| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676127 | A. Building<br>B. Wing | 12/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avir at North Richland Hills | 5600 Davis Blvd<br>North Richland Hills, TX 76180 |

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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 of 6 residents (Resident #3) reviewed for pharmaceutical services. MA A failed to supervise Resident #3 after he left the resident's medications in her room during morning medication administration on 12/09/25. This failure could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Record review of Resident #3's Face Sheet, dated 12/09/25, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #3's Quarterly MDS Assessment, dated 11/14/25, reflected the resident had diagnoses of Medically Complex Conditions (multiple serious medical issues at the same time), Hypertension (high blood pressure), Diabetes Mellitus (condition where the body was unable to control blood sugars properly), and Alzheimer's Disease (brain disease that causes progressive memory loss). The MDS also reflected a BIMS score of 13, indicating she was cognitively intact. Record review of Resident #3's Care Plan, dated 09/09/25, reflected the resident had impaired visual function, cognitive loss/dementia, a swallowing problem, hypertension, Diabetes Mellitus and prescribed an oral hypoglycemic (medications that lower blood sugar), and anemia (low red blood cells) with an intervention to give medications as ordered. Record review of Resident #3's Assessment Notes on 12/09/25 reflected no assessment for self-administration of medications and no assessment that the resident was competent to manage their own medications. Record review of Resident #3's Physician Orders reflected the following orders: Order date: 11/11/25 B12 Active (mecobalamin (vitamin b12)) tablet, chewable; 1,000 mcg; amt: 1 tab; oral Once A Day. Cholecalciferol (vitamin D3) capsule; 50 mcg (2,000 unit); amt: 1 CAP; oral Once A Day. cranberry tablet; 450 mg; amt: 1 Tab; oral Twice A Day. Gabapentin capsule; 400 mg; amt: 1 CAP; oral Twice A Day. Glipizide tablet; 5 mg; amt: 1 TAB; oral; Once A Day. Magnesium oxide [OTC] tablet; 400 mg (241.3 mg magnesium); amt: 1 tab; oral Once A Day. omeprazole [OTC] tablet, delayed release ;20 mg; amt: 1 tab; oral Special Instructions: DO NOT CRUSH; Once A Day. aspirin [OTC] tablet, delayed release; 81 mg; amt: 1 tab; oral Special Instructions: DO NOT CRUSH; Once A Day. Prozac (fluoxetine) capsule; 20 mg; amt: 1 Capsule; oral; Once A Day.Record review of Resident #3's MAR reflected on 12/09/25 at 8:03 AM, she was given the following medications and supplements: cranberry tablet, gabapentin (medication for nerve pain), aspirin, vitamin B12, vitamin D3, glipizide (diabetic medication), magnesium oxide, omeprazole (medication to reduce stomach acid), and Prozac (antidepressant). Observation and interview on 12/09/25 at 8:04 AM revealed MA A took a medication cup into Resident #3's room. Resident #3 was in her wheelchair eating breakfast in her room. MA A left the medication cup with medications on the bedside table. Resident #3 stated she would take them when she was done eating. Observation of the medication cup revealed there were 9 pills/tablets in the cup. Interview on 12/09/25 at 9:25 AM with Resident #3 revealed that staff typically watched her take her medications. Resident #3 stated MA A left the medications because she was busy doing something. Resident #3 stated she took her pills just fine. Interview on 12/09/25 at 11:43 AM with MA A revealed he had left medications in the resident rooms when a resident refused to take them. MA A stated he left the medications in Resident #3's room today (12/09/25). MA A stated he would only leave them if Resident #3 was doing something, but most of the time, she took the medications immediately. MA A stated he did go back to ensure Resident #3 took the medications. MA A stated he was not supposed to leave medications in the room. He stated the risk of leaving medications in the room was that the residents would not take them, or that another resident could take the medication. Interview on 12/09/25 at 2:44 PM with ADON C revealed that staff should never leave medications unattended in resident rooms. ADON C stated the residents could forget or not take the medications. ADON C also stated another resident could take the medications. Interview on 12/09/25 at 3:20 PM with ADON D revealed it was unacceptable to leave medications in the room. ADON D stated staff were to watch all the residents swallow the medications. ADON D stated the risk of leaving medications was the resident could drop them, hoard them, or another resident could take them. Interview on 12/09/25 at 3:32 PM with ADON E revealed medications should never be left in the rooms. She stated if a resident requested to self-administer medications, they must go through a process to ensure it was safe. ADON E revealed there were currently no residents in the facility, who were able to self-administer medications. ADON E stated the risk of leaving medications was the resident not taking the medication |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 6 residents (Resident #4) reviewed for medication administration.The facility failed to administer Resident #4's Keppra/levetiracetam (an anti-epileptic drug used to treat seizures) as prescribed. This failure could place residents at risk of inadequate therapeutic outcomes, increased adverse side effects, and decline in health. Findings included: Record review of Resident #4's Quarterly MDS assessment, dated 12/03/25, reflected the resident was a [AGE] year-old female who admitted on [DATE]. The resident's diagnoses included cerebral palsy (a permanent neurological disorder that causes muscle and movement problems) and epilepsy (repeated seizures due to abnormal electrical activity in the brain). The MDS also revealed the resident had severe cognitive impairment. The MDS also revealed the Resident #4 was dependent on all ADLs. Record review of Resident #4's Care Plan dated 09/16/25 reflected the following: Problem: [Resident #4] has a seizure disorder. Goal: [Resident #4] will remain free from injury related to seizure activity through review date .Approach: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness.Record review of Resident #4's physician orders revealed the following:Order date 04/08/24: Keppra (levetiracetam) solution - give 7.5 mL; orally twice a day for epilepsyOrder date 01/31/25: Lactulose solution - give 30 mL; orally every 12 hours, PRNLab order - Order date 9/15/25: Carbamazepine (Tegretol); Keppra level; [DX: Epilepsy, unspecified, intractable, with status epilepticus] Once A Day on the 15th of Every 6th MonthObservation on 12/09/25 at 10:00 AM, revealed LVN B administering medications to Resident #4. LVN B administered 7.5 mL of lactulose (medication for constipation). LVN B did not administer the scheduled dose of Keppra. After medication administration, LVN B checked off the Keppra dose was given on Resident #4's MAR. LVN B did not document that she had administered the lactulose. Interview on 12/09/25 at 1:47 PM with LVN B revealed that after checking the MAR, she confirmed the lactulose was administered instead of the Keppra. She stated the medication bottles looked different, and she was unable to determine why she made the error. LVN B stated Resident #4 did have PRN Lactulose scheduled. LVN B stated she normally gave Resident #4 the Keppra. She stated she could have been nervous. LVN B stated not giving the Keppra put Resident #4 at risk of seizures. She stated it was important to take the Keppra regularly to prevent seizures. LVN B stated she fed Resident #4 lunch, and she had no change in condition or seizures. LVN B stated she had been trained on the medication rights of administration and had completed them during the medication pass. LVN B stated it was a simple error, and she would notify the charge nurse, DON, Guardian, and physician for new orders. Interview on 12/09/25 at 2:44 PM with ADON C revealed that staff were expected to complete the medication rights of administration to prevent medication errors. ADON C stated missing a Keppra dose could put Resident #4 at risk of seizures. ADON C stated she expected her staff to safely administer medications. Interview on 12/09/25 at 3:20 PM with ADON D revealed that staff were expected to complete the 5 rights of medication administration. ADON D stated Keppra was for seizure and seizures could occur if a dose was missed. She stated Resident #4 received an assessment and had no change in condition.Interview on 12/09/25 at 3:32 PM with ADON E revealed that staff were expected to review the MAR and complete the rights of medication administration to prevent errors. ADON E stated Keppra was used for seizures and a missed dose could cause seizure activity. She stated she was made aware of the medication error from LVN B. ADON E revealed the physician was notified and advised to hold this morning's dose of Keppra since it had not been administered. ADON E stated the guardian was also notified and Resident #4 would be put on seizure monitoring for 3 days. ADON E stated in-servicing had been started on medication administration. Interview on 12/09/25 at 4:04 PM with the DON revealed that she expected her staff to complete the 5 rights of medication administration. The DON stated Keppra was used for seizure activity and Resident #4 could have had a seizure if a dose was missed. The DON stated that she was doing in-services to prevent it from happening. Interview on 12/09/25 at 4:25 PM with the Administrator-In-Training revealed that the DON had started in-servicing about medication administration and preventing errors. The Administrator also stated Resident #4 would be on seizure observation for 3 days. Record review of the facility's Administering Medications policy, revised April 2019, reflected the following: .The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**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 program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 6 residents (Residents #1 and #2) reviewed for infection control. MA A failed to sanitize a re-useable blood pressure cuff between uses on Resident #1 and Resident #2.This failure could place the residents at risk of exposure to infections. Findings included: Record review of Resident #1's Quarterly MDS, dated [DATE] reflected the resident was a [AGE] year-old female who admitted on [DATE]. The resident's diagnoses included progressive neurological condition (brain or nerve disorder that gets worse over time) and hereditary motor and sensory neuropathy (genetic condition that causes the nerves in the arms and legs to slowly lose strength and sensation). The MDS also reflected a BIMS score of 15, indicating she was cognitively intact. Record review of Resident #1's care plan, dated 09/03/25, reflected she had, Increased susceptibility to infection due to nutritional deficiencies and dehydration, evidenced by inadequate oral intake, impaired immune function, and compromised hydration status.Record review of Resident #2's annual MDS dated [DATE], reflected the resident was a [AGE] year-old female who admitted on [DATE]. The resident's diagnoses included Non-Traumatic Brain Dysfunction (The brain not working properly due to a medical problem) and Dementia (Severe mental decline). The MDS also reflected a BIMS score of 12, indicating she had moderate cognitive impairment. Record review of Resident #2's care plan, dated 09/09/25, reflected that she required assistance with ADL functions and had impaired cognition and memory loss. Observation on 12/09/25 at 8:32 AM revealed MA A checked Resident #1's blood pressure with a re-usable blood pressure cuff and returned it to the medication cart without sanitizing it. Observation on 12/09/25 at 8:40 AM revealed MA A checked Resident #2's blood pressure with the same re-useable blood pressure cuff used on Resident #1 without sanitizing the cuff prior to or after using it on Resident #2. Interview on 12/09/25 at 11:43 AM with MA A revealed he did not clean the blood pressure cuff between residents. MA A stated he was never taught that, but it made sense. MA A stated the risk of not cleaning it was transferring bacteria to other residents.Interview on 12/09/25 at 2:44 PM with ADON C revealed blood pressure cuffs should always be sanitized from resident to resident. ADON C stated cross contamination and infection issues could occur if re-useable blood pressure cuffs were not sanitized. Interview on 12/09/25 at 3:20 PM with ADON D revealed blood pressure cuffs should be wiped down between residents. ADON D stated the risk of not cleaning the blood pressure cuff was infections and cross contamination. Interview on 12/09/25 at 3:32 PM with ADON E revealed reusable blood pressure cuffs should be disinfected before each resident. ADON D stated the risk of not disinfecting the blood pressure cuff was spreading infection. Interview on 12/09/25 at 4:04 PM with the DON revealed blood pressure cuffs should be sanitized between residents. She stated there were cleaning wipes in each cart and around the building to clean the blood pressure cuffs. The DON stated the risk of blood pressure cuffs not being sanitized was spreading infection from resident to resident. Interview on 12/09/25 at 4:25 PM with the Administrator-In-Training revealed the risk of blood pressure cuffs not being disinfected was cross contamination to residents. Record review of the facility's Standard Precautions policy, revised September 2022, reflected: .5. Resident-Care Equipment.b. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. |