

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Avir at Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen. 1. The facility failed on 07/23/2025 to ensure food items in the facility walk-in refrigerator was dated. 2. The facility failed on 07/23/2025 to ensure the seasoning containers were tightly covered.3. The facility failed on 07/23/2025 to ensure the top and back of the oven was clean and free from debris and dust.4. The facility failed on 07/23/2025 to ensure the ice making machine was free from leaks and accumulation of scale. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination.Findings included: Observation on 07/23/2025 at 9:18 AM of the kitchen revealed: An open box of single packet sour cream was not dated in the walk-in refrigerator. Seasoning containers of black pepper, whole celery seed, garlic powder, Italian seasoning, meat tenderizer were not tightly covered and exposed to air. The top back of the oven had oil debris and dust buildup. The ice making machine was leaking and had scale accumulation around it. An interview on 07/21/2025 at 9:26 AM with the Dietary Manager who stated she and her 9 employees that were responsible for dating, covering food items, and keeping the kitchen equipment clean. She stated her expectation was all food items in the kitchen should be marked with received date once they arrive at the facility and used by date for leftovers and opened food items, and all food items should be appropriately dated, covered for freshness, and labeled by the kitchen staff. She stated the risk of not dating, covering food items, not cleaning and maintaining the ice machine and oven could cause cross contamination, growth of bacteria, resulting in food borne illness. She stated all employees were in serviced regarding dating, labeling, covering food items and cleaning, properly maintaining kitchen equipment. An interview with [NAME] on 07/23/2025 at 09:36 AM stated he and all other kitchen staff were responsible to make sure the food items were covered, dated and labelled, the ice machine and oven were clean. He stated not dating, covering food items and not cleaning and maintaining kitchen equipment could cause residents to get sick due to food borne illness. [NAME] stated he had received training regarding food and kitchen equipment handling within the past two months. An interview with the facility Dietician on 07/22/2025 at 1:38 PM stated covering and putting date on foods items were important to ensure freshness, rotation of first in and first out of that item. She stated she expected the kitchen staff to put date when they receive the food item and when they open it. Dietician stated it was important to ensure kitchen equipment such as oven and ice machine were clean to ensure food was safe to serve. Record review of the facility policy titled food storage with a revised date of June 1, 2019, reflected: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Code and HACCP guidelines. Dry storage: To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labelled and dated. Refrigerators: Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Record review of the facility policy titled General Kitchen Sanitation: dated October 1, 2018, reflected The facility recognizes that food-borne illness has the potential to harm elderly and frail (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents. All Nutrition and foodservice employees will maintain, clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness. Clean and sanitize all food preparation areas, food contact surfaces, dining facilities and equipment. Keep food contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil. Clean non-food-contact surfaces of equipment at intervals as necessary to keep them free of dust, dirt and food particles and otherwise in a clean and sanitary condition. Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage. 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. (B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety		

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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, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when doing so would endanger the health or safety of the resident or other residents for 1 of 23 residents (Resident #33) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light device was within the reach of Resident #33 on 07/21/2025 when the resident was lying in bed in his room. This failure could have placed residents at risk of being unable to have a means of directly contacting the caregivers. Findings included: A record review of Resident #33's MDS dated [DATE] revealed he was a [AGE] year-old male with an admission date of 07/03/2025 and a BIMS score of 14, which indicated intact cognition. Resident #33 had a diagnosis of stroke (damaged brain cells due to reduced blood flow), history of falling, and hip fracture. Resident #33 was occasionally incontinent of urine, frequently incontinent of bowel, and required substantial/maximal assistance with bed to chair and toilet transfers. A record review of Resident #33's care plan dated 07/10/2025 reflected he used a wheelchair for mobility and was at risk for falls, at risk for skin breakdown and pressure ulcers related to incontinence and impaired mobility. Goal: (Resident #33) would remain free from injury. Approach: Gave (Resident #33) verbal reminders not to ambulate/transfer without assistance. Observation and interview on 07/21/2025 at 11:29 AM revealed Resident #33 who was lying in bed. Resident #33's call light was kept on the bedside stand, away from Resident #33, and Resident #33 was unable to reach his call light device. Resident #33 stated he could not find his call light device. An interview with CNA A on 07/22/2025 at 2:50 PM stated she had worked at the facility for two months and she worked on different halls. CNA A stated she ensured the call light was always within reach of the resident before she left a resident's room after providing care. She stated it was all employees' responsibility to ensure the call light was within resident's reach. She stated not having a call light within reach of a resident could have led to fall risk, injury, not receiving emergency care, not receiving timely incontinent care, and skin damage. She stated she had received in-service training on call lights within the past three weeks. An interview with LVN D on 07/22/2025 at 3:25 PM stated she expected the resident's call light had to always be within reach and all employees who went into a resident's room were responsible for making sure the call light was within reach of that resident. She stated she received in-service on call lights twice a month along with other employees and not having a call light within reach could have led to residents becoming frustrated, not receiving emergency care, falls, and injury. An interview with CNA B on 07/22/2025 at 3:36 PM stated she had worked at the facility for a month. She stated call lights were life saver, and she always made sure the call light was within reach of the resident whenever she went to a resident's room. She stated not having a call light within reach could have increased the risk for falls, injuries, and even death of the resident by not getting timely care. She stated all staff were responsible for making sure the call light was within reach of the resident, and she had received orientation and in-service training on call lights. An interview with RN E on 07/23/2025 at 11:45 AM stated the call light should have been within the resident's reach at all times, and she expected all staff to ensure the call light was within resident's reach before they exited the resident's room. She stated not having a call light within reach of a resident could have caused falls, injuries, and death. She stated she had received in-service training on call lights that week. An interview with the DON on 07/23/2025 at 3:59 PM stated he expected the call light to be within reach of the resident and it was all the employees' responsibility to make sure the call light was within the reach of the residents. He stated the residents were at risk for not receiving ample care, falls, and injuries if the call light was not within reach. He stated all employees received in-service training on call lights every month. A record review of the facility's call light policy dated 12/2017 revealed: It is the policy of this home to ensure residents have a call light within reach that they are physically able to access and that they (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been instructed on its use. When providing care to residents, be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. Be sure call lights are placed near the resident, never on the floor or bedside stand.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 8 residents (Residents #1 & #2) reviewed for care plans. 1. The facility failed to develop a comprehensive person-centered care plan that reflected Resident #1's diet was a puree diet as ordered on 07/10/25. 2. The facility failed to develop a comprehensive person-centered care plan that reflected Resident #2's diet order for double protein portions as ordered on 06/13/25. This deficient practice could place residents at risk of not receiving the necessary care or services. Findings included: 1. Record review of Resident #1's Comprehensive MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of dementia (loss of cognition), heart failure, and dysphagia (difficulty swallowing). She had a BIMS of 7 (severely impaired cognition). Record review of Resident #1's care plan, dated revised 06/13/25, reflected she was on a therapeutic diet due to being NPO (nothing by mouth) and had a feeding tube due to dysphagia (difficulty swallowing). Interventions included the dietary manager to monitor and discuss food preferences and provide feedings and water flushes as ordered. Record review of Resident #1's physician orders reflected diet NPO with a start date of 06/04/25 and end date of 07/10/25 and an order for a Regular Diet-Puree, liquids, thin with a start date of 07/10/25. In an interview on 07/21/25 at 9:50 AM with Resident #1 revealed she used to be NPO due to a feeding tube and she currently was on a pureed diet. 2. Record review of Resident #2's MDS reflected he was a [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses of heart failure, dementia (loss of cognition), and kidney failure. He had a BIMS score of 13 (intact cognition). Record review of Resident #2's care plan, dated 06/06/25 reflected he was on a liberalized renal diet and interventions included monitoring and discussing of food preferences with the Dietary Manager and offer snacks within diet. Resident #2's care plan did not reflect a meal supplement or double protein portions. Record review of Resident #2's physician orders reflected Renal diet- regular texture, thin liquids; double protein portions. with a start date of 06/13/25. In an interview on 07/23/25 at 11:04 AM with Resident #2 revealed he received double protein for meals and was included in care planning and did not recall meals being discussed. In an interview on 07/23/25 at 1:33 PM with the Regional MDS Nurse Consultant revealed she was responsible for creating and updating care plans. She reviewed Resident #1's care plan and stated the care plan did not reflect resident was on a pureed diet and showed she was NPO and had a feeding tube. She stated Resident #1's care plan should have been updated to reflect the change in her diet. She reviewed Resident #2's care plan and stated she did not think an order for double protein and health supplement would be something they care planned because it was too specific. She stated it was important to ensure a resident's care plan was specific. In an interview on 07/23/25 at 2:36 PM with the DON revealed the MDS Nurse was responsible for care plans, and he expected care plans to be resident centered and the be up to date with their diet. He it was important to ensure the resident's care plan accurately reflected their current diet orders because it directed the resident's plan of care. In an interview on 07/22/25 at 1:38 PM with the Dietician revealed she spoke with Resident #1 on 07/16/25 and was NPO at the time and did not recall any changes to her diet. She stated Resident #2 was on a renal diet and she spoke with him on 07/13/25 and updated his diet order, he requested a supplement and double protein portions. She stated when she updated a resident's diet, she sent the information to the clinical team including the DON and Dietary Manager to ensure everyone was aware of changes. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated it was important to ensure resident diets were care planned and updated upon changes in orders to ensure they received the adequate protein and calories and reflected their food preferences. In an interview on 07/23/25 at 2:11 PM with the Dietary Manager revealed Resident #1 was on a puree diet and used to be NPO (nothing by mouth). She stated Resident #2 was on a renal diet. She stated she was not aware Resident #1 and Resident #2's care plans were not updated to reflect their orders. She stated that it was important to ensure the resident's diet was care planned to ensure their food preferences were honored. She stated that resident's diet orders automatically changed their meal tickets and Resident #2 had been receiving a puree diet as ordered and Resident #2 received double protein. Record review of the facility's care plan policy, titled Care Plan- Resident, dated December 2017, reflected: .It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident. Approach/Plan.b. Coordinate care to be provided to the resident for the most effective, efficient utilization of resources.c. Individualize care to ensure the care plan is person centered for the unique needs of the resident.d. Communicate vital information to staff providing direct resident care.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #82) of 23 residents reviewed for ADLs. The facility failed to ensure Resident #82 had his fingernails cleaned and trimmed on 07/23/2025. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings included: Record review of Resident # 82's face sheet dated 07/23/2025 revealed he was a [AGE] year old male with an admission date of 07/14/2025, diagnoses include Encephalopathy (Brain disfunction which can severely impact cognitive abilities, hinder ability to perform routine tasks, maintain personal hygiene), Undifferentiated Schizophrenia (a mental illness affecting thought and ability to function independently), Necrotizing fasciitis (An illness that ca lead to significant functional impairment and reduced quality of life), Type 2 diabetes mellitus without complications (elevated blood sugar levels). Record review of Resident #82's care plan dated 07/22/2025 reflected he had ADL self-care performance deficit and required staff assistance. Resident #82 had frequent episodes of urinary and bowel incontinence; he was at risk for impaired thought process related to Encephalopathy. An observation and interview on 07/21/2025 at 2:40 PM with Resident #82 revealed he was on isolation precaution due to positive Covid-19 (Infectious disease caused by SARS-CoV-2 virus, affects the respiratory system) diagnosis, he was lying on his bed. Resident #82 had long, dirty fingernails, he stated he would like it to be trimmed and cleaned, but nobody offered him assistance yet. An interview with LVN D on 07/22/2025 at 3:25 PM stated she was the nurse for Resident #82 that shift. She stated Resident #82 had a diagnosis of diabetes; she was not aware Resident #82 had a long dirty fingernail. She stated she expected fingernail trimming to be completed during the shower and as needed. She stated long dirty fingernails could cause harmful germs to grow and increase the risk of infections. She stated she had received Inservice on fingernail care within that month. An interview with CNA B on 07/22/2025 at 3:36 PM at Resident #82's room stated she saw Resident #82's long dirty fingernails when the surveyor brought it to her attention. The interview continued outside resident's room; CNA B stated she did not notice resident #82's long fingernails when she provided care to him. She stated dirty long fingernails can cause skin tear, harbor harmful germs and bacteria, infections and illness. CNA B sated she would let her nurse know if a resident had a long dirty fingernail and she would follow her nurses' instructions. She stated nurse was responsible to trim a resident's fingernail if that resident had elevated blood sugar level. She stated she had received in services, frequent reminders about fingernail care since she started working at the facility a month ago. An interview with RN E on 07/23/2025 at 11:45 AM stated the nurse and the aide were responsible to clean and trim resident's fingernails during bath days and as needed. She stated if a resident was diabetic, the nurse was responsible to trim the fingernails, and the nurse could do the cleaning after checking with the nurse. She stated long dirty fingernails increased the risk for infections, illness and skin tear. She stated the charge nurse was responsible to trim Resident #82's fingernails since he was diabetic. She stated she and her staff received in service on fingernail care every month. An interview with the DON on 07/23/2025 at 03:59 PM stated he expected the resident's fingernails to be cleaned and trimmed as needed. He stated if a resident preferred to have long fingernails, it had to be care planned. He stated the nursing team was responsible to ensure all residents had clean and trimmed fingernails unless they refused. He stated long dirty fingernails could affect the skin integrity and cause infections. DON stated all the employees received in services on fingernail care on every month and as needed. Record review of facility policy titles nail/hand and foot care dated 12/2017 reflected it is the policy of this home to ensure residents receive nail care (hand and foot) in a safe manner. Precautions: Nursing assistants will provide nail care to those residents who requiring assistance . nursing assistants will follow (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	home guideline for hand, foot and nail care, nursing assistants will receive permission and instructions from the charge nurse prior to cutting fingernails or toenails.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (Nurses Cart 300 Short Hall) of 3 carts reviewed for pharmacy services. The facility failed to ensure LVN J, LVN K, and LVN L responsible for Nurses Cart 300 Short Hall, counted all controlled drugs for every shift change on 06/07/2025, 06/08/2025 and 06/16/2025 when LVN I and Surveyor reviewed the count sheets on 07/21/2025. This failure could place residents at risk of not having the medication available due to possible drug diversion. Findings included: Record review and interview on 07/21/25 at 12:57 PM of Nurses Cart 300 Short Hall, with LVN I (nurse responsible for the Nurses Cart 300 Short Hall) revealed missing signatures for Off duty and On duty for 06/07/2025 (10:00 PM to 6:00 AM shift), 06/08/25 (2:00 PM to 10:00 PM shift), and 06/16/2025 (6:00 AM to 2:00 PM shift) of the narcotic count sheet. LVN I stated nurses were responsible to sign the narcotic sheet after counting the narcotics at the beginning and at the end of the shift. Interview on 07/23/2025 at 12:18 PM, LVN K stated she should have signed the narcotic sheet after counting the narcotics, on 6/8/25 at the beginning and at the end of the shift 2 PM to 10 PM. She stated she was not sure why she did not sign the count sheet. She stated she knows that she supposed to sign immediately after the count was done. She stated the risk would be potential for drug diversion. Interview on 07/23/25 at 12:31 PM, LVN J stated she should have signed the narcotic sheet after counting the narcotics on 6/7/25 at the beginning and at the end of the shift 10 PM to 6 AM. LVN J stated, I counted the narcotics, but I forgot to sign. LVN J stated this failure could potentially cause a drug diversion. She stated she was trained and learned that she supposed to sign the narcotic count sheet immediately after counting with the other nurse. Attempted to call LVN L on 07/23/25 at 12:38 PM who worked on 06/16/2025 and was missing LVN L's signature. Interview on 07/23/25 at 3:50 PM, the DON stated he expected nurses to sign the narcotic count sheet at the beginning and at the end of their shift after they completed count with the incoming and off-going nurse. The DON stated if the staff was not signing the narcotic count sheets, he was unable to prove they were counting. The DON stated it was important to ensure a drug diversion did not occur. The DON stated the ADONs would weekly check the carts for monitoring. Review of the facility's policy Narcotic Count dated December 2017, reflected . 1. The nurse coming on duty and the nurse going off duty must count and justify narcotics supply for each individual resident at the change of shift. 2. Each nurse counting must record the date and his/her signature verifying that the count is correct on the [Narcotic Count Sheet], at the beginning and end of each shift.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (Nurses Cart 300 Short Hall) of 3 medication carts reviewed for pharmacy services. The facility failed to ensure LVN I responsible for Nurses Cart 300 Short Hall, removed medications in unsecure containers from the Nurses Cart on 07/21/2025 when a controlled medication used for pain had broken seals. This failure could place residents at risk of not having the medication available due to possible drug diversion. The findings included: Record review and observation on 07/21/25 at 12:57 PM of Nurses Cart 300 Short Hall, with LVN I revealed the blister pack for Resident #24's hydrocodone acetaminophen 5-325 mg tablet (controlled medication used for pain) had 2 blister seals broken and the pill still inside the broken blister and taped over. Interview on 07/21/25 at 1:03 PM, LVN I stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seals were broken, and she was not aware of who might have damaged the blisters. She stated the risk would be a potential for drug diversion. LVN I stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shifts. She stated when a broken seal was observed, she would waist the pill with another nurse. Interview on 07/23/25 at 3:50 PM, the DON stated he expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened or tapped over. The DON stated the risk would be potential for drug diversion. He stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADONs were supposed to check the carts weekly. The DON stated the pharmacy consultant checked the carts monthly and he stated ADONs were supposed to check of the medication carts for monitoring. Record review of the facility's policy titled Medication Storage - in the Home, dated December 2017, revealed in part . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of per procedures for medication destruction, and reordered from the pharmacy .		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Avir at Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Live Oak St Dallas, TX 75204	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 residents (Resident #15 and Resident #21) of 3 observed for infection control. The facility failed to ensure:1- CNA F changed gloves during incontinent care for Resident #21 on 07/21/2025.2- CNA G performed hand hygiene and changed gloves during incontinent care for Resident #15 on 07/21/25.These failures could place residents at risk for infection and cross contamination of pathogens and illness.Findings included:1.Record review of Resident #21's Quarterly MDS assessment dated [DATE] reflected Resident #21 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning), diabetes mellitus, and elevated blood pressure. Resident #21's BIMS score of 08, which indicated Resident #21's cognition was moderately impaired. The MDS assessment indicated Resident #21 required maximal assistance with toileting hygiene.Observation on 07/21/25 at 10:40 AM revealed CNA F was in Resident #21's room to provide incontinence care. CNA F had gloves on, she unfastened Resident #21's brief, she then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. She rolled resident on her side. CNA F wiped the resident's buttock area with peri-wipes, front to back, she then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. She rolled the resident on her back onto the clean brief. Once finished, she fastened the resident's brief. She removed and discarded her gloves and washed her hands. In an interview on 07/21/25 at 12:30 PM, CNA F stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA A stated failing to provide proper care exposed the resident to infections. 2.Record review of Resident #15's Quarterly MDS assessment dated [DATE] reflected Resident #15 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included dementia (a group of thinking and social symptoms that interferes with daily functioning), muscle weakness, and need for assistance with personal care. Resident #15's BIMS score of 13, which indicated Resident #15's cognition was intact. The MDS assessment indicated Resident #15 required maximal assistance with toileting and personal hygiene. Observation on 07/21/25 at 12:38 PM revealed CNA G entered Resident #15's room to provide incontinence care. CNA G washed his hands and donned gloves, he unfastened Resident #15's brief, he cleaned her front pubic area with wipes. CNA G changed his gloves without performing any kind of hand hygiene. He rolled resident on her side revealing small bowl movement. CNA G wiped the resident's buttock area with peri-wipes, front to back, removing the fecal material. CNA G then removed the soiled brief and changed gloves without performing hand hygiene. He placed the clean brief under the resident and applied barrier skin to the resident's buttocks. CNA G changed his gloves without hand hygiene. He rolled the resident on her back onto the clean brief, he applied skin barrier to the resident's pubis area and the groins area. CNA G changed gloves without hand hygiene. Once finished, CNA G fastened the resident's brief. In an interview on 07/21/25 at 12:45 PM, CNA G stated he should perform hand hygiene between change of gloves when he went from dirty to clean. CNA A stated failing to provide proper care exposed the resident to infections. CNA A stated he was trained to sanitize hands between change of gloves. In an interview on 07/23/25 at 3:50 PM, DON stated he expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. DON stated CNAs where trained to perform hand hygiene between change of gloves. DON stated failure to do so would potentially lead to cross-contamination and possible spread of infection. DON stated the ADONs would do random rounds for monitoring. Record review of the facility's policy, Hand Washing, dated December 2017, reflected, .Employees must wash their hands for at least twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . Before and after assisting a resident with personal care . After removing gloves or aprons .		