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

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676127	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at North Richland Hills	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)
F 0777 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promptly notify the ordering physician of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for 1 of 3 residents (Resident #1) reviewed diagnostic services. LVN A failed to ensure x-ray results for Resident #1's swollen left wrist was reported to the physician when they were available in the lab portal at 11:00 PM on 04/07/26. The facility did not check the lab portal for Resident #1's x-ray results until the morning of 04/08/26 around 6AM when LVN B arrived to work, and the x-ray report revealed Resident #1 had a fractured left wrist, which had resulted from a fall. This failure could affect residents by placing them at risk for untreated illnesses, and delays in necessary care and deterioration in condition. Findings included:Record review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included non-Alzheimer's dementia and depression. The resident had a BIMS of 6 which indicated her cognition was severely impaired. The MDS reflected Resident #1 was independent with ambulation and required partial to supervision of one staff with other ADLs. Record review of Resident #1's care plan revised on 04/09/26 reflected the resident had an ADL self-care performance deficit. Interventions included providing partial supervision assistance for all ADLs. Record review of Resident #1's progress note dated 04/07/26 documented by LVN A reflected Resident has c/o pain in her left wrist. Her wrist was swollen and painful to touch. Resident was given Tylenol for c/o left wrist pain. order X-Ray.Record review of Resident #1's incident/accident report dated 04/07/26 reflected the following: Incident Description .Resident has swollen wrist that's painful to touch, states she had fell and got herself off the floorImmediate Action TakenOrder for Xray from NP on file, prn pain med given. Record review of 24-hour report dated 04/07/26 reflected the following:.Evening 2-10[Resident #1] x ray left wrist pending resultsNight 10-6 [LVN A initials]L wrist swollen and painful.Record review of Resident #1's x-ray results dated 04/07/26 at 11:06 PM reflected the following: Acute-subacute distal radial and ulnar fractures with displacement (wrist fracture with broken bones in the forearm).Record review of Resident #1's hospital record dated 04/08/26 reflected the following: .Findings:Bones: Acute intra-articular fracture of the distal radius [a break in the wrist joint's main bone that extends in the articular surface]. Acute fracture of the ulnar styloid [a break in the small bony prominence on the pinky side of the wrist] .Keep arm immobilized in splint and sling.Assessment Plan.recommend proceeding with open reduction and internal fixation of her left distal radius fracture (a two-part surgical procedure used to treat severe, displaced bone fractures)During an observation and interview on 04/22/26 at 9:30 AM, Resident #1 was sitting on the side of her bed in her room on the facility's secure unit. The resident had a cast to her left hand. Resident #1 stated something happened about three weeks to a month ago, but she could not give any further details or recall the incident. The resident was asked if she was in any pain and she looked at her cast and said not much. Resident #1 was ambulatory in her room with no assistance, and her gait was steady. During an interview on 04/22/26 at 10:46 AM, LVN B revealed Resident #1 was ambulatory and independent for most of her ADLs and she had moments of confusion. LVN B said the morning of the incident, 04/07/26, during shift change, the night nurse (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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NAME OF PROVIDER OR SUPPLIER Avir at North Richland Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 5600 Davis Blvd North Richland Hills, TX 76180	

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F 0777 Level of Harm - Actual harm Residents Affected - Few	(LVN A) said Resident #1 complained of pain to her left wrist and when they looked at her wrist, it appeared to be swollen and painful to touch so they called the doctor for an x-ray order. LVN B said she asked the resident what happened and the resident was not able give her details. The following day, 04/08/26, LVN B said she noticed Resident #1's x-ray results during the overnight shift but no one had pulled them from the computer, so she called the nurse practitioner about the results, who ordered the resident to be sent to the hospital. LVN B said that throughout her shift the day of the incident, Resident #1 did not complain of pain therefore they did not think the resident had a fracture. During an interview on 04/22/26 at 11:01 AM, LVN A revealed during the change of shift on 04/07/26, Resident #1 complained of pain to her left wrist and the resident said she had fallen overnight and gotten herself back up, so the resident was given some Tylenol. LVN A stated the doctor was contacted and an x-ray was ordered. LVN A said she did not recall if she saw or read the 24-hour report that indicated they were waiting for Resident #1's x-ray results when she arrived for her 10:00 PM to 6:00 AM shift (04/07/26). LVN A further stated she did not recall the events of that night, 04/07/26, and possibly missed checking for the x-ray because she was the nurse over two halls, and there was a lot going on during her shift. During an interview on 04/22/26 at 11:35 AM, the PTA revealed she treated Resident #1 the day of her incident, 04/07/26. She stated the resident did not want to use her left hand that day; however, Resident #1 never complained about pain. She stated Resident #1 just guarded her left hand. The PTA said she did not notice that resident's left wrist was swollen until it was placed next to her other hand, and then they noticed it was slightly swollen. The PTA said she asked Resident #1 what happened, and the resident said she had fallen the night before and got herself back up. The PTA had been made aware by LVN B that they had ordered x-rays for Resident #1's hand. The PTA said they continued to do lower body exercises and the resident never complained of pain during her therapy. During an interview on 04/22/26 at 11:43 AM, the PTA Student said he worked with Resident #1 the morning of the incident, 04/07/26, and the resident did not want to use her left hand. The PTA Student said the nurse told him Resident #1 had a fall overnight and they were waiting for the x-ray company. The PTA Student said the resident was taken back to the therapy gym and she was able to participate in lower extremity exercises and never complained of pain but did notice her left wrist was slightly swollen. During an interview on 04/22/26 at 11:46 AM, the OTA revealed she worked with Resident #1 the day of her incident, 04/07/26, and the resident did not want to use her left hand but participated in therapy with her right hand and never complained of pain in her left hand. The OTA said she had been made aware by the PTA that Resident #1 said she had fallen and they were awaiting x-rays to her wrist. The OTA said she did not notice any swelling to the resident's left hand. During an interview on 04/07/26 at 12:32 PM, the ADON revealed she was told on 04/07/26 by LVN B that they had ordered an x-ray for Resident #1's left hand. The ADON said the x-ray results came in during the night shift (04/07/26) but they were not pulled from the lab portal until the next morning (04/08/26) by LVN B. The ADON said the lab company will call the facility when there are critical labs/x-rays but the company appeared to have called another facility with the similar name with the results of Resident #1's x-rays. The ADON said the charge nurses were still responsible for checking the lab portal each shift and Resident #1's pending x-ray results also should have been on the 24 hour-report for LVN A to see. During an interview on 04/22/26 at 12:40 PM, LVN C revealed she worked the 2:00 PM to 10:00 PM shift the day of Resident #1's incident. She stated she was told Resident #1 had fallen, and the x-ray company completed the resident's x-rays during her shift. She stated the x-ray results for Resident #1 did not come back until after she left the facility for the night. She stated Resident #1 did not complain about wrist pain during her shift. Record review of the facility's Lab and Diagnostic Test Results policy, revised November 2018, reflected the following: Assessment and Recognition1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.2. The staff will process test requisitions and arrange for tests.3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. Procedure.4. Licensed nurse reviews lab/diagnostic (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	results and notification is made to the physician 5. Critical Values: Must be immediately communicated to the provider (within 1 hour) .