STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676132	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Fort Worth	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to provide reasonable accommodation of resident needs and preferences for one (Resident #1) of four residents reviewed for resident rights. The facility failed to provide an alternative means of communication to the call light system for Resident #1. This failure could place residents at risk for delayed assistance and an inability to request help when needed. Findings included: Record review of Resident #1's MDS, dated [DATE], revealed Resident #1 was a [AGE] year-old admitted to the facility on [DATE] with severely impaired vision and had a BIMS score of 6, indicating severe impairment in cognition, thinking and memory. Resident # 1 was incontinent of bowel and bladder and had a primary diagnosis of hypertensive heart (structural and functional changes to the heart caused by long-term high blood pressure) and chronic kidney disease without heart failure. Record review of Resident #1's care plan, not dated, revealed the following: Focus: Sensory/Perception Alterations: Visual Goal: Resident to achieve maximum functional status within limits of visual impairments Intervention: Evaluate Resident's ability to function safely within limits of visual impairmentsRemove possible environmental barriers to ensure safety Further review of Resident #1's care plan did not reveal an entry reflecting the resident was known not to use the call light, nor was there an entry identifying an alternative means of communication to the call light system. During an observation on 03/11/2026 at 12:07pm, Resident #1 was observed standing in the middle of her room, motionless and silent. Resident #1 was observed in this position for approximately one minute and was asked from the hallway if she needed help. The resident responded she needed the bathroom. Upon entering Resident #1's room, the smell of BM was observed. Resident #1 was asked if she needed help and she said yes. Resident #1 was asked if she had pressed the call light to request help and she stated she did not know what that was. Resident #1 was asked if she knew how to press the call light to get a nurse and she stated she did not know how to do that. The call light was observed to be inaccessible with the cord wrapped up and against the wall, behind the privacy curtain. The surveyor requested assistance from staff down the hall. During an interview with LVN A on 03/11/2026 at 12:40pm, LVN A was asked if Resident #1 used her call light. LVN A stated she was fully blind, and she could not press the call light. She further stated if they put the call light within reach, Resident #1 would not press the call light, even if they clipped it to her shirt. LVN A was asked how Resident #1 communicated that she needed help, and LVN A stated she was able to verbalize what she needed, she would shout if she did need help and her door was always left open. LVN A stated she kept an eye on Resident #1, and mostly everyone knew to do that for her because she was one of two blind patients on that hall. LVN A was asked if an alternative method to the call light had been designated for Resident #1 and she stated she was not aware of one. LVN A was asked if there was a risk for the resident not using the call light, and she stated she did not think there was because she could tell them or shout out what she needed, when she was agitated, she was very vocal. During an interview with CNA B on 3/11/2026 at 2:16pm, CNA B was asked if she knew Resident #1 used the call light. CNA B stated she had only worked at the facility for three days, but she knew Resident #1 was blind and did not think she used the call light. CNA B further stated she knew Resident #1 needed assistance, and she could eat on her own. CNA B stated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would poke her head in and check on her; she was constantly rounding on the hall. CNA B was asked if she was aware of an alternative method to the call light for Resident #1 and she stated she was not aware of one. During an interview with the DON on 03/11/2026 at 3:43pm, the DON was asked if it was known that Resident #1 did not use her call light, and she stated she has used it in the past, but maybe she had days she did not recognize what it was. The DON stated they kept her door open, and she was close to the nurse's station so that they could see her when they went by. The DON was asked if Resident #1 did not use her call light, had an alternative communication method been identified and documented, and the DON stated it had not. The DON was asked if there was a risk for the resident not having a way to communicate she needed help and the DON stated her safety, and she could have skin breakdown if she wore a soiled brief for too long. A review of the facility's Call System, Residents Policy, dated September 2022 and updated January 2025 revealed the following: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. 4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care that meet the professional standards of quality of care for one (Resident #2) of four residents reviewed for baseline care plans. The facility failed to complete a baseline care plan within 48 hours of Resident #2's admission to the facility. This failure could place the residents at risk of not receiving effective, person-centered care and experiencing adverse events that are most likely to occur right after admission. Findings included: Record review of Resident #2's initial MDS, dated [DATE], revealed she was a [AGE] year-old admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction (a type of stroke caused by a blockage in a blood vessel). Resident #2's BIMS score was 13, indicating her cognition was intact. Resident #2 had a Foley catheter (a thin tube inserted through the urethra into the bladder to provide continuous drainage of urine) and was incontinent of bowel. Record review of Resident #2's baseline care plan revealed it was not completed, with only one entry that revealed the following: Focus: Resident is at risk for falls r/t gait/balance problems and fearful of falling Goals: The resident will not sustain serious injury through the review date Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach of the resident to use it for assistance as needed. Pt evaluate and treat as ordered or PRN. Use gait belt with transfers. During an interview with the Social Worker on 03/11/2026 at 1:13pm, the Social Worker was shown the care plan section for Resident #2 in PCC (an electronic health record software platform used to manage resident data) and confirmed the baseline care plan was not completed. The Social Worker was asked whose responsibility it was to make sure the care plan was complete and she stated it was the responsibility of every discipline of the IDT to make sure their section was complete. The Social Worker stated they must have missed that one. The Social Worker identified the risk for the resident was the staff did know what care they needed to provide if it's not there. During an interview with the DON on 03/11/2026 at 3:43pm, the DON was shown Resident #2's record in PCC and was shown the baseline care plan was not there. The DON looked under the miscellaneous tab, stating sometimes they scanned it to the miscellaneous tab instead. The DON confirmed the baseline care plan was not in Resident #2's chart. The DON stated she usually went into PCC and checked the care plans, but she must have missed it. The DON was asked if there was a risk for the resident if the care plan was not completed and she stated of course, to be able to care for her, it's so they knew what to do, it's the staff's plan of care. A review of the facility's Care Planning-Interdisciplinary Team policy, dated March 2022, updated 12/2024, revealed the following: The interdisciplinary team is responsible for the development of resident care plans.Resident care plans are developed according to the timeframes and criteria established by S483.21.