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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Emerald 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 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 ensure a Registered Nurse was on duty in the facility for a minimum of eight consecutive hours a day, seven days a week, for 1 of 4 quarters, (Quarter 1), reviewed for RN coverage. 1. The facility failed to have 8 consecutive hours of RN coverage for 7 of 31 days in October 2025.2. The facility failed to have 8 consecutive hours of RN coverage for 1 of 30 days in November 2025.This failure could affect the residents by placing them at risk for not having their nursing and medical needs met and receiving improper care.Findings included:Record review of the CMS PBJ Staffing Data Report revealed no RN hours for the following dates: 10/02/25, 10/05/25, 10/18/25, 10/19/25, 10/20/25 and 10/21/25.Record review of an excel file, undated, for RN time stamp hours from 10/01/25 through 12/31/25 revealed no RN coverage on the following dates: 10/02/25, 10/05/25, 10/18/25, 10/19/25, 10/20/25 and 10/21/25.Further review of the excel file revealed there was less than 8 hours of RN coverage on the following dates: - 2.00 hours on 10/11/26 - 5.73 hours on 11/01/26Interview on 06/18/26 at 3:49 PM, the DON stated he had been at the facility for about 3 weeks and was not at the facility in October of 2025. He said the staffing coordinator was responsible for scheduling but was unavailable for an interview. The DON stated he did not know why there was no RN coverage on those days in October. He stated they currently had consecutive 8-hour RN coverage during the week with an RN working the 2-10 pm shift and an RN for the weekends. He said there could be a risk to residents because there were some things LVNs could not do, and RNs would supervise. Interview on 06/18/26 at 4:16 PM, the Administrator stated the staffing coordinator was responsible for scheduling RN coverage. He said the risk of not having an RN could be not doing assessments residents may need or follow up for an LVN. He said RNs can do a little more than LVNs can and it could put a dent in care. Record review of the facility policy titled, Staffing, Sufficient and Competent Nursing revised August 2022, revealed .3. A registered nurse provides services at least eight (8) hours every 24 hours, seven (7) days a week.

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

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Emerald 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure that, a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal care for 2 of 4 residents (Residents #84 and #2) reviewed for ADL care. 1. The facility failed to ensure personal hygiene and grooming, to include hair care and oral care, was provided to Resident #84. 2. The facility failed to ensure nail care, to include trimming and cleaning, was provided to Resident #2. These failures put residents at risk for not receiving the care they require and poor quality of life.Findings included:1.Record review of Resident #84's MDS dated [DATE], revealed the resident was an [AGE] year-old female who admitted on [DATE]. The resident's diagnoses included: anemia (a deficiency of red blood cells that leads to insufficient oxygen delivery to the body), cancer, and high blood pressure. Further review revealed the resident's cognition was intact with a BIMS score of 15 and that the resident had not exhibited behaviors of rejecting care that was necessary for the resident's wellbeing during the assessment period and that the resident was coded as totally dependent for bathing and personal hygiene. Record review of Resident #84's care plan revised 01/26/26 revealed that Resident #84 had an ADL/self-care performance deficiency due to limited range of motion. The care plan listed Resident #84 as totally dependent on staff for personal hygiene and oral care. Observation and interview on 06/16/26 at 10:45 AM revealed that Resident #84 was lying in bed. Her teeth were noted to be a dark brown color, and her hair was matted. Resident #84 stated that she brushed her teeth using dental gum. She stated that she took the dental gum and ran it across her teeth. When asked if she got her teeth cleaned, Resident #84 stated no, but that would be nice. When asked if Resident #84 had seen a dentist, she responded that she had not seen a dentist in her time at the facility. When asked about getting her hair brushed, Resident #84 did not respond, but stated that the staff does help her receive bed baths. Observation on 06/18/26 at 11:50 AM revealed that Resident #84's hair was still matted, and she was lying in bed asleep. In an interview on 06/18/26 at 1:04 PM, CNA B stated that he had worked with Resident #84 for six months. He stated that Resident #84 had sensory issues and did not like using a regular toothbrush. He stated that when staff brushed Resident #84's teeth they tried to do it quickly, but she may refuse. CNA B stated that staff used a sponge brush on the resident's teeth after each meal if they could. CNA B stated thatResident #84 sometimes did not want her hair to get wet. CNA B stated that occasionally Resident #84 would let staff wet her hair with a towel and dry it, but not a deep wash. He stated that Resident #84's family member came in the afternoons and sometimes would brush the resident's hair. In an interview on 06/18/26 at 2:41 PM, Resident #84's RP stated that staff did not come in to brush Resident #84's teeth, and that her hair had gotten so bad that a brush cannot even go through it anymore. The RP stated that she was unable to come up every day to brush Resident #84's teeth and stated that Resident #84 told her that staff will not brush her teeth or brush her hair. The RP stated that she provided Resident #84 with dental gum to try and help since the resident's teeth were not getting brushed. The RP stated that she was unhappy with the care being provided and that the facility had not contacted her about Resident #84 refusing care. Record review of Resident #84's Progress Notes for May 2026 and June 2026 revealed there were no notes for the refusal of oral care, hair maintenance, or conversations with the family for Resident #84. In an interview on 06/18/26 at 3:18 PM, the ADON stated that she had been working there since July 2025. She stated Resident #84's teeth had always been brown. The ADON stated that no one notified her that Resident #84 had been refusing oral care. She stated that if the resident was refusing, the family should be notified, and the facility should be coming up with alternatives. The ADON stated she was unaware that Resident #84 was using dental gum instead of brushing and that this could lead to infection and tooth loss. She stated that the facility would be responsible for getting Resident #84's hair cut if the family refused to cover the cost because her hair was matted, and matted hair could lead to hair loss and head sores. In (continued on next page)

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Emerald 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on 06/18/26 at 3:51 PM, the DON stated that Resident #84 refuses care. He stated that Resident #84 refuses oral care and refuses to have her hair detangled. When asked if the facility was documenting these refusals and documenting conversations with Resident #84's RP, he stated the refusals should be documented and care planned and that he would look for documentation. The DON stated that the risk of residents not getting assistance with their ADLs was that the services help them with everyday life. In an interview on 06/18/26 at 4:17 PM, the Administrator stated that if a resident was refusing ADL care, the staff would notify the nurse, and the nurse was expected to document and encourage the resident to accept ADL care. He stated that if a resident was refusing, there should be interventions in place and that they would speak with the family. The Administrator stated that if ADLs were not being done, the resident was at risk for decline and infection. 2. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a [AGE] year-old female who admitted on [DATE]. Resident #2's diagnoses included Alzheimer's disease (a type of dementia that affects memory, thinking and behavior), cerebrovascular accident (stroke), and hemiplegia (paralysis) and hemiparesis (weakness) following cerebrovascular disease (stroke) affecting left non-dominant side. Further review of the MDS revealed Resident #2's BIMS score was 12 indicating moderate cognitive impairment, and Resident #2 required partial/moderate assistance with personal hygiene. Record review of Resident #2's care plan, dated 03/19/26, revealed an ADL self-care performance deficit and the resident required maximal assist for personal hygiene/oral hygiene. Record review of Resident #2's progress notes, dated 01/01/26 to 06/18/26, revealed no documentation or refusal of fingernail care. Observation on 06/16/26 at 12:29 PM revealed Resident #2's fingernails on the right hand were long. The pinky nail on the resident's right hand were jagged with a brown and reddish substance underneath and on top of the nails. Resident #2's fingernails on the left hand were long with a brown substance underneath the thumb nail. In an interview on 06/16/26 at 12:34 PM, CNA C stated she noticed Resident #2's nails when the surveyor was talking to the resident. She stated she did not have that part of the hall, so she did not know who was responsible to cut Resident #2's nails. She said they had activities and a nail day where they did clipping, cleaning, and color if the resident wanted color. She said the risk if resident's nails were not trimmed or clean would be infection or they could cut themselves with their fingernails. In an interview on 06/16/26 at 1:32 PM, CNA D said CNAs were responsible for cutting nails on their shower days and Resident #2 had an evening shower. She said the risk would be residents could possibly get sick and she did know Resident #2 used her hands to eat. CNA D said residents could hurt themselves if nails were jagged. In an interview on 06/18/26 at 1:11 PM, LVN E stated when CNAs gave showers they were supposed to do nail care unless the resident was diabetic or they refused. He stated most of the time Resident #2 would let him trim her nails. He said they were long and he trimmed them yesterday. He said there could be dirt and there could be a risk of infection or residents could scratch themselves. In an interview on 06/18/26 at 3:49 PM, the DON stated CNAs do nail care on the days they did showers and if the patient was diabetic the nurse would. The DON said it was an infection risk. He stated they started an in-service. He also stated that he and the ADON would go on the hall on shower days to randomly spot check that nail care was provided. In an interview on 06/18/26 at 4:16 PM, the Administrator stated his expectation was CNAs cut residents' fingernails unless the resident was diabetic and then the nurse would. Record review of facility policy titled Activities of Daily Living (ADL), Supporting, updated February 2025, revealed 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.2.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a.hygiene (bathing, dressing, grooming, and oral care);.

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Emerald 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 incontinent of bladder receives appropriate treatment and services for 3 of 3 residents (Resident #65, Resident # 60 and Resident #7) reviewed for urinary catheters.1. Resident #60's catheter bag was observed to be hanging on the back of his wheelchair and was so full it was dragging the ground on 06/16/26.2. Resident #65's catheter bag was observed to be hanging from his bed and was touching the floor on 06/17/26.3. Resident #7's catheter bag was observed hanging from her bed and was touching the ground on 06/18/26.These failures could place residents who use catheters at risk of infection or injury. Findings included:Record review of Resident #60's MDS dated [DATE], revealed that the resident was a [AGE] year-old male who was re-admitted to the facility on [DATE]. His diagnoses included insomnia (difficulty falling asleep), urine retention, and atrial fibrillation (irregular heart rhythm) and was documented to have a catheter. The MDS revealed that he had a BIMS score of 4 (indicating that cognition is severely impaired) and that the resident was dependent on staff for toileting hygiene management and the resident was to have assistance with the maintenance of his catheter bag, including emptying and maintaining cleanliness. Record review of Resident #65's MDS dated [DATE], revealed that he was a [AGE] year-old male who was re-admitted to the facility on [DATE]. His diagnoses included UTI (an infection in any part of the urinary system), anemia (a deficiency of red blood cells that leads to insufficient oxygen delivery to the body), and high blood pressure and was documented to have a catheter. The MDS revealed that he had a BIMS score of 15 (indicating that cognition is intact) and that the resident was to have assistance with the maintenance of his catheter bag, including emptying and maintaining cleanliness. Record review of Resident #7's MDS 04/13/26, revealed that she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included anxiety disorder (persistent or excessive worry about various aspects of life), respiratory failure, and idiopathic progressive neuropathy (sensory, motor, and autonomic nerves worsen overtime but the cause is unknown), and was documented to have a catheter. The MDS revealed that she had a BIMS score of 9 (indicating that cognition is moderately impaired) and that the resident was to have assistance with the maintenance of his catheter bag, including emptying and maintaining cleanliness. Observation and interview on 06/16/26 at 11:09 AM revealed that Resident #60 was rolling down the hall and his catheter bag was dragging the floor. Resident #60 stated he wanted to get to his room so that he could lay down. Resident #60's catheter bag was observed to be covered with a blue privacy bag, and the bag was bulging and could be heard as it scraped the floor when Resident #60 rolled his wheelchair forward. In an interview on 06/16/26 at 11:15 AM, CNA A stated that Resident #60's catheter bag was last checked between 8:00 AM-8:30 AM. CNA A stated that Resident #60's catheter bag was set at the lowest setting and that after she emptied the bag it was no longer touching the floor. CNA A stated that she placed the catheter bag a little higher so that when the bag was full it will not drag the ground moving forward and stated that she was responsible for emptying Resident #60's catheter bag and that it should be covered and off the ground. CNA A stated that having the catheter bag dragging on the floor could put the resident at risk for contamination. Observation on 06/17/26 at 2:23 PM revealed that Resident #65 was in bed and his catheter bag was hanging clipped to his bed frame. Resident #65's catheter bag was observed to be touching the floor.In an interview on 06/17/26 at 3:06 PM, LPN A stated that that the catheter bag should not be on the floor dragging, with a privacy bag and that the strap was to be placed on the resident's lap if they were in their wheelchair, so the line was not dragging. He stated that it was an infection control issue if the catheter bag was on the floor, and it could be spreading infection, or someone could step on it, trip, or slipObservation on 06/18/26 at 9:41 AM revealed that Resident #7 was in bed and her catheter bag was hanging clipped to the bed frame. Resident #7's catheter bag (continued on next page)

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Emerald 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was observed touching the floor.In an interview on 06/18/26 at 3:51 PM, the DON stated that the catheter bag placement could be tricky, especially when the resident has a low bed setting. The DON stated that catheter bags needed to be closed properly, in a privacy bag, and off the floor. He stated that having a catheter bag touching the floor could be an infection control risk for residents. Record review of facility policy Catheter Care, Urinary updated July 2024 stated: PurposeThe purpose of this procedure is to prevent catheter-associated urinary tract infections.Infection Control. b.Be sure the catheter tubing and drainage bag are kept off the floor.

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Emerald 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in one of one kitchen in that:1. One pack of opened lunch meat was undated and unlabeled in refrigerator #2.2. One pack of opened chicken patties was undated and unlabeled in freezer #1.This failure could affect residents who receive meals from the kitchen in that they could be at risk of contracting food borne illnesses.Findings included:Observation on 06/16/26 at 9:27 AM revealed a pack of partially used lunch meat on the top shelf of refrigerator #2 was placed on top of an open box. The package was observed to be unlabeled and undated. During an interview and observation with the Dietary Manager on 06/16/26 at 9:30 AM, a bag of partially used chicken patties was observed to be placed on top of another open box in freezer #1. The bag was not labeled or dated. The Dietary Manager stated that it was the responsibility of all kitchen staff to date and label food if they open them. The Dietary Manager stated that all food should be labeled with the date it was opened and a use by date if applicable. She stated that the risk of not dating or labeling food was that serving undated and unlabeled food to residents could cause them to get sick. The Dietary Manager stated that staff want to ensure food does not go into the danger zone.In an interview on 06/18/26 at 4:27 PM, the Administrator stated that all food should be dated and labeled and that he and the Dietary Manager were responsible for monitoring labeling and dating. The Administrator stated that labeling and dating was done to prevent food spoilage and the risk of it not being done was that it could cause foodborne illness for residents. Record review of facility policy Food Receiving and Storage revised November 2022 stated: .Refrigerated/Frozen Storage1.All foods in the refrigerator are covered, labeled and dated (use by date).7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen,, or discarded.