected Resident has a post-surgical wound of the right, medial foot. Resident's post-surgical wound of the right medial foot will have no complications. Interventions included: Encourage good nutrition and hydration in order to promote healthier skin. Monitor/document location, size, and treatment of wound. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to physician. Record review of Resident #52's physician orders, dated 09/11/25, reflected: 1. Post-surgical wound of the left, distal foot: Cleanse area with N/S, pat dry and apply. Iodosorb and cover with alginate as then wrap with kerlix For 30 days every day shift every Monday, Wednesday, Friday for surgical wound on the left distal foot for 30 Days start date 09/12/25 - 10/12/25. Post-surgical wound of the right, medial foot: Cleanse area with N/S, pat dry and apply Iodosorb once daily and cover with kerlix and ace wrap. every day shift every Mon, Wed, Fri for Wound Active 09/11/2025 start 09/12/2025 with no end date. Observation and interview on 09/16/25 at 11:43 AM revealed Resident #52 lying in bed, according to Resident #52 he has had all his toes removed during surgeries. Observation of resident's right foot revealed there was no dressing. Resident #52 stated his right foot has healed and looked good so staff was no longer wrapping his right foot. Resident #52 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he had a surgical wound on his left foot, observation revealed the wrap to be loosely wrapped around Resident's left foot and ankle. There was a deep red area at the toes, gauze was not in place and the wrap was not supporting the wound. According to Resident #52 the deep red color at the toe area was betadine. Resident #52 stated there was a guy that came in and changed it on 09/14/25, and it had not been changed since. Resident #52 denied any pain. Interview on 09/18/2025 at 10:22 AM with the Wound Care Nurse revealed he has had only 2 days into the wound nurse position. The Wound Care Nurse stated he was aware that Resident #52 had a wound to his left foot due to his toes being removed. The Wound Care Nurse stated Resident #52 had orders for treatment on Monday, Wednesday, and Friday. According to the Wound Care Nurse he was responsible for providing wound care for residents, however if he was not in the building charge nurses would complete the care. Observation and interview on 09/18/25 at 2:30 PM with the Wound Care Nurse revealed Resident #52's left foot was fully wrapped with an intact dressing. The toe area had soiled through dressing and onto the top sheet. The Wound Care Nurse stated he last changed Resident #52's dressing on 09/17/25. When asked about the time prior, he stated, it was 09/15/25. The Wound Care Nurse further expressed the manner in which Resident #52's left foot was dressed and wrapped when he entered on 09/17/25 was not ok, he stated that the dressing must have come off over night and the nurse on the floor redressed it. The Wound Care Nurse stated when wound care was provided by himself or charge nurse staff initials and date must be identified on the wound. The Wound Care Nurse stated he was responsible for ensuring Resident #52's treatment and dressing was completed according to physician orders, not doing so placed Resident #52 at risk for infections and missed treatments. Interview on 09/18/2025 at 2:35 PM with ADON C revealed she was not aware of any concerns with Resident #52's wound or dressing. ADON C stated it was her expectation that the Wound Care Nurse provided treatment for Resident #52's wound care according to physician orders. ADON C further stated nurses were also responsible to address any dressing concerns if the Wound Care Nurse was not present, once treatment was completed staff initials and the date should be indicated on the wound dressing along with updated clinical records that treatment had been completed. ADON C stated when staff do not place their initials or the date on the dressing it placed residents at risk of infections. Interview on 09/18/25 at 3:52 PM with the DON revealed the Wound Care Nurse was responsible for wound care treatments, if the Wound Care Nurse was not available charge nurses were responsible for treatment if there was a need. The DON stated he expected wounds to be treated according to the physician order, after treatment staff were to include their initials and the date. The DON stated staff not including their initials and the date placed residents at risk of infection and missed treatments. Record review of the facility's current, undated Wound Care policy and procedure, reflected the following: The purpose of this procedure is to provide guidelines for the care for wounds to promote healing.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #10) reviewed for tube feeding management. The facility failed to label and date Resident #10's tube feeding formula and water bags to indicate when the feeding was started. This failure could place residents receiving tube feedings at risk of gastrointestinal disturbances (relating to the stomach and the intestines), and bacterial infection. Findings included: Record review of Resident #10's MDS quarterly assessment, dated 08/07/25, reflected Resident #10 was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #10's MDS assessment reflected Resident #10's BIMS score of 00 indicating resident was not able to complete the interview. Resident #10's MDS indicated he had parenteral/IV feeding and feeding tube while a resident of the facility. His diagnoses included paraplegia (inability to move or control the legs and lower body), contracture of muscle right and left lower leg (muscles or other tissues tighten or shorten causing deformity), unspecified protein-calorie malnutrition (inadequate intake of protein and calories), dysphagia (difficulty swallowing), gastrostomy status (an opening in the stomach through the abdominal wall, allowing for the placement of a feeding tube). The MDS reflected Resident #10 was dependent on staff for eating and all activities of daily living skills. Record review of Resident #10's care plan, last reviewed/revised 10/05/21, revealed Resident #10 had an impaired nutritional status. Goal: Resident #10's intake of nutrients will meet metabolic needs . Interventions included to consult a dietician per order. Educate Resident to consume high-calorie foods first. Encourage intake of nutritional supplements between meals. Record review of Resident #10's care plan further indicated Resident #10 had an Activity of Daily Living Skills performance deficit. Goal: will maintain or improve current level of function in eating. Interventions included eating: required 1 staff assistance. Record review of Resident #10's care plan also indicated Resident #10 has alteration in gastrointestinal status (G-Tube) related to Dysphagia; Nutren 2.0 at 44 cc/hr x 22 hours and 100 water flush every hour. Goal: Resident #10 will remain free from discomfort, complications, signs, or symptoms related to gastrointestinal alterations. Interventions included Keep Head Of Bed elevated. Give medications as ordered. Monitor/document side effects and effectiveness. Monitor vital signs as ordered/per protocol and record. Notify physician of significant abnormalities (rapid pulse, shallow, rapid, or labored respirations, low blood pressure). Obtain and monitor lab/ diagnostic work as ordered. Report results to physician and follow up as indicated. Revision on: 05/08/2025. Resident #10's care plan also noted he required tube feeding related to Dysphagia calorie requirements changed and new order received for 1. Nutren 2.0 at 44mL/hr x 22hr 2. Water flush at 50mL/hr x 22hr. Provides 1936kcal, 968mL formula, 1770ml Total water. Revision on: 04/18/2025 Goal: Resident #10 will remain free of side effects or complications related to tube feeding. Interventions included to Clean insertion site daily as ordered, monitoring for signs and symptoms infection or breakdown such as redness, pain, drainage, swelling, and/or ulceration and report to physician if symptoms arise. Discuss with the resident/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications. Monitor/document/report to Physician PRN: Aspiration- fever, Short of Breath, Tube dislodged. Infection at tube site, Self-extubation, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. NPO status Revision on 04/23/2025 1. Nutren 2.0 at 44mL/hr x 22hr 2. Water flush at 50mL/hr x 22hr. Provides 1936kcal, 968mL formula, 1770ml Total water (not counting med flushes). Obtain and monitor lab/diagnostic work as ordered. Report results to Physician and follow up as indicated. Provide local care to G-Tube site as ordered and monitor for signs and symptoms of (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Avir at Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection. Registered Dietitian to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. The resident is dependent with tube feeding and water flushes. See physician orders for current feeding orders. The resident needs assistance with tube feeding and water flushes. See physician orders for current feeding orders. The resident needs the Head of Bed elevated 30 degrees during and thirty minutes after tube feed. Record review of Resident #10's physician's order for feeding revealed one time a day Nutren 2.0 at 44mL/hr via PEG, up at 1200pm until total volume of 968mL has been infused. Provides 1936kcal. FWF 70mL/hr x 22hrs. Total volume= 1540mL fluid. Enteral Feed Order Active as of 9/16/2025. Observation of Resident #10 on 09/16/25 at 11:18 AM revealed him sitting in the television room. Resident #10 was not connected to his tube feeding machine, it was left in his room. Observation of Resident #10's room revealed his tube feeding machine was currently off, the formula bag was dated 9/15/25 12:30 PM with rate of 44ml, water was dated 09/15/25 12:30 PM rate 70ml. Observation of Resident #10 on 09/16/2025 at 1:12 PM revealed him in the bed with staff checking for tube placement, residual and connecting the tube for his feeding. Observation of Resident #10 on 09/16/2025 at 1:54 PM revealed Resident #10 in bed, observation of feeding machine revealed 44ml 1698, water flush 70 ml. Resident #10's formula bag or water bag did not indicate the date, time, initials, or rate. Observation and interview on 09/17/2025 at 12:15 PM with LVN B revealed him working with Resident #10. LVN B checked for placement of the feeding tube, checked for residual, and connected Resident #10 to the tube feeding machine. LVN B was observed prior to leaving the room writing information on the formula bag and the water bag. Interview with LVN B revealed he did not write Resident #10's name, date, flow rate, his initials or the time formula was administered on either bag on 09/17/25. According to LVN B every feeding and water bag should have written the patient's name, date, time, the flow rate, and nurse initials so that the next nursing staff could follow up if needed. LVN B stated he was responsible for ensuring the clinical information was on both the formula and water bags, however thought it was done for each administration. LVN B stated not doing so could place residents with feeding tubes at risk of receiving the wrong flow rate, malnutrition, or dehydration. Interview on 09/18/25 2:02 PM with ADON C revealed Resident #10 was on tube feeding 22 hours a day, his machine was turned off at 10:00 AM and turned back on at 12:00 PM. ADON C stated nursing staff were responsible for taking Resident #10 off his feeding machine, hooking him back to his feeding machine with a new bag of formula and water according to physician orders. ADON C stated nurses from the next shift, ADON C and the DON were responsible to follow up and monitor residents throughout their shifts to ensure residents on tube feedings were provided with the correct formula and flow rates. ADON C stated her expectations included checking for placement of the tube, checking for residual and connecting the feeding tube. ADON C further stated she expected nurses to include clinical information on the formula and the water bag that included resident name, date, time, flow rate and nurse initials. ADON C stated not doing so placed Resident #10 at risk of feeding from outdated formula and water, diarrhea, infections, and unwanted side effects. ADON C stated nurse from the next shift, ADON C and the DON were responsible to follow up and monitor residents throughout their shifts. During an interview on 09/18/25 at 3:52 PM with the DON revealed he was aware Resident #10 utilized tube feeding for nutrition. The DON stated nurses on the floor were responsible for ensuring resident name, date, time, flow rates and staff initials were written on the formula and water bags during administration. The DON said it was important for Resident #10's tube feeding to have been properly labeled, not doing so placed him at risk of feeding errors and not following physician orders. Record review of the facility's policy revised November 2014, updated February 2025 Physician Orders policy reflected: Purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services. Enteral Orders - when recording orders for enteral tube feedings, specify the type of feedings, specify the type of feeding, amount, frequency of feeding and rationale if as needed. The order should always specify the amount of flush following the feeding. Record review (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Avir at Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility's policy revised November 2018, Enteral Nutrition revealed The recommendation to initiate the use of enteral nutrition is based on the results of the comprehensive nutritional assessment and is consistent with current standards of practice.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 disease and infection for 2 of 2 residents (Residents #4 and #52) reviewed for infection control during medication administration. MA E failed to disinfect the blood pressure cuff in between blood pressure checks for Resident #4 and Resident #52. These failures could place residents at risk of cross-contamination which could result in infections or illness. Findings included: Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included hypertension (high blood pressure) and heart failure (a serious condition but not the same as a heart attack, where blood flow to the heart is suddenly blocked). He had a BIMS score of 13 which indicated his cognition was intact. Record review of Resident #52's quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #52 had diagnoses which included hypertension (high blood pressure). He had a BIMS score of 14 which indicated his cognition was intact. Observation on 09/17/25 at 7:58 AM revealed MA E did not disinfect the blood pressure cuff after she checked the blood pressure for Resident #52. She went directly from Resident #52's room to Resident #4's room and checked Resident #4's blood pressure without disinfecting the blood pressure cuff. Interview with MA E on 09/17/25 at 8:39 AM revealed she did not disinfect the blood pressure cuff between Residents #52 and #4. She stated she knew she was supposed to disinfect between residents. She stated she forgot because she was nervous. She stated failure to disinfect between residents could lead to cross contamination and infection. She stated she had done training on infection control, on her other job. Interview with the DON on 09/18/25 9:07 AM revealed his expectation was for staff to disinfect blood pressure cuffs between each resident due to risk of cross contamination and infection. He stated the facility had done in-services on disinfecting of equipment, but he could not recall when. He stated he was supposed to be doing spot checks on staff for equipment disinfection, but he could not recall when he checked on staff last. Record review of the facility's training records for infection control, dated 07/02/25, revealed (disinfect the blood pressure cuff between residents) MA E, was not in attendance. Record review of the facility's policy for standard precautions, dated 2022, reflected, 5. Resident-Care Equipment: - Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed.		