

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 01/20/2026
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**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 and control program, including hand hygiene, 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 Resident #2) reviewed for infection control practices 1. CNA A and CNA B failed to perform hand hygiene prior to and after providing Resident #2 with incontinence care.2. CNA A and CNA B failed to wear a gown when providing incontinence care to Resident #2, who was on EBP due to having a feeding tube. 3. CNA A failed to perform hand hygiene and glove changes while providing Resident #1 and Resident #2 with incontinence care.These failures could place residents at risk of cross-contamination and infections. Findings included: Record review of Resident #2's Face Sheet, dated 01/20/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's Quarterly MDS, dated [DATE], reflected the resident's diagnoses included: cerebral palsy (neurological condition affecting movement, posture, and muscle coordination); urinary tract infection (bacterial infection in any part of the urinary system); seizure disorder (condition characterized by recurring, unprovoked seizures); chronic pain; and muscle weakness. The MDS also reflected Resident #2's cognitive skills were severely impaired, indicating she was unable to make decisions. In addition, the MDS reflected that the resident was dependent on staff for all care, incontinent of bowel and bladder, and had a feeding tube for nutrition. Record review of Resident #2's Care Plan, revised 01/09/26, reflected the resident required tube feeding, had a urinary tract infection in December, had impaired communication due to intellectual disability (limitations with thinking and learning), had an ADL self-care performance deficit with interventions for staff to reposition every 2 hours and revealed she was dependent on staff for showering, eating, hygiene, incontinent care, and transfers. Record review of Resident #2's active physician orders, dated 01/20/26, reflected the following: Enhanced-Barrier Precautions every shift for infection prevention.Observation on 01/20/26 at 9:46 AM revealed CNA A and CNA B entered Resident #2's room, did not wash/sanitize their hands, and did not put on PPE (gown and gloves) prior to entering the room. Resident #2 was observed lying in bed. CNA A and CNA B applied clean gloves, closed the door, and pulled the privacy curtain. CNA A prepared supplies on a clean barrier, unlatched Resident #2's brief, and began to clean the resident's perineal area. CNA A then assisted Resident #2 to turn onto her side, used new wipes and cleaned the buttocks. CNA A rolled the soiled brief within itself and discarded it in the trash. Without performing hand hygiene or changing gloves, CNA A obtained a clean brief and placed it under Resident #2's buttocks, turned the resident onto her back, and secured the brief. CNA A and CNA B then repositioned Resident #2. Both CNAs removed their gloves and exited the room. No hand hygiene was observed upon exit, and both CNAs proceeded down the hallway. CNA A and CNA B did not apply PPE for EBP and did not perform hand hygiene prior to or after providing incontinent care. CNA A also</p> <p>(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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 676132	If continuation sheet Page 1 of 4

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 01/20/2026
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>did not change gloves or perform hand hygiene prior to applying a clean brief during incontinent care. Observation at 01/20/26 at 12:21 PM revealed the enhanced barrier precautions sign next to Resident #2's name plate. The sign reflected the following: Enhanced Barrier precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene. Observation also revealed PPE was available right inside the room door and hand sanitizer noted right outside the door. Record review of Resident #1's Face Sheet, dated 01/20/26, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #1's Annual MDS, dated [DATE], reflected the resident had diagnoses of Hemiplegia following Cerebral Infarction affecting right dominant side (Right side paralysis following a stroke), Aphasia (disorder that affects how you communicate), Seizure Disorder (Condition characterized by recurring, unprovoked seizures), and Anxiety. The MDS also reflected Resident #1's cognitive skills were severely impaired, indicating she was unable to make decisions. In addition, the MDS reflected that Resident #1 was dependent on staff for toileting, showering, dressing, and was incontinent of bowel and bladder. Record review of Resident #1's Care Plan, reflected the resident had impaired physical mobility with interventions for staff to assist resident in performing movements/tasks, had memory loss, and had an ADL self-care performance deficit with interventions that resident was dependent on staff assistance for transfers, incontinent care, personal hygiene, showering, and bed mobility. Observation on 01/20/26 at 1:43 PM revealed CNA A and CNA B entered Resident #1's room and performed hand hygiene. The door was shut, and the privacy curtain was pulled. CNA A gathered supplies on a clean barrier, and both CNAs applied clean gloves. The brief was unlatched, and CNA A cleansed the perineal area, using a new wipe with each swipe. CNA B assisted Resident #1 to turn onto her side and CNA A wiped her buttocks. CNA A folded the soiled brief inward and discarded it into the trash. Without performing hand hygiene or changing gloves, CNA A obtained and applied a clean brief. Resident #1 was rolled back onto her back, and the brief was secured. Resident #1 was scooted up and repositioned by CNA A and CNA B. Both CNAs removed their gloves. CNA B performed hand hygiene. CNA A did not perform hand hygiene and exited the room, proceeding down the hallway. CNA A did not change gloves or perform hand hygiene prior to applying a clean brief and did not perform hand hygiene after incontinent care was completed. Interview on 01/20/26 at 2:55 PM with CNA A revealed she had been working at the facility for 2 months. CNA A stated hand hygiene should be performed anytime she enters or exits a resident's room. CNA A stated she washed her hands in the utility room when getting the supplies for Resident #2 but did not perform hand hygiene after entering or exiting the room. CNA A stated she must have forgotten. CNA A stated she washed her hands before incontinent care on Resident #1 but must have forgotten to do so afterward. CNA A stated she was not taught to change gloves during incontinent care. She stated she usually uses the same gloves for incontinent care but changes them before putting new sheets on the bed. CNA A stated the risk of not performing appropriate hand hygiene or glove changes, was it could spread infections. CNA A stated she did not have many residents in her hallway on EBP. She stated that PPE should be applied before entering the room. CNA A stated she was not aware that Resident #2 was on EBP and missed seeing the sign. CNA A stated she was not trained to use a gown for any of Resident #2's care. CNA A stated she was trained on incontinent care and infection control upon hire; however, she did not recall being taught this. CNA A stated not wearing PPE was an infection problem and could cause cross contamination. Interview on 01/20/26 at 3:15 PM with CNA B revealed hand hygiene should be performed before and after any care. CNA B stated she did not perform hand hygiene before or after incontinent</p> <p>(continued on next page)</p>		

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 01/20/2026
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>care on Resident #2. CNA B stated she normally washes her hands but had not been feeling good and forgot. ten. She stated if hand hygiene were not performed properly, it could spread infection from one room to the other. CNA B stated she was familiar with EBP. She stated a gown, and gloves should be worn before entering the room. CNA B stated she was aware of the sign and saw the PPE in Resident #2's room but thought it was only used if the resident was sick. She stated she was not aware that the feeding tube meant she needed to wear a gown. CNA B stated the risk of not wearing PPE was spreading infections. Interview on 01/20/26 at 4:12 PM with ADON C revealed she expected her staff to perform hand hygiene when entering or leaving a resident room. She stated with any incontinent care, hand hygiene should be performed between glove changes. ADON C stated glove changes should be completed between removing the soiled brief and applying a clean brief. ADON C stated if the CNAs were not performing hand hygiene or glove changes appropriately, it could cause a risk of spreading infections or UTIs. ADON C stated if staff are not performing hand hygiene in-between residents, they could take infections from patient to patient or even to themselves. ADON C stated if a resident was on EBP, staff should be using the PPE provided to them. She stated the staff were aware of residents on EBP by reading the sign. ADON C Stated there was a sign by the name plate and if it was A bed, it was above the plate and if it was B bed, it was below the name plate. She stated the bins were also right outside or right inside the room and contained the PPE needed. ADON C stated the CNAs should be wearing PPE for any resident care. ADON C stated if the staff were not wearing PPE, it puts them at risk of spreading infection. Interview on 01/20/26 at 4:19 PM with the DON revealed her expectation with hand hygiene was that staff perform it when entering or leaving any rooms. She stated with incontinent care, hand hygiene should be performed when going from dirty to clean. The DON stated if they were not performing hand hygiene or changing gloves appropriately, the risk was infection. She stated it was an infection control issue. The DON stated she expected her staff to wear a gown and gloves before entering a resident room on EBP. She stated the staff were aware of residents on EBP because of the sign on the wall and the PPE present. The DON stated that CNAs were trained upon hire and as needed on infection control and incontinent care. The DON stated she was the infection preventionist and was unable to recall the last in-service completed on infection control. The DON stated if the staff were not using PPE, it was also an infection control issue. The DON stated her and the ADONs were responsible and monitored the staff during their daily rounds. The DON stated she was going to start in-services and training for infection control. Interview on 01/20/26 at 4:50 PM with The Administrator revealed he expected his staff to wash their hands before and after care, before wearing gloves and with any glove changes. He stated if staff were not properly performing hand hygiene, it could transfer infections. Record review of the facility's Enhanced Barrier Precautions Policy, revised March 2024, reflected the following: Policy Statement: Enhanced barrier precautions (EBP) are utilized to reduce the transmission of multi-drug-resistant organisms to residents. 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions for not otherwise apply. A. Gloves and gown are applied prior to performing the high contact resident care activity. 3. Examples of high contact resident care activities requiring the use of gowns and gloves for EBPs include A. dressing; b. Bathing/showering; c, transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting. Record review of the facility's Handwashing/Hand Hygiene policy, revised January 2025, reflected the following: .1. Hand hygiene is indicated: a. Immediately before touching a resident. d. after touching a resident; e. after touching a resident's environment; f. before moving from work on a soiled body site on the same resident; g. immediately after glove removal. Record review of the facility's</p> <p>(continued on next page)</p>		

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 01/20/2026
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Perineal Care Policy, revised February 2018, reflected the following: .4. Discard soiled gloves, sanitize hands. Re-glove prior to touching clean linens/adult brief b. If gloved, remove and discard gloves following center guidelines at the appropriate time to avoid environmental contamination. Sanitize hands. Record review of the CDC guidelines, Clinical Safety: Hand Hygiene for Healthcare Workers, updated on 02/27/24, reflected the following: Know when to clean your hands: Immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal. When to change gloves and clean hands: If gloves become damaged, if gloves become soiled with blood or body fluids after a task. If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs. If moving from care on one patient to another patient. If they look dirty or have blood or body fluids on them after completing a task. Before exiting a patient room.</p>		