

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Avir at Fort Worth		STREET ADDRESS, CITY, STATE, ZIP CODE  7100 Trail Lake Dr Fort Worth, TX 76133	
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 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 3 residents (Resident #1) reviewed for abuse and neglect. CNA C, who was responsible for providing Resident #1 with one-to-one supervision, failed to protect the resident when the resident entered into a verbal altercation with CNA A, which escalated to CNA A spraying [NAME] at the resident on 11/16/25. The noncompliance was identified as past noncompliance. The noncompliance began on 11/16/25 and ended on 11/18/25. The facility had corrected the noncompliance before the investigation began. The failure placed residents at risk for serious physical and psychological harm. Findings included: Record review of Resident #1's admission MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included bipolar disorder (a chronic mental health condition characterized by extreme mood swings, energy level shifts, and difficulty with activity levels, ranging from manic episodes to depressive episodes), schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a distorted perception of reality), and spinal stenosis (a narrowing of the spinal canal that puts pressure on the spinal cord and nerves, causing symptoms like back and leg pain, numbness, tingling, and weakness). The residents' cognition was intact with a BIMS score of 15. The resident had other behavioral symptoms not directed towards others at least 4 to 6 days during the assessment review period but less than daily. Those behavioral symptoms included but were not limited to physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds and had the potential to interfere with the resident's participation in activities or social interactions. These behavioral symptoms had the potential to put others at significant risk of physical injury and/or significantly intrude on the privacy or activity of others. The MDS also showed that Resident #1 used a wheelchair due to impairment on both sides to his lower extremities. Record review of Resident #1's care plan revised on 11/12/25 reflected he had a mood problem related to the disease process of bipolar disorder. Interventions included administering medications as ordered, consulting behavioral health, and monitor/record/report to MD mood patterns, signs/symptoms of depression, anxiety, sad mood, impulsiveness or euphoria as per facility behavior monitoring protocols. Record review of the Provider Investigation Report dated 11/21/25 reflected the following: [Resident #1] was around the Activity room arguing with [CNA A]. [CNA A] sprayed resident with pepper spray to the back side of head Record review of Resident #1's progress notes dated 11/16/25 documented by RN B reflected she was at the nurses' station when she heard people yelling/fighting and hear Resident #1 say CNA A had sprayed pepper spray to the back of his head. Other residents and staff in the area were coughing. RN B documented CNA C, who was providing 1:1 supervision told her (RN B) that Resident #1 had gone to the activity room and then began to kick the activity room door when it closed and at that time CNA A came out of the activity room and told everyone around to step back as she sprayed pepper spray on the back of Resident #1's head. The notes also reflected that Resident #1 had called the police after the incident, and the resident had refused a head-to-toe assessment or have the pepper spray washed off his head until the police arrived at the facility. The notes reflected RN B observed multiple small clear liquid scattered on Resident #1's head and once the 2 police men left, the resident allowed RN B to assess/wash his head and she did not notice any redness, bruises, or a rash to Resident #1's head nor did he complain of burning or irritation to his eyes and his speech was clear. Record review of Resident #1's hospital records dated 11/16/25 reflected the resident was seen for toxic effect of lacrimogenic gas (tear gas), assault, initial encounter. Further review of the hospital records reflected there were no injuries documented and no further orders. Observation and interview on 11/18/25 at 10:31 AM revealed Resident #1 was sitting in a wheelchair outside in the courtyard patio socializing with a female resident. CNA C sat near the residents monitoring them. Resident #1 was moved to another part of the patio for a private conversation. Resident #1 stated a staff member (CNA A) had sprayed him with [NAME]. He stated it happened out of nowhere, and he denied having an altercation with CNA A. The resident stated he was going down the hall and CNA A was staring at him, and then all a sudden he had to back out because the CNA was coming at him with the [NAME]. The resident said he was sprayed on the back of the head with [NAME], and some had gotten in his eyes. He stated that both areas began to burn. After CNA A sprayed him with the [NAME] he</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>		

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The noncompliance began on 11/16/25 and ended on 11/18/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of incidents of abuse or neglect not being reported timely and thoroughly investigated. Findings included: Record review of Resident #1's admission MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included bipolar disorder (a chronic mental health condition characterized by extreme mood swings, energy level shifts, and difficulty with activity levels, ranging from manic episodes to depressive episodes), schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a distorted perception of reality), and spinal stenosis (a narrowing of the spinal canal that puts pressure on the spinal cord and nerves, causing symptoms like back and leg pain, numbness, tingling, and weakness). 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