

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER Avir at North Richland Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 5600 Davis Blvd 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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**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 needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents (Residents #1) reviewed for respiratory care. The facility failed to ensure there was a physician order for Resident #1's oxygen therapy when the resident admitted to the facility on [DATE]. This failure could place residents at risk for respiratory infections. Findings included: Record review of Resident #1's entry MDS dated [DATE] reflected a [AGE] year-old female was admitted on [DATE]. Resident #1 had diagnoses which included: pneumonitis due to inhalation of food and vomit (lung inflammation caused by inhaling food, vomit, or saliva often leading to rapid lung injury due to stomach acid). Record review of Resident #1's baseline care plan dated 04/07/2026 reflected the resident was diagnosed with Pneumonitis due to inhalation of food and vomit. The resident required assistance with ADL functions that included: Set up and clean up assistance for meals, Partial to moderate assistance for rolling left to right, and substantial assistance for sit to stand, toilet transfer, transfers to bed. She will be evaluated for PT, OT, ST, and DMI (identifies patients functional deficits). Record review of Resident #1's PHQ-9 (assesses degree of depression severity) that was completed by the SW on 04/08/2026 at 11:35 AM, reflected that Resident #1 had moderate cognitive impairment with a BIMS score of 11. The resident was referred to for psychological services for an evaluation. She was alert and able to communicate her needs to the staff. Record review of Resident #1's physician orders dated 04/07/2026 reflected admit to SNF, full code, PT, OT, ST, RT to evaluate and treat as indicated. Order dated 04/09/2026 Change O2 tubing water . Change Oxygen administration device NC, and humidifier bottle weekly on Sunday night. every night shift every Sun related to pneumonitis due to inhalation of food and vomit. check oxygen Concentrator filter for placement and clean filter every week and PRN every night shift every Sun related to Pneumonitis due to inhalation of food and vomit. Oxygen at <u> </u> LPM via N/C every shift for SOB and to maintain pulse ox (device, usually clipped to the finger, that measures blood oxygen saturation) > less than 90% related to pneumonitis due to Inhalation of food and vomit (choking during swallowing aspiration pneumonia). Record review of Resident #1's TAR did not reflect an admissions order for Oxygen treatment at the time of record review. The facility provided the physician order that was reflected in Resident #1's TAR prior to exit on 04/09/2026. During an observation and interview on 04/09/2026 at 1:10 PM, Resident #1 was observed awake in her wheelchair wearing NC receiving oxygen via the portable green tank attached to her wheelchair. Observation of the NC and oxygen equipment revealed the tubing was not dated. Resident #1 stated that the NC had not been changed on the oxygen concentrator or portable tank since being admitted on [DATE]. Resident #1 stated that she was receiving oxygen to assist with breathing due to a DX of pneumonia. During an interview on 04/09/2026 at 1:27 PM, LVN-A stated he worked at the facility for two weeks. LVN-A stated he had not changed Resident #1's oxygen tubing during his shift 04/08/2026. LVN-A reviewed Resident #1's file and observed she did not have an order for oxygen use on file. LVN-A stated Resident #1 must have an order for treatments from the MD. LVN-A stated that Resident #1 was receiving continuous (continued on next page)</p>		

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>oxygen. LVN-A stated that it was the assigned nurses (LVN-A) responsibility to ensure Resident #1' had an order for Oxygen on file, tubing was changed and dated to prevent overuse of treatment equipment. LVN-A stated the oxygen tubing was expected to be changed and dated weekly or as needed. LVN-A stated the equipment should be checked each shift; however, he did not notice the residents' equipment was not dated. During an interview on 04/08/2026 at 1:45 PM, the ADON stated she had worked at the facility for a couple of weeks. She stated she was unaware Resident #1's oxygen equipment was not dated and labeled. The ADON stated it was standard practice for oxygen equipment to be changed and dated once a week and as needed. She stated the expectation was for all nurses to check the oxygen equipment daily during each shift. She stated that failing to date and change the equipment placed residents at risk for infections. She said it was her responsibility to ensure that the task was completed. An interview with the DON was not conducted because the position was vacant. During an interview on 04/08/2026 at 3:00 PM, the Administrator stated the ADON and DON were responsible for monitoring and ensuring resident oxygen equipment was checked every shift. He stated he expected nurses to change and date oxygen tubing as needed and according to facility protocols weekly. The Administrator stated not changing out the equipment at least once a week could place the residents at risk of infection. The Administrator stated that he was hiring for the DON position. During an interview on 04/09/2026 at 12:16 PM, the Administrator stated the policy the facility had only addressed oxygen. He stated in regard to changing the oxygen equipment, they followed the physician's orders. He provided the facility's policy regarding oxygen storage. Record review of the facility's current, undated Oxygen Storage policy reflected the following: It is the policy of this center to maintain appropriate and safe storage of oxygen. The policy did not address the care, maintenance, labeling, and dating of oxygen tubing.</p>		