STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675789	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Arden Wood	8810 Long Point Dr Houston, TX 77055

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 9 residents (Resident #8) reviewed for quality of care. The facility failed to properly notify MD of Resident #8's radiology results reporting a fracture to the resident's leg resulting in a delay in the resident's need for hospital transfer (27-hrs.) after a reported fall. This failure placed residents at risk for injuries, infections, unwanted hospitalization, and amputation leading to a decrease in quality of life. Findings Included:Record review of Resident #8's face sheet reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnosis included spinal stenosis (pressure on the spinal cord and nerves), chronic obstructive pulmonary disease (progressive irreversible lung disease that restricts airflow and makes breathing difficult), sacral (pressure ulcer injury to skin and underlying tissues) of sacral region (a large, triangular bone at the base of the spine, positioned just below the lumbar region (lower back) and above the coccyx (tailbone)) and sacrococcygeal region (base of the spine, where the triangular sacrum (the tail end of the lower back) connects to the coccyx (the tailbone)), state 4 (a severe, full-thickness tissue injury where the damage extends deep into muscles, tendons, or bones) obesity (chronic disease of excessive body fat), acute embolism and thrombosis acute embolism and thrombosis (clotting of blood that blocks blood flow) of unspecified deep veins of lower extremity (major blood vessels beneath the deep fascia (3-dimensional web of tissue surrounding, protecting, and supporting muscles, bone, and blood vessels) in the legs), (near-complete paralysis (loss of muscle function) and hemiparesis (partial weakness or loss of strength) following cerebral infarction affecting (blood flow to an area of the brain is interrupted) unspecified side. Record review of Resident #8's Quarterly MDS dated [DATE], reflected that the resident had a BIMS score of 12 reflecting the resident had moderate impaired cognition. Record review of Resident #8's care plan reflected, resident required 2-person assist with mobile transfers by use of mechanical aid sling 11/22/2022 and revised on 11/22/2022, and repositioning and turning in bed date initiated on 11/22/2022 and revised on 05/19/2026. Resident was at risk for falls; staff were to anticipate and meet the resident's needs and keep furniture in locked position 11/10/2022 and revised on 02/15/2023. Goal: the resident will not sustain serious injury through the review date of 08/17/2026. The resident had a mildly comminuted nondisplaced fracture of right distal femur without dislocation and sent to the hospital date initiated on 04/10/2026 and revised on 04/27/2026. Goal: The resident will remain free of complications related to right knee fracture, such as contracture formation, embolism and immobility through review date initiated on 04/10/2026 and revised on 05/04/2026. The resident was on anticoagulant therapy. Resident was of paraplegia status date initiated on 11/10/2022 and revised on 02/15/2023. Goal: Resident to remain free of complications or discomfort related to paraplegia through review date. The resident had ADL self-care performance deficit date initiated on 11/10/2022 and revised on 11/10/2022. The resident uses a wheelchair date initiated on 11/10/2022. Staff were to encourage turning and repositioning resident frequently while in bed date initiated on 06/04/2025. Resident had a low loss air mattress to bed date initiated on 03/26/2025. Record review of Resident #8's Change of (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 0684 Level of Harm - Actual harm Residents Affected - Few	Condition Communication dated 04/09/2026 at 09:00 a.m. and created by LVN K, reflected, WCN who witnessed fall, walked in the room and observed the resident positioned on her left side in bed. The resident was alert, bed was noted to be in high position, and resident's right hand on the bed's quarter rail. The WCN placed treatment supplies down on the right side of the bed. Resident's head slightly turned towards WCN, the resident began to slide off the left side of the bed near the wall onto the floor. The bed moved as the resident fell. Pain noted to resident's right elbow, right hand, and right knee. No neurological changes observed. Resident on anticoagulants. No laboratory tests/diagnostic procedures to report. Record review of Resident #8's skin and wound dated 04/09/2026 at 09:13 a.m., created by NP B reflected, resident was unable to be evaluated by the skin and wound team today. Resident declined care after experiencing a fall just prior to wound care team arriving. Record review of Resident #8's pain interview dated 04/09/2026 at 09:18 p.m., reflected resident received Tylenol 500mg 2 tablet by mouth every 4 hours as needed for pain. Record review of Resident #8's progress note dated 04/09/2026 at 09:38 a.m. and created by LVN K reflected, upon walking into resident's room, WCN observed the resident positioned on left side in bed. The bed was noted to be in high position, and resident was alert with her right hand on quarter rail. The resident spoke to WCN while WCN put treatment supplies down on the right side of the bed. As the resident spoke, she slightly turned her head towards WCN and began to slide off the left side of the bed near the wall onto the floor. The bed moved as the resident was falling. WCN attempted to reach the resident to prevent the fall, but the attempt was unsuccessful. LVN K immediately assisted providing vital signs. Resident was assisted from the floor back to the bed x 5. LVN K notified MD, DON, and ADON A and new orders received and noted. Record review of Resident #8's progress note dated 04/09/2026 at 09:38 a.m. and created by NP B reflected, upon walking in the room, NP B observed the resident positioned on left side in bed. The resident was alert. The bed was noted to be in high position with resident's right hand on quarter rail. The resident spoke as treatment supplies were placed down on the right side of the bed. As the resident spoke, she slightly turned her head towards NP B and began sliding off the left side of the bed near the wall onto the floor. The bed moved as the resident fell. NP B attempted to reach resident to prevent fall, but attempt was unsuccessful. Immediate assistance was provided to resident and NP B observed vital signs being taken and the resident was assisted from the floor back to the bed x 5. LVN K notified MD, DON, and ADON A receiving new orders. Record review of Resident #8's progress note dated 04/09/2026 at 09:40 a.m., created by LVN K reflected, MD ordered to administer Tylenol Oral Tablet 325 MG Give 2 tablet by mouth every 4 hours as needed for pain. Record review of Resident #8's April 2026 MAR dated 04/09/2026 at 09:40 a.m., Tylenol Oral Tablet 325 MG Give 2 tablet by mouth every 4 hours as needed for pain. Record review of Resident #8's April 2026 MAR reflected, pain assessment to be completed every shift, for pain, starting 03/04/2026 at 10:00 p.m.Pain dated 04/09/2026, reflected, day pain at a 0, evening at 3, and evening at 0.Pain dated 04/10/2026, reflected, day pain at a 5, evening at 4, and evening at 0.Pain dated 04/11/2026, reflected, day pain at a 0, evening at 2, and evening at 0.Pain dated 04/12/2026, reflected, day pain at a 0, evening at 0, and evening at 0.Pain dated 04/132026, reflected, day pain at a 0, evening at 5, and evening at 0. Record review of Resident #8's progress note dated 04/09/2026 at 01:09 p.m. created by MD reflected, MD examinate resident with new order. Record review of Resident #8's Radiology Results Report in the dated 04/09/26 reflected:- Procedure: Hand Right. Examination Date: 04/09/26 at 01:09 PM, Reported date: 04/09/26 at 02:50 PM, Observation Value: Right Hand, History: Pain, Findings: There is no evidence of obvious acute fracture or dislocation- Procedure: Knee Right. Examination Date: 04/09/26 at 01:10 PM, Reported date: 04/09/26 at 02:55 PM, Observation Value: Right Knee, History: Pain. Findings: mildly-comminuted (bone is broken and splintered into more than two pieces, though they are tiny) nondisplaced fracture (broken bone pieces that have not shifted out of their normal alignment) seen across distal femoral along the lateral femoral condyle(at the very end of the thighbone, specifically on the outer bump that forms the knee joint) with overlying periarticular soft tissue swelling and effusion noted (inflammation, and excess fluid built up inside the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	knee joint in response to a fracture). a small, crack in the thighbone at the knee joint, accompanied by welling.- Procedure: Hand Right. Examination Date: 04/09/26 at 01:15 PM, Reported date: 04/09/26 at 03:25 PM, Observation Value: Right Elbow, History: Pain, Findings: There is no evidence of obvious acute fracture or dislocation Record review of Resident #8's progress note dated 04/10/2026 at 06:16 a.m., created by LVN L reflected s/p fall day 1/3 no injury and no complins of pain or discomfort. Neuro check continues and vital signs stable. Record review of Resident #8's progress note dated 04/10/2026 at 09:33 a.m., created by LVN L reflected, MD notified of resident's right knee x-ray results - impression, mildly, comminuted nondisplaced fracture, with no evidence of dislocation. New order to transport resident to the ER. Record review of Resident #8's progress note dated 04/10/2026 at 10:48 a.m., reflected ER informed resident in route with right knee fracture. Record review of Resident #8's progress note dated 04/10/2026 at 11:16 a.m., reflected, resident left facility to ER via stretcher with EMS. Record review of Resident #8's Discharge summary dated [DATE] at 11:19 a.m., reflected, resident received new order to send to hospital ER for right knee fracture s/p fall from bed for evaluation. Record review of Resident #8's progress note dated 04/10/2026 at 07:50 p.m., reflected, resident returned to facility with new order Norco 5/323 mg 1 tab every 6 hours as needed for pain (7-10) x 3 days. Resident had splint to her right leg. Resident lying in bed with 4/10 pain. Resident requested only Tylenol. Record review of Resident #8's April 2026 MAR reflected:Tylenol Oral tablet 325 mg (Acetaminophen) give 2 tablets by mouth every 4 hours as needed for pain. Start date 04/03/2026 at 03:45 p.m.04/09/2026 at 09:04 a.m., pain levels: 4, PRN medication received.04/09/2026 at 05:29 p.m., pain levels: 3, PRN medication received.04/10/2026 at 10:29 a.m., pain levels: 5, PRN medication received.04/11/2026 at 04:00 a.m., pain levels: 4, PRN medication received.04/15/2026 at 09:40 a.m., pain levels: 4, PRN medication received.04/18/2026 at 06:00 p.m., pain levels: 4, PRN medication received.04/19/2026 at 01:00 a.m., pain levels: 4, PRN medication received.04/19/2026 at 07:00 p.m., pain levels: 4, PRN medication received.04/23/2026 at 09:40 a.m., pain levels: 5, PRN medication received.04/23/2026 at 08:57 p.m., pain levels: 4, PRN medication received.04/24/2026 at 04:12 p.m., pain levels: 4, PRN medication received.04/24/2026 at 08:51 p.m., pain levels: 3, PRN medication received.04/26/2026 at 02:30 a.m., pain levels: 3, PRN medication received.04/26/2026 at 06:30 pm., pain levels: 4, PRN medication received.04/27/2026 at 03:03 a.m., pain levels: 3, PRN medication received.04/28/2026 at 12:30 a.m., pain levels: 4, PRN medication received.HYDROcodone-Acetaminophen Oral Tablet 5.325 mg, to give 1 tablet by mouth every 6 hours PRN for sever pain 7-10 related to unspecified fracture of unspecified femur, initial encounter for closed fracture state dated 04/11/2026 at 12:15 a.m. and discontinued on 04/25/2026 at 03:35 p.m.04/11/2026 at 12:17 a.m., pain levels: 7, PRN medication received.04/12/2026 at 12:14 a.m., pain levels: 5, PRN medication received.04/13/2026 at 01:23 p.m., pain levels: 5, PRN medication received.04/14/2026 at 07:43 p.m., pain levels: 4, PRN medication received.04/15/2026 at 08:15 p.m., pain levels: 4, PRN medication received.HYDROcodone-Acetaminophen Oral Tablet 5.325 mg, to give 1 tablet by mouth every 8 hours as needed for pain related to unspecified fracture of unspecified femur, initial encounter for closed fracture state dated 04/25/2026 at 03:45 p.m.04/27/2026 at 08:34 a.m., pain levels: 5, PRN medication received.04/27/2026 at 08:15 p.m., pain levels: 4, PRN medication received.04/28/2026 at 09:01 p.m., pain levels: 4, PRN medication received.Right leg splint-monitor skin for any bruising or swelling every shift for femoral fractures, starting 04/21/2026 06:00 p.m. Record review of Resident #8's late entry IDT progress note dated 04/24/2026 at 09:05 a.m. created by DON, reflected on 04/09/2026 at 08:49 a.m., resident rolled from bed to floor in witnessed fall. WCN entered room to provide wound care. Resident was lying on side in preparation for care. Resident inadvertently shifted weight and rolled over side of bed falling between bed and wall. Head to toe assessment completing. A knee injury sustained. Resident complained of pain to right knee. X-rays ordered of leg, hand and foot. Fracture of leg near knee confirmed. Resident sent to ER per resident's request for further evaluation and treatment. Resident returned with mild comminuted, nondisplaced fracture diagnosed. RP notified, therapy consults requested, and care plan reviewed. During an (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	interview on 05/19/2026 at 10:30 a.m., Resident #8 stated on 04/09/2026 at 8:15 a.m., she fell from the bed after CNA A left her positioned on her side awaiting the WCN to provide care to her sacrum area. She stated the bed moved and feels the wheels on her bed were not locked in place. She stated she required 2-persons assistance during incontinent and wound care, and she was not to be left without hands on her until after wound care was completed and she was repositioned to her back in the bed. She stated that she was left alone in the room for 5 to 10 minutes with no staff in the room before WCN and NP B entered the room. She stated she saw the bed moving away from the wall and looked over her right shoulder and saw the WCN and NP B with their backs to her when she spoke out I'm falling and she fell to the floor between the bed and the wall. She stated she landed on her right knee, right elbow, and right hand being careful while falling to keep her head up to prevent injury. She stated she was paralyzed in her lower extremities after suffering 2-strokes and 2-heart attacks. She stated she could not move the left side of her body, and the right side was extremely weak. During an interview on 05/19/2026 at 01:05 p.m., WCN stated on 04/09/2026 at 08:15 a.m., CNA A informed her that Resident #8 was ready for wound care. She stated that her and NP B entered the resident's room and observed the resident positioned on her left side, back to the door. She stated while her and NP B were getting items together for care, she saw the resident looking over the resident's right shoulder vocalized, she was falling and fell to the floor. She stated her and NP B ran over to the floor having to move the bed away from the resident to reach her. During an interview on 05/19/2026 at 1:47 p.m., CNA A stated on 04/09/2026 at 08:00 a.m., her and. CNA B changed Resident #8's brief in preparation for WCN and NP B to perform wound care. She stated they position the resident on her left side with the resident facing the window. She stated she and CNA B had to leave the resident to pass the meal trays. She stated while passing the meal trays, she heard the resident hollering and went to the resident's room and was shocked to see the resident on the floor between the bed and the wall after falling out of bed. During an interview on 05/19/2026 at 2:40 p.m., Resident #8 stated on 04/09/2026, she asked LVN K if they were sending her to the ER for x-rays after the fall. She stated that LVN K told her the facility would be send in their own imaging company to perform the x-rays. She stated she cried for 30 minutes in pain from the fall with a pain rate of 10 out of 10, awaiting x-ray to arrive after several hours. She stated no physician came to assess her and no new orders were received. She stated on 04/10/2026, she learned her x-ray results showed a hairline fracture to her right leg, and the facility sent her to the ER. During an interview on 05/19/2026 at 03:28 p.m., LVN K stated Resident #8 was a resident who required total assistance, could move her hands, could barely move her legs, and had constant pain, and wounds that were healing. She stated on 04/09/2026, at 08:49 a.m., she was called to Resident #8's room and observed the resident on the floor laying on her left side between the bed and the window after having a witnessed fall from the bed. She stated the WCN, NP B, and CNA A were in the room and the resident insisted staff immediately pick her up off the floor immediately. She stated she checked the residents' vital signs and assessed the resident for pain and injury finding no adverse effects from the fall. She stated the resident told her she had fallen on her right hand, knee, and elbow and she was able to move with no pain. She stated she found the resident to have no bruises, bleeding, swelling, or pain. She stated the resident was lifted into bed and told LVA A her knee was hurting. She stated she gave the resident an existing PRN Tylenol and notified NP A. She received an x-ray order for the resident's hand, knee, and elbow. She stated the DON and ADON A were on shift and were notified the resident fell. She stated it took between 1-3 hrs. for x-ray to arrive. She stated a few hours later, the resident complained of pain again, and she administered the resident's PRN Tylenol. She stated the x-ray results came back just before she ended shift at 10:00 p.m. She stated she took a picture of the printed results and sent the results to NP A via text message. She stated NP A responded, Nothing there. and she assumed the NP A was saying that there were no injuries found from the x-ray. She stated she had read the x-rays and saw that there was a fracture to the resident's right leg. She stated she had not questioned NP A's response because she followed the direction of the physicians and the resident's condition had not worsened. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	She stated had there been swelling she would have called NP A and shared those changes in condition. She stated she left shift and was on vacation for a few days and had not spoken to the NP A, had not called the on-call physician, received no new orders, had not updated the resident on the x-ray results, nor could not recall which on-coming nurse she reported the resident's fall and x-ray results with. She stated the resident's fall was listed on the 24-hr. report and she laid the resident's x-ray results on top of the 24-report for the oncoming nurse to review. She stated she should have called on-call after 9:00 p.m. with emergencies and critical x-rays. She stated because NP A had been most familiar with the resident, NP A was sent the results. She stated because NP A stated nothing there she thought there was no need to report anything to the on-call physicians. She stated the risks of a fracture going untreated could cause the condition to worsen, bad swelling, and pain. She stated that she medicated the resident and the resident had no pain and the resident stated the Tylenol was effective. She stated when she returned to shift on 04/13/2026, she learned the resident had in fact had a fracture and that was communicated to the MD. She stated she was not aware if the resident had been sent to the hospital, because the resident often refused hospital transfers and she thought the resident would not have gone. She stated that the resident had transferred to the hospital on [DATE] and returned the same day with a narcotic prescribed for pain and a splint to stabilize the resident's right leg. She stated she received several in-service trainings on falls, locking bed wheels, repositioning residents, performing neurological checks every 2-hrs. after a fall, falls for residents on anticoagulants, and pain management. During an interview on 05/20/2026 at 08:22 a.m., MD stated that on 04/09/2026 while making rounds she learned of Resident #8's fall and learned NP A ordered x-rays. She stated x-rays that resulted after 06:00 p.m., were to be directed to the on-call physician. She stated it had not been her expectation to send pictures of x-ray results after hours to NP A's cellphone. She stated that the official form of contact for relaying critical reports after hours was by calling the on-call team, allowing them to respond on what to do for the resident next. She stated not following the official form of contact could result in a resident having unmedicated pain, delays in x-ray imaging, and delay in the resident being sent out for higher level of care. During an interview on 05/20/2026 at 08:40 a.m., LVN Q stated on the morning of 04/10/2026, she saw x-ray reports showing Resident #8 had a fracture of her right knee. She stated she went to the resident's clinical chart and learned the resident had a fall on 04/09/2026. She stated she called MD and read MD the report results and MD ordered the resident's ER transfer. She stated she called LVN L and asked if she was aware of the resident's x-ray results, and LVN L was unaware. She stated LVN L told her that the resident slept throughout the night with no complaints of pain. She stated when coming on shift, nurses were expected to read over the 24-hr report which outlined resident incidents, changes of condition, transfers in and out of the facility. She stated she would have expected LVN L to have shared Resident #8's fall event and incoming x-ray results at shift change on 04/10/2026. She stated that LVN K had not shared the information with LVN L to share with her resident's change of condition at shift change on 04/09/2026 and she was unaware of the need for a hospital transfer as a result of fracture results. She stated the resident sent to the ER on [DATE], returning the same day with an immobilizer around her right leg and the ER discharges notes indicated a bone break too small for surgery. She stated that x-ray results usually took no more than 4-hours to receive after imaging. She stated he nurses had the ability to check the imaging portal and see results and all the nurses were responsible to check the portal for results. She stated that x-ray results could be texted to the resident's NP or MD from a nurse's phone as a form of physician notification, and all critical x-rays required a phone call to the resident's physician team. She stated had the resident's x-rays resulted after hours, the nurses were to contact the on-call physician. During an interview on 05/20/2026 at 09:05 a.m., NP A stated on 04/10/2026, she stated the facility informed her Resident #8 had a fall from the bed on 04/09/2026 while WCN and NP B were providing wound care services. She stated MD was notified of the fall and ordered for the resident to receive x-ray imaging. She stated the x-ray images resulted that the resident had a fracture, and MD ordered the resident's transfer to the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hospital on [DATE]. She stated the resident returned to the facility the same day with a right leg immobilizer and pain medication. She stated on 04/09/2026, she could not recall nor had any text message receipts from LVN K regarding the resident's x-ray results. She stated that she had no issues with staff sending her text messages before 7:00 p.m. She stated after that time, it was her expectation that staff directed critical events to the on-call service. She stated a fracture was a critical event. She stated when waiting on x-rays to result, she had the capability to access and view results on the company's online portal. She stated that the x-ray imaging company normally called the facility and faxed the imaging results before the images populated into the online portal. She stated the facility had not been equipped to handle orthopedic injuries and a fracture required the evaluation of an orthopedic physician.She stated it was her expectation that critical x-rays were immediately reported to her the MD and if after hours, to on-call. She stated the risk of delayed physician notification could delay injury identification, resident pain, and swelling. She stated she had in-serviced the facility on the importance of following the proper physician notification procedure for reporting critical events. During an interview on 05/20/2026 at 10:58 a.m., the ADON A stated on 04/09/2026, LVN K notified NP A of Resident #8's the fall and NP A ordered x-rays. She stated on 04/10/2026, in the IDT's morning meeting, it was known that the resident had a fall on 04/09/2026, and there were no x-ray results. She stated that LVN Q logged into the imaging portal and printed out the resident x-ray reports. She stated LVN Q notified MD of the results and received an order to send the resident to the ER due to a fracture to the resident's right leg. She stated that LVN Q had told her she had not been made aware of the resident's pending x-rays, and LVN L had not communicated the results at shift change, because LVN L had not received any communication about the event from LVN K at shift change. She stated she looked in the resident's clinical chart and reviewed an in-completed change of condition report, found no skin or pain assessments, and no MD, NP, or on-call physician notification. She stated on 04/10/2026, there were no through notes to know what post fall care the resident received. During an interview on 05/20/2026 at 03:27 p.m., LVN L stated on 04/13/2026, ADON A asked her about Resident #8 post fall events. She stated she learned the resident had a fall on 04/09/2026, and had not been made aware when she came on shift that night at 10:00 p.m. She stated the resident had not expressed any pain and had slept thought the evening. She stated it had been her expectation that LVN K would have informed her for about the fall to perform neuro checks throughout the night and follow-up on x-ray to obtain orders from the on-call physician. During an interview on 05/20/2026 at 01:36 p.m., the DON stated that on 04/09/2026, he was on shift when Resident #8 had a witnessed fall by WCN and NP B. He stated that the resident received an existing PRN medication and LVN K received an order from NP A for an x-ray. He stated on 04/10/2026 during the facility's morning meeting the IDT reviewed the incidents and accident report from 04/09/2026 and found that the resident had no follow-up orders on the radiology dashboard from her fall. He stated the IDT pulled up the resident's clinicals and found there were no orders, follow-up orders, and no communication to the provider documented. He stated ADON A spoke to LVN K and learned NP A ordered x-rays, the x-rays had returned with a fracture result, and LVN K sent NP A a text with the x-ray results. He stated that NP A responded, Nothing there because NP A only saw 1 of 3 screenshotted x-rays and not the x-ray showing the resident leg fracture. He stated LVN K told ADON A she thought NP A would call the oncoming nurse with new orders and LVN K left shift without completing the change of condition report, noting NP A notification, without new orders for the fractured x-ray, and no notes communicating post fall results and findings. He stated it had been his expectation that LVN K would have completed the change of condition report prior to leaving her shift to ensure no information was forgotten, and information was translated accurately for post care purposes. He stated the charging events was not just repository, it served as communications to make care adjustments. He stated on the morning of 04/10/2026, and the resident's knee looked fine and told the resident her knee x-ray had returned showing a fracture. He stated the resident told him she wanted to go to the hospital and she was sent out 911. He stated that the resident returned from (continued on next page)

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	675789	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Arden Wood	8810 Long Point Dr Houston, TX 77055

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the ER the same day with a narcotic pain medication and a soft splint for her right leg. He stated the resident had a prior dx off chronic pain and had a history of refusing narcotic medication due to a constipated side of effect. He stated there were no hospital records received when the resident returned and the facility had to place records request to obtain. He stated that LVN K should have spoken directly to NP A regarding the resident's facture and made notes that the provider's notification was made, noting new orders, and completing the change of condition report. He stated on 04/09/2026, LVN K worked a double shift and was off shift the next day to addend a wedding and assumed she was rushing to complete her duties and get off to attend her event. She stated LVN K had worked for the facility for some time and had no previous incidents. He stated when LVN K returned to shift on 04/13/2026 and received a 1:1 in-service training on proper physician notifications, because LVN K told him she knew the resident had a fracture and sent those results via a text message when LVN K should have spoken to the provider verbally and ensued new orders were received to send the resident to the hospital before she left shift. He stated on 04/10/2026, in-service training began notifying physicians of labs and x-ray reports, and getting physician orders for ER treatment when fractured imaging was received. During an interview on 05/20/2026 at 03:03 p.m., LVN K stated on 04/09/2026 Resident #8 had a fall and she opened a change of condition report, completed the physical post-fall skin and pain assessments, and addressed the resident's pain. She stated the resident stated she hit her knee when she fell. She stated she reported the fall the same day to NP A, DON and ADON A. She stated NP A ordered an x-ray. She stated no one from the imaging laboratory called nor had she spoken to anyone regarding the residents' labs and she checked the radiology portal throughout the shift. She stated she logged in at 09:45 p.m. and 3-imaging reports were available, 1-noting a fracture to the resident's right leg. She stated the fractured results made the x-ray report critical and she printed out the reports, took pictures of the reports with her phone, and sent the reports via text to NP A at 09:51 p.m. She stated at 09:51 p.m., NP A responded back, Nothing there and she assumed that the resident had not had a critical x-ray. She stated because NP A was familiar with the resident, she had not contacted the on-call physicians with the results. She stated she had printed x-ray reports and placed them on the 24-hour report for the on-coming nurse to see and left shift at 10:00 p.m. She stated it had been normal for her to text and not call NP A with critical labs and x-rays such as a fracture. She stated she returned to shift on 04/13/2026 at 08:00 a.m., and learned the resident went to the hospital on [DATE]. She stated she was to complete the assessment documents as soon as resident was stable as it was important to note what may have caused the fall, what information and actions were learned, what actions were taken post fall, who was notified, and what orders were received. She stated she updated the change of condition form on 04/24/2026. She stated the risk of not completely a change of condition report and entering progress notes on the residents' fall could result in no one knowing the resident had a fall, pain could worsen from not being noted and addressed, and result in the IDT asking what took place after the fall. She stated she received an 1:1 in-service training from ADM, DON and ADON A on notifying NP, MD, She stated the in-services covered: reporting critical labs to the o[TRUNCATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that resident environment remains as free of accident hazards as is possible for 1 of 9 (Resident #8) resident reviewed for quality of care. The facility failed to safely secure the locking mechanisms on Resident #8's bed wheels on a bed in high position, resulting in resident's fall with injury fracture on 04/09/2026. This failure could place residents at risk of injury or anxiety due to unstable environmental hazard. Findings included:Record review of Resident #8's face sheet reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnosis included right knee pain, spinal stenosis (pressure on the spinal cord and nerves), chronic obstructive pulmonary disease (progressive irreversible lung disease that restricts airflow and makes breathing difficult), pressure ulcer (injury to skin and underlying tissues) of sacral region (a large, triangular bone at the base of the spine, positioned just below the lumbar region (lower back) and above the coccyx (tailbone) state 4 (a severe, full-thickness tissue injury where the damage extends deep into muscles, tendons, or bones) and right buttock unstageable (severe injury - full-thickness tissue loss, but the true depth is hidden by dead tissue: slough or eschar), obesity (chronic disease of excessive body fat), along term use of anticoagulants (medication to prevent blood clots, strokes, and heart attacks), acute embolism and thrombosis (clotting of blood that blocks blood flow) of unspecified deep veins of lower extremity (major blood vessels beneath the deep fascia (3-dimensional web of tissue surrounding, protecting, and supporting muscles, bone, and blood vessels) in the legs), and hemiplegia (near-complete paralysis (loss of muscle function) and hemiparesis (partial weakness or loss of strength) following cerebral infarction affecting (blood flow to an area of the brain is interrupted) unspecified side. Record review of Resident #8's Quarterly MDS assessment dated [DATE], reflected that the resident had a BIMS score of 12 reflecting the resident had moderate impaired cognition. The resident required 2 or more helpers repositioning and turning in bed, and personal care assistance. Record review of Resident #8's care plan reflected, resident required 2-person assist with mobile transfers by use of mechanical aid sling revised on 11/22/2022, resident required 2-person assist with repositioning and turning in bed date initiated on 11/22/2022 and revised on 05/19/2026. Resident was at risk for falls; staff were to anticipate and meet the resident's needs and keep furniture in locked position 11/10/2022 and revised on 02/15/2023. Goal: the resident would not sustain serious injury through the review date of 08/17/2026. The resident had a mildly comminuted nondisplaced fracture of right distal femur without dislocation and sent to the hospital date initiated on 04/10/2026 and revised on 04/27/2026. Goal: The resident will remain free of complications related to right knee fracture, such as contracture formation, embolism and immobility through review date initiated on 04/10/2026 and revised on 05/04/2026. The resident was on anticoagulant therapy. Resident was of paraplegia status date initiated on 11/10/2022 and revised on 02/15/2023. Goal: Resident to remain free of complications or discomfort related to paraplegia through review date. The resident had ADL self-care performance deficit date initiated on 11/10/2022 and revised on 11/10/2022. The resident uses a wheelchair date initiated on 11/10/2022. Staff were to encourage turning and repositioning resident frequently while in bed date initiated on 06/04/2025. Resident had a low loss air mattress to bed date initiated on 03/26/2025. Resident was on anticoagulant therapy 11/10/2022 and revised on 06/09/2025. Resident was on pain medication therapy dated 04/04/2024. Record review of Resident #8's Change of Condition Communication dated 04/09/2026 at 09:00 a.m. and created by LVN K, reflected, WCN who witnessed fall, walked in the room and observed the resident positioned on left side in bed. The resident was alert, and the bed was noted to be in high position with resident's right hand on quarter rail. The resident spoke to WCN as treatment supplies were put down on the right side of the bed. As the resident spoke, she slightly turned her head towards WCN and began to slide (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	off the left side of the bed near the wall onto the floor. The bed moved as the resident fell. Pain noted to resident's right elbow, right hand, and right knee. No neurological changes observed. Resident on anticoagulants. No laboratory tests/diagnostic procedures to report. Record review of Resident #8's skin and wound dated 04/09/2026 at 09:13 a.m., created by NP B reflected, resident was unable to be evaluated by the skin and wound team that day. Resident declined care after experiencing a fall just prior to wound care team arriving. Record review of Resident #8's progress note dated 04/09/2026 at 09:13 a.m., and created by NP B reflected, upon walking in the room, NP B observed the resident positioned on left side in bed. The resident was alert. The bed was noted to be in high position with resident's right hand on quarter rail. The resident spoke as treatment supplies were placed down on the right side of the bed. As the resident spoke, she slightly turned her head towards NP B and began sliding off the left side of the bed near the wall onto the floor. The bed moved as the resident fell. NP B attempted to reach resident to prevent fall, but the attempt was unsuccessful. Immediate assistance was provided to the resident and NP B observed vital signs being taken and the resident was assisted from the floor back to the bed x 5. LVN K notified MD, DON, and ADON A receiving new orders. Record review of Resident #8's pain interview dated 04/09/2026 at 09:18 p.m., reflected resident received Tylenol 500mg 2 tablets by mouth every 4 hours as needed for pain. Record review of Resident #8's progress note dated 04/09/2026 at 09:38 a.m. and created by LVN K reflected, upon walking into resident's room, WCN observed the resident positioned on left side in bed. The bed was noted to be in high position, and resident was alert with her right hand on quarter rail. The resident spoke to WCN while WCN put treatment supplies down on the right side of the bed. As the resident spoke, she slightly turned her head towards WCN and began to slide off the left side of the bed near the wall onto the floor. The bed moved as the resident was falling. WCN attempted to reach the resident to prevent the fall, but the attempt was unsuccessful. LVN K immediately assisted providing vital signs. Resident was assisted from the floor back to the bed x 5. LVN K notified MD, DON, and ADON A and new orders received and noted. Record review of Resident #8's progress note dated 04/09/2026 at 09:40 a.m. reflected MD ordered to administer Tylenol Oral Tablet 325 MG Give 2 tablet by mouth every 4 hours as needed for pain. Record review of Resident #8's progress note dated 04/09/2026 at 01:09 p.m. created by MD reflected, MD examinate resident with new order. Record review of Resident #8's Radiology Results Report in the dated 04/09/26 revealed,- Procedure: Hand Right. Examination Date: 04/09/26 at 01:09 PM, Reported date: 04/09/26 at 02:50 PM, Observation Value: Right Hand, History: Pain, Findings: There is no evidence of obvious acute fracture or dislocation- Procedure: Knee Right. Examination Date: 04/09/26 at 01:10 PM, Reported date: 04/09/26 at 02:55 PM, Observation Value: Right Knee, History: Pain. Findings: mildly-comminuted (bone is broken and splintered into more than two pieces, though they are tiny) nondisplaced fracture (broken bone pieces that have not shifted out of their normal alignment) seen across distal femoral along the lateral femoral condyle(at the very end of the thighbone, specifically on the outer bump that forms the knee joint) with overlying periarticular soft tissue swelling and effusion noted (inflammation, and excess fluid built up inside the knee joint in response to a fracture). a small, crack in the thighbone at the knee joint, accompanied by welling.- Procedure: Hand Right. Examination Date: 04/09/26 at 01:15 PM, Reported date: 04/09/26 at 03:25 PM, Observation Value: Right Elbow, History: Pain, Findings: There is no evidence of obvious acute fracture or dislocation Record review of Resident #8's progress note dated 04/10/2026 at 06:16 a.m., created by LVN L reflected s/p fall day 1/3 no injury and no complins of pain or discomfort. Neuro check continues and vital signs stable. Record review of Resident #8's progress note dated 04/10/2026 at 09:33 a.m., created by LVN K reflected, LVN K spoke to MD regarding right knee x-ray results - impression, mildly, comminuted nondisplaced fracture, no evidence of dislocation. New order to transport resident to the ER. Record review of Resident #8's progress note dated 04/10/2026 at 10:46 a.m., created by LVN Q reflected, MD notified of resident's x-ray report of fracture to right femur, new order for resident to be3 sent out to hospital for further evaluation. Resident was medicated with Tylenol for pain to right leg. Vitals: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	blood pressure 95/63, temperature 97.2, respirator 18, heartrate 98, oxygen saturation at 97%.Record review of Resident #8's progress note dated 04/10/2026 at 10:48 a.m., reflected ER informed resident in route with right knee fracture. Record review of Resident #8's progress note dated 04/10/2026 at 11:16 a.m., created by LVN Q reflected, resident left facility to ER via stretcher with EMS. Record review of Resident #8's Discharge summary dated [DATE] at 11:19 a.m., reflected, resident received new order to send to hospital ER for right knee fracture s/p fall from bed for evaluation. Record review of Resident #8's progress note dated 04/10/2026 at 07:50 p.m., reflected, resident returned to facility with new order Norco 5/323 mg 1 tab every 6 hours as needed for pain (7-10) x 3 days. Resident had splint to her right leg. Resident lying in bed with 4/10 pain. Resident requested only Tylenol. Record review of Resident #8's late entry IDT progress note dated 04/24/2026 at 09:05 a.m. created by DON, reflected on 04/09/2026 at 08:49 a.m., resident rolled from bed to floor in witnessed fall. WCN entered room to provide wound care. Resident was lying on side in preparation for care. Resident inadvertently shifted weight and rolled over side of bed falling between bed and wall. Head to toe assessment completing. A knee injury sustained. Resident complained of pain to left knee. X-rays ordered of leg, hand and foot. Fracture of leg near knee confirmed. Resident sent to ER per resident's request for further evaluation and treatment. Resident returned with mild comminuted, nondisplaced fracture diagnosed. RP notified, therapy consults requested, and care plan reviewed. Record review of Resident #8's PT notes certification period: 4/11/2026 - 5/8/2026. Start of resident's care: Reduce risk of injury by target date of 05/08/2026. Resident to remain in right knee extension 24-hrs. a day. Goal: Resident to position and reposition self in bed with substantial/maximal assistance without use of positioning devices in order to facilitate intact skin integrity, in order to achieve proper joint alignment, in order to enhance comfort, in order to reduce the risk for falls, in order to increase functional use of extremity, in order to increase level of ADLs, in order to promote adequate hygiene, in order to maintain joint integrity, in order to reduce tone, promote mobility, in order to facilitate joint mobility and in order to facilitate participation in activities of interest by target date of 04/24/2026. During an interview on 05/19/2026 at 10:30 a.m., Resident #8 stated she had suffered 2-strokes and 2-heart attacks that left her lower extremities paraplegic. She stated she could not move her left side of her body, and the right side was extremely weak. She stated on 04/09/2026 at 8:15 a.m., she fell from the bed in preparation for wound care after the wheels on her bed were not locked in place. She stated she sustained a hairline fracture to her right leg as a result of the fall. She stated on that date; CNA A had changed her brief and positioned her on her left side with her back to the door and face forward towards the wall in preparation for wound care to her sacrum area. She stated she required 2-persons assistance during incontinent and wound care, and she was not to be left without hands on her until after wound care was completed and she was repositioned to her back in the bed. She stated that she was left alone in the room for 5 to 10 minutes with no staff in the room before WCN and NP B entered the room and began setting up their supplies on a bedside table. She stated as she spoke to the wound care team, she began to see that the bed was moving away from the wall and quickly realized she was falling forward. She stated she looked over her right shoulder and saw the WCN and NP B with their backs to her when she spoke out I'm falling and she fell to the floor between the bed and the wall. She stated she landed on her right knee, right elbow, and right hand being careful while falling to keep her head up to prevent head injury. During an interview on 05/19/2026 at 01:05 p.m., the WCN stated on 04/09/2026 at 08:15 a.m., CNA A informed her that Resident #8 was ready for wound care. She stated that her and NP B entered the resident's room and observed the resident positioned on her left side, back to the door, and facing the wall. She stated the bed was in a high position and she had not stabilized the air flow in the resident's air mattress and was unaware if it was in stagnant mode. She stated no other staff were in the room when they entered. She stated while her and NP B were getting items together for care, she saw the resident looking over the resident's right shoulder to speak when the resident vocalized, she was falling and fell to the floor. She stated her and NP B ran over to the floor having to move the bed away (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	with 10 being the worst pain, and she learned she would receive an x-ray. She stated she asked LVN K if they would send her to the ER for the x-ray, but LVN K told her the facility would send in their own imaging company to perform the x-rays. She stated she cried for 30 minutes due to pain, received PRN Tylenol, and waited a few hours for x-ray to arrive. She stated no physician came to assess her and no new orders were received for pain. She stated the next day, the x-ray results came in showing she had a hairline fracture to her right leg, and the facility sent her to the ER. She stated since the fall, staff have not left her unattended on her side with at least one person in preparation for wound care and made sure the bed wheels were locked. She stated the bed wheels not being locked was partially her fault, as she should have made sure the staff locked the bed. She stated her pain in her leg was at a 5 on the day of the interview. She stated that she would have declined a stronger pain medication than Tylenol had one been offered to reduce any side effects of constipation, drowsiness, and dizziness to stay awake and maintain awareness during the day. She stated that had narcotic medication been offered for pain management, she would have accepted the medication at bedtime only. During an interview on 05/19/2026 at 03:28 p.m., LVN K stated on 04/09/2026, she was called to Resident #8's room and observed the resident on the floor laying on her left side between the bed and the window. She stated the WCN, NP B, and CNAs were in the room. She stated the resident insisted staff immediately pick her up off the floor. She stated she began vital signs and checked and slightly moved the resident's hands and lower extremities checking for injuries. She stated the resident told her she had fallen on her knee and she was able to move with no pain. She stated the resident was not crying or hollering and she found the resident to have no bruising, bleeding, swelling, or pain. She stated after assessing the resident, the staff in the room took a sheet and tucked it under the resident, rolled the resident onto the sheet and while 5 staff members left the resident, LVA A used both her arms as a splint to stabilize the resident's leg with pain. She stated once the resident was in bed she rechecked the resident's vitals, oxygen, and pulse finding them all within range. She stated the resident stated her arm and knee hit the floor and her knee was hurting. She stated she gave the resident PRN Tylenol right away. She stated she notified NP A of the fall, and an x-ray was ordered for the resident's hand, knee, and elbow. She stated that the DON and ADON A were on shift when the resident fell and were aware of the resident's fall. She stated CNA A told her when the WCN and NP B walked into the room; the resident had turned in the bed and fell to the floor. She stated it took between 1-3 hrs. for x-ray. She stated a few hours later, the resident complained of pain again, and she administered the resident's PRN Tylenol. She stated the x-ray results came back just before she ended shift at 10:00 p.m. She stated she took a picture of the printed results, sent them via text message to the NP and she left shift. She stated NP A responded, Nothing there. and she assumed NP A was saying that there were no injuries found from the x-ray. She stated had NP A not responded she would have called. She stated she had read the x-ray and saw that there was a fracture to the resident's right leg and had not questioned NP A's response because she followed the direction of the physicians and the resident's condition had not worsened. She stated had there been bad swelling she would have called the NP A and shared those changes in condition. She stated she left shift, was on vacation a few days, and had not spoken to the NP A. She stated she had not called the on-call physician, received no new orders, and had not updated the resident on the x-ray results, nor informing the on-coming nurse about the resident's fall or x-rays that day. She stated she could not recall which night nurse relieved her from shift. She stated that the resident's fall was listed on the 24-hr. report and she laid the resident's x-ray results on top of the report for the oncoming nurse to review. She stated she should have called on-call after 9:00 p.m. with emergencies and sent NP A the x-ray results because she was most familiar with the resident. She stated because NP A stated, Nothing there, she thought there was no need to report anything to the on-call physicians. She stated the risks of a fracture going untreated could cause the condition to worsen, bad swelling, and pain. She stated that she medicated the resident and the resident had no pain and the resident stated the Tylenol was effective. She stated when she returned from vacation, she learned the resident in fact (continued on next page)

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	675789	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Arden Wood	8810 Long Point Dr Houston, TX 77055

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F 0689 Level of Harm - Actual harm Residents Affected - Few	had a fracture that was communicated to the MD and the resident was prescribed a narcotic medication for pain and a splint to stabilize the resident's leg. She stated she was not aware if the resident had been to the hospital, because the resident had a history of refusing to go to the hospital, she thought the resident had not gone. She stated when she returned to shift, she received several in-service trainings on falls, locking bed wheels, repositioning residents, performing neurological checks every 2-hours, falls for residents on anticoagulants, and pain management. She stated that the resident was a total assist, could move her hands, could barely move her legs, was in constant pain, and wounds that were healing. During an interview on 05/20/2026 at 08:22 a.m., MD stated that on 04/09/2026 while making rounds she learned of Resident #8's fall. She stated she could not recall any other details on the resident's fall event or of identified pain. She stated it had been routine for the NP to be notified of a resident's fall, and the NP would decide on new orders and translate those events to the MD. She stated a fall or x-rays resulted after 6:00 p.m., were to be directed to the on-call team. She stated it had not been her expectation nurses send pictures of x-ray results via text after hours to a MD or NP. She stated the official physician notification required nurses to place a call to the resident's medical team and if result came in after business hours, the nurse would call the on-call team to receive orders on the next level of care the resident needed. She stated not following the official form of contact could result in a resident having unmedicated pain, delays in x-ray imaging, and delays in the resident being sent out for higher level of care. During an interview on 05/20/2026 at 08:40 a.m., LVN Q stated on the morning of 04/10/2026, she saw x-ray reports showing Resident #8 had a fracture of her right knee. She stated she went to the resident's clinical chart and learned the resident had a fall on 04/09/2026. She stated she called the MD, read MD the report results and MD ordered the resident's ER transfer. She stated the resident was informed of the fracture and order to transport to the ER. She stated the resident made no mention of pain and when asked, the resident stated her leg was feeling better. She stated once staff began moving the resident to her dressed for the ER, the resident expressed pain to her leg. She stated the resident refused pain medication, but after encouragement the resident accepted PRN Tylenol. She stated she called LVN L and asked if she was aware of the resident's x-ray results, and LVN L told her she had not been aware of the fall and fracture until she herself read the report. She stated LVN L told her that resident slept throughout the night with no complaints of pain. She stated when coming on shift, nurses were expected to read over the 24-hr report which outlined resident incidents, changes of condition, and transfers in and out of the facility. She stated she would have expected LVN L to have shared Resident #8's fall event and incoming x-ray results at shift change on 04/10/2026, but LVN L told her LVN K had not shared the resident's change of condition at shift change on 04/09/2026 and was unaware new orders were needed for the fracture results. She stated the resident returned from the ER the same day with an immobilizer around her right leg and the ER discharges notes indicated the bone break was too small to do surgery. She stated that x-ray results usually took no more than 4-hrs to receive after imaging and if not received, they check the imaging website portal before leaving shift and at the beginning of coming on a shift. She stated it was all the nurses responsibility to check the portal for results. She stated the x-ray results could be texted to the resident's NP or MD from a nurse's phone as a form of physician notification, and all critical labs and x-rays required a phone call to the resident's physician team. She stated the resident's fracture was considered a critical lab and required a phone call to be made. She stated that since the x-rays resulted after hours, a phone call should have been made to the on-call physician team. She stated she would not text a resident's imaging report from her own phone to stay within HIPAA requirements. During an interview on 05/20/2026 at 09:05 a.m., NP A stated on 04/10/2026, she stated the facility informed her Resident #8 had a fall from the bed on 04/09/2026 while the WCN and NP B were in the room to provide wound care She stated MD was notified of the fall and ordered for the resident to receive x-ray imaging. She stated the x-ray images resulted the resident had a fracture and MD ordered the resident's transfer to the hospital on [DATE] for pain. She stated the resident returned to the facility the same day with a right leg immobilizer and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pain medication. She stated the pain medication was too strong for the resident who declined administration, and accepted Tylenol as a substitute. She stated the resident was alert, oriented and able to make her needs beknown. She stated that she was not aware of how the resident's all occurred or the details of the bed wheels as locked or unlocked. She stated her expectations were that staff knew locked bed wheels avoided falls and injuries. She stated that the resident had weaknesses on the left side. She stated the resident was not able to hold her own body weight, hold her own weight while positioned on her side with or without holding on to a mobilizer bar, and was not safe as anything could happen resulting in a fall and injury. She stated that the resident could not sustain that position by herself and needed to have staff attended to her at all times while in that position. She stated the resident required multiple accommodations and was a functional paraplegic. She stated on 04/09/2026, she could not recall nor had any text message receipts from LVN K regarding the resident's x-ray results. She stated that she had no issues with staff sending her text messages before 7:00 p.m. She stated after that time, it was her expectation that staff directed critical events to the on-call service. She stated a fracture was a critical event. She stated when waiting on x-ray results, she had the capability to access and view results on the company's online portal. She stated that the x-ray imaging company normally called the facility and faxed the imaging results before the images populated into the online portal. She stated it was her expectation that critical labs and results were immediately reported to her the MD and on-call after hours. She stated the risk of delayed notification could delay injury identification, resident pain, and swelling. She stated the facility was not equipped to handle orthopedic injuries and a fracture required the evaluation of an orthopedic physician. She stated she had in-serviced the facility on the importance of following the proper physician notification procedure for reporting critical events. During an interview on 05/20/2026 at 10:58 a.m., the ADON A stated prior to performing wound care CNAs were trained to make sure a resident received incontinent care and were clean. She stated Resident #8 required 2-staff assistance with incontinence and wound care. She stated the resident's bed was to be moved away from the wall for a staff to be on each side of the bed. She stated the bed wheels should be relocked to ensure the bed would not move and the resident would not slide off the bed. She stated during that care, there was to be a staff member on each side of the resident and one staff person to make physical contact (hands on) with the resident at all times, never taking hands off the resident until the care had completed, and the resident was put into a comfortable position. She stated a resident left on their side with their sacrum facing out, was a position a resident should not be left unsupervised, or unattended. She stated leaving a resident unsupervised without hands on the resident put the resident at risk for anything to happen and the resident to fall to the floor. She stated on the morning of 04/09/2026 CNA A repositioned Resident #8 in preparation for wound care. She stated the WCN entered the room and the resident slid off the bed. She stated when she came on shift on 04/10/2026, LVN Q printed out the resident's x-ray results, and she noti[TRUNCATE

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify the ordering physician, results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner for 1 of 7 residents (Resident #8) reviewed for diagnostic services. The facility failed to ensure LVN K notified the physician/ NP of the Resident #8's femur fracture using the facility's approved notification methods leaving Resident #8 with an undiagnosed/untreated femur (longest bone in th body that extends from the hip to the knee) fracture and in pain documented up to 5 out of 10 for 18 hours before she was transported to the hospital on [DATE]. This failure could place residents who required radiology services at risk for delayed identification and treatment of undiagnosed illnesses, hospitalization, pain, and suffering. Findings included: Record review of Resident #8's Face Sheet dated 05/20/26 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: heart failure, depression, pressure ulcers of the sacrum, left buttock & right buttock, bine infection, muscle weakness and paralysis following a stroke (lack of blood flow to the brain), blood clots to the deep veins in lower extremity, and unspecified femur fracture. Record review of Resident #8's Significant Change in Status MDS assessment dated [DATE], moderately impaired cognition as indicated by a BIMS score of 12 out of 15, use of a wheelchair, total dependence to move from sit to lying, lying to sitting on the side of the bed, and all transfers. Resident #8 could not walk and used a motorized wheelchair. Record review of Resident #8's undated Care Plan downloaded 05/19/26 revealed:Focus- anticoagulant (anti-blood clot) therapy, intervention- avoid activities that could result in injury, take precautions to avoid falls; paraplegia (complete paralysis of lower body including both legs), intervention- obtain and monitor lab/diagnostic work as ordered, assist with ADLs and locomotion as required.Focus- ADL self-care performance deficit, intervention- bed mobility- requires extensive 2 staff participation to reposition and turn in bed; focus- risk for falls, keep furniture in locked position, 2 staff to assist with transfers; focus- fracture of right femur without dislocation, interventions- monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain. Record review of Resident #8's Pain Assessments dated 05/21/26 revealed, - 04/09/26 at 09:04 AM pain level of 4 out of 10.- 04/09/26 at 05:22 PM pain level of 3 out of 10.- 04/10/26 at 10:29 AM pain level of 5 out of 10. Record review of Resident #8's Order Summary Report dated 04/09/26 revealed, an order for an x-ray of the right knee and right hand 2 views. Record review of Resident #8's Radiology Results Report in the dated 04/09/26 revealed,-Procedure: Hand Right. Examination Date: 04/09/26 at 01:09 PM, Reported date: 04/09/26 at 02:50 PM, Observation Value: Right Hand, History: Pain, Findings: There is no evidence of obvious acute fracture or dislocation-Procedure: Knee Right. Examination Date: 04/09/26 at 01:10 PM, Reported date: 04/09/26 at 02:55 PM, Observation Value: Right Knee, History: Pain. Findings: mildly-comminuted (bone is broken and splintered into more than two pieces, though they are tiny) nondisplaced fracture (broken bone pieces that have not shifted out of their normal alignment) seen across distal femoral along the lateral femoral condyle(at the very end of the thighbone, specifically on the outer bump that forms the knee joint) with overlying periarticular soft tissue swelling and effusion noted (inflammation, and excess fluid built up inside the knee joint in response to a fracture). a small, crack in the thighbone at the knee joint, accompanied by welling.-Procedure: Hand Right. Examination Date: 04/09/26 at 01:15 PM, Reported date: 04/09/26 at 03:25 PM, Observation Value: Right Elbow, History: Pain, Findings: There is no evidence of obvious acute fracture or dislocation An observation and interview on 05/19/26 at 10:30 AM revealed, Resident #8 was in her room. She said 6 weeks ago, she fell out of her bed and sustained a hairline fracture. Resident #8 said she was laying on her side awaiting wound care, the staff had their backs to her, when she noticed the bed moved away from the wall and she fell hitting her right knee and elbow. She said she did not get sent to the hospital the day of the fall, she was in pain, crying, and cursing, and the pain was unbearable In an (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	interview on 05/19/26 at 01:47 PM, CNA L said Resident #8 fell out of bed while she laid on her side awaiting wound care unattended. She said when Resident #8 fell, she could hear the resident hollering through the closed door ,and the resident reported pain in her knee. In an interview on 05/19/26 at 02:40 PM, Resident #8 said after the fall (on 04/09/26), she was placed in bed where she was cursing and crying and she was told she needed to get an x-ray with a company that came into the facility. She said the facility gave her acetaminophen for her pain, but it didn't help, so she was crying for 30 minutes and it took a couple of hours for the x-ray to be completed. She said she was sent to the hospital the next day (04/10/26). In an interview on 05/19/26 at 03:28 PM, LVN K said after Resident #8 reported knee pain during an assessment completed after she sustained a fall on 04/09/26, an x-ray was ordered. She said the xray results came out before she left her shift that night so she sent a picture to the NP but she did not speak to the NP, and no orders were received from the NP in response to the result before she left at 10 PM. LVN K said after hours, the facility had an on call physician and since a fracture was considered a critical result and after 9 PM, the on call physician should be contacted if it was emergent. She said she just sent the picture of the results to the NP, she did not think to call the on call physician because the NP knew the resident while the on call physician did not. LVN K said the facility policy, negative [NAME] results required staff to get acknowledgment of the result and the doctors is to be notified either by call or text. She said if a negative finding, like a fracture, was communicated via text, and the staff did not receive acknowledgement or response from the NP, the resident could be placed at risk of worsening conditions, bad swelling, and pain. In an interview on 05/20/26 at 08:22 AM, the MD said she did not recall how she was notified of Resident #8's fall or fracture. She said when a result of a fracture came out, the NP was typically notified first. She stated if they were unavailable, the MD was notified, and if it was after hours, the on call physician was notified. The MD said after 6 PM, the on call physician must be notified as per their provider groups contract with the facility. She said the official method of communication of radiology results was a call being placed to the physician in order to ensure there was a response. The MD said failure to notify a provider of a resident's fracture could place residents at risk of pain. In an interview on 05/20/26 at 08:40 AM, LVN Q said when she looked at Resident #8's records on 04/10/26 at an unknown time in the morning, she saw the resident had a knee fracture, so she called the MD, read the results to her and the MD ordered Resident #8 sent out to the hospital for further evaluation. LVN Q said the night shift nurse did not notify her of the xray results, and she found out Resident #8 had a fracture when she read the xray results herself. She said stat x-rays are usually completed within 4 hours of the order being entered, and staff monitor the radiology reports portal at the beginning and end of their shift for any pending results but she didn't know who monitored it between the shift. She said a fracture was a critical result and staff were expected to call providers for notification of the results. LVN Q said some staff sent the results via text, but she didn't due to it being a HIPAA (health care regulations that restrict the use and communication of private health records) violation. She said if a result came in after hours (after 6 PM), nurses were expected to call the provider on call number to communicate results. In an interview on 05/20/26 at 09:05 AM, the NP said Resident #8 was one of her residents and the resident was a functional paraplegic. She said the resident was unable to hold her body safely on her side and required assistance. The NP said on 04/09/26, she was not aware Resident #8 had a fracture and once she was made aware, the resident was sent to the hospital. She said since Resident #8's fracture results came out after 7 PM, LVN K should not have called her because their provider group had an on call doctor. The NP said negative radiology results of a fracture, required a call to the provider, and during night shift, the on call provider must be notified. She said she was not notified of Resident #8's fracture until 04/10/26, and when the resident returned from the hospital, she had her knee in a splint to limit mobility as well as an order for pain medication. The NP said the facility could not manage an acute fracture, they did not have the equipment such as an immobilizer and orthopedic (medical specialty focused on muscles, bones and joints) so residents must be transferred to the (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	hospital. She said failure to timely transfer residents to the hospital after a sustained fracture, placed them at risk for pain and swelling. In an interview on 05/20/26 at 10:16 AM, the Radiology Provider Staff said typically the diagnostic company made multiple attempts during the day to reach the ordering facility once a negative finding was identified, but the results also populated in the integrated radiology results in the EMR. She said the diagnostic company notified LVN K of Resident #8's femur fracture over the phone on 04/09/26 at 09:39 PM. In an interview on 05/20/26 at 10:58 AM, ADON A said ADONs were responsible for verifying orders were in place after an incident and ensuring all communication between the family and doctors were made, as well as monitoring for pending radiology results. She said she was not there when Resident #8 had a fall, but when she came in, LVN Q actually printed the results out and they called the MD. ADON A said the night nurse (LVN LK) did not communicate to the oncoming nurse (LVN Q) on 04/10/26 about the fracture or pending radiology results because she did not think the night nurse knew. She said no one had told them Resident #8's x-rays had resulted, the radiology result was not included in the 24 hour report (a report that provided a summary of significant changes in resident status) and she should have been in the report. ADON A said she did not know Resident #8 had a fall or pending radiology results, and if she did, she would have called the radiology provider to inquire about result since that was one of her responsibilities as the ADON of that floor. She said when a resident experienced a change of condition such a fall, the nurse first assessed the resident, and everything should be documented in the nursing nurse, incident note and SBAR. ADON A said on the morning of 04/10/26 nothing existed in the EMR regarding Resident #8's fall or fracture. She said if there were pending diagnostic results, she expected nurses to continually call the xray provider to get results, all attempts should be documented in a progress note and the MD must be notified through a call in which the results are read to them. The ADON said failure to call the resident's provider placed residents at risk of deterioration of condition. She said after the incident was investigated they identified that LVN K notified the NP of the results via text, instead of a phone call, she failed to contact the after hours physician and she did not notify the next nurse through walking rounds or documentation. ADON A said after Resident #8's fall and subsequent fracture, LVN K should have called the radiology provider throughout her shift till she got a result, and reported the results directly to the provider. In an interview on 05/20/26 ay 01:36 PM, the DON said he knew Resident #8 had a fall, but didn't know about the fracture until the next day (04/10/26). He said during the IDT morning meeting on 04/10/26 as they reviewed the accident and incidents from the previous day, they identified LVN K had not documented any orders, follow up orders or communication to the provider regarding Resident #8's fall and injury so they contacted the NP and the NP was unaware of the xray results that found a fracture. The DON said LVN K told him she sent a text message to the NP, but the response from the NP was that there was nothing there. He said LVN K sent results for x-rays to the arm/elbow, wrist and knee via text message but the NP did not see the results for the knee xray. He said during the morning meeting on 04/10/26, while reviewing the radiology dashboard, they identified the xray results with the fracture, so he sent the ADON to look into it. In an interview on 05/20/26 at 03:27 PM, LVN L said she worked the night shift (10 PM- 6 AM) on 04/09/26 and on that shift she did not know about Resident #8's fall, pending radiology results, or fracture. She said during the night Resident #8 did not appear to be in pain, she slept all night and she (LVN L) did not learn about the fall until the next day (04/10/26). LVN L said she expected LVN K to have notified her that there were pending or read x-ray results, but she did not tell her anything regarding the fall or fracture, so she did not assess the resident following the fall or ask her about pain. She said she did not check the diagnostic results portal because she didn't know anything was pending, she didn't perform neurological checks on the resident because she didn't know Resident #8 had any injuries before she left her shift. LVN L said if she had received x-ray results after hours she would have called the on call physician. In an interview on 05/22/26 at 11:25 AM, the Administrator said LVN K should have pulled Resident #8's x-ray results on 04/09/26 and called the on-call physician to ensure action was taken. She said Resident #8's x-ray results came (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	out midafternoon but LVN K retrieved the results in the late evening and when she did she should have called the on call physician. The Administrator said she expected documentation to be completed timely and to accurately paint a picture of the situation. She said documentation was used to communicate to other people what actions they need to continue or initiate whatever the situation called for, and failure to document could result in a resident not receiving the care needed and being left uncomfortable and in pain. The Administrator said following Resident #8's fall, the nurse (LVN K) did document or communicate information with her managers and other staff. In an interview of on 05/22/26 at 12:51 PM, the DON said LVN K failed to notify the doctor and didn't do a proper shift report about Resident #8's fracture. He said LVN K told him she looked at Resident #8's radiology report but she didn't necessarily read it, and he expected nursing staff to read the results to understand the severity of the findings. The DON said the nurse (LVN K) was responsible for notifying the ADON of Resident #8's fracture. He said the ADONs and DON are busy, so it is the responsibility of charge nurse to check on pending radiology because they can't stay on top of it. Record review of the facility's policy titled Test Results Policy Statement: The resident's attending physician will be notified of the results of diagnostic tests. 1- results of laboratory, radiological and diagnostic tests shall be reported in writing to the resident's attending physician or to the facility. 2- should the tests be provided to the facility, the attending physician shall be promptly notified of the results. 3- the DON or the charge nurse receiving the test results, shall be responsible for notifying the physician of such test results. Record review of the facility's policy Nurse Shift-to-Shift Communication/Change of Shift Report dated April 2026 revealed, It is the policy of this facility to complete a structured nurse-to-nurse change-of-shift report at every shift change to support resident safety, continuity of care, timely follow-up, regulatory compliance, and accountability. Purpose: 1. Ensure critical resident information is communicated clearly, consistently, and timely between shifts. 2. Reduce missed follow-up, delayed notification, medication/treatment omissions, and preventable adverse events. Change of shift report elements: Labs/diagnostics - Orders pending, specimens to obtain, results requiring review, abnormal values, provider notification, and follow-up appointments. Record review of the 200 Hall [MD] Notification Manual on 05/20/26 at 10:50 AM revealed, Immediate Notification- After Hours 6 PM Weekends/Holidays: a phone number for the on call physician service was listed. Test/Procedure- x-ray, report immediately new or unsuspected finding (fracture0; report next day- old or long standing finding, no change. Change in Condition: When to report to the MD/NP/PA, Immediate Notification- Any symptom, sign or apparent discomfort that is: acute or sudden in onset and a marked change in relation to usual symptoms and signs or unrelieved by measures already prescribed. Signs and Symptoms: Fractures and discoloration- immediate notification of any suspected fracture or discoloration.

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	675789	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Arden Wood	8810 Long Point Dr Houston, TX 77055

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to coordinate an assessment with the Preadmission Screening and Resident Review program (PASRR) under Medicaid for 1 of 12 resident (Resident #4) reviewed for PASRR services. - The facility failed to refer Resident #4 to identify and update Resident #4's PL1 when she had a newly evident mental illness diagnoses of MDD with severe psychotic symptoms on 04/29/21 and Schizophrenia in 09/23/21 until 05/21/26, preventing a PASRR (a screening required that ensures individuals with MI or ID/DD are not inappropriately placed in nursing homes and received required specialized services) evaluation and determination of services needed. This failure could place residents with a positive PASRR evaluation at risk of not receiving specialized PASRR services which could contribute to a decline in physical, mental, psychosocial well-being and quality of life. Findings included: Record review of Resident #4's Face Sheet date 05/21/26 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with a primary/principal/admission diagnosis of PVD (a slow progressive circulation disorder where there is reduced blood flow to the legs and feet), additional admission diagnosis of: vitamin deficiency, and asthma (a chronic breathing disease that makes breathing difficult). Other diagnosis included: anxiety disorder with an onset date of 12/30.24; MDD, recurrent, severe with psychotic symptoms with an onset date of 06/202/22 and Paranoid Schizophrenia(disorder where you see things that aren't there and believe things that aren't real) with an onset date of 04/01/23. Record review of Resident #4's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 6 out of 15, resident reported feeling down, depressed, or hopeless several days (2-6 days) in the last 2 weeks, rejection of care 1-3 days, and active diagnosis of PVD, dementia, Parkinson's Disease (a progressive brain disorder marked by uncontrolled tremors, muscle stiffness and balance issues), anxiety disorder, depression and schizophrenia. Record review of Resident #4's Care Plan printed 05/21/26 revealed, focus- behavior problem of taking other residents items, intervention- assist Resident #4 to develop more appropriate methods of coping and interactions, encourage the resident to express feelings appropriately. Focus- mood problem r/t disease process, interventions- administer medications as ordered. Focus- impaired cognition/thought r/t to dementia, interventions- administer medications as ordered, keep the residents routine consistent. Focus- use of anti-anxiety medications r/t depression, intervention- administer medications as ordered and monitor for side effects and effectiveness. There was no documented focus area for Resident #4's Schizophrenia diagnosis. Record review of Resident #4's PASRR Level 1 Screening dated 04/02/20 revealed, is there evidence or and indicator this is an individual that has mental illness- No. Record review of Resident #4's EMR on 05/19/26 revealed, no documented PE and 1 PL1 completed after 04/20/20. Record review of Resident #4's Psychiatric Evaluation dated 04/29/21 revealed, past medical history: MDD. [AGE] year-old female with past psychiatric history. Mood symptoms: depressed mood; Anxiety symptoms: restlessness; psychotic symptoms- no psychotic symptoms noted or reported; Noncompliance with treatment: Medications non-adherence. Record review of Resident #4's Psychiatric Periodic Evaluation dated 09/13/21 revealed, past medical history: dementia with behavioral disturbances, schizophrenic disorder. [AGE] year-old female with past psychiatric history significant for dementia with behavior disturbances, MDD with psychotic features, and generalized anxiety. Record review of Resident #4's PASRR Level 1 Screening created on 05/21/26 at 12:21 PM by the Regional Reimbursement Consultant revealed, is there evidence or and indicator this is an individual that has mental illness- Yes. Record review of Resident #4's Mental Illness/Dementia Resident Review (form 1012) created 05/21/26 at 12:15 PM and signed by the RCC revealed, Complete this form only for nursing facility residents with a current Negative PASRR Level 1 (PL1) Screening for Mental Illness to determine whether to submit a new positive PL1 screening form on the (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Long Term Care Portal because further evaluation is needed. Section B. Dementia Review: For the purposes of PASRR, dementia is a neurologically driven disease that results in a decline in mental ability severe enough to interfere with independence and daily life. Neither dementia nor psychosis or depression related to dementia is a mental illness. Does this individual have a primary diagnosis of Dementia (or related disorder) as defined above? The major neurocognitive disorder is advanced to the degree that a co-occurring serious mental illness is not likely ever again to be the primary focus of treatment. No, the individual does not have a dementia diagnosis or has a dementia diagnosis, but it is not primary. Complete Section C. The physician does not need to sign Section B.1. Indicate each diagnosis that is applicable for the resident. Each diagnosis selected must be documented in the NF medical record by the admitting, attending, or consulting physician. If yes is checked, and it is a new diagnosis, include the date of onset. Does this individual have a diagnosis of: 1.Schizophrenia: Yes, Date of Onset: 04/01/2023. 2. Mood Disorder (Bipolar Disorder, Major Depression, or other mood disorder): Yes- Date of Onset: 06/20/2022. If any of the responses are YES, the nursing facility needs to complete a new PL1 and Sections D and E of the form. A full PASRR Evaluation will be conducted after the nursing facility submits the new positive PL1. Section D. Nursing Facility Action: A new positive PL1 was submitted on 05/21/2026 according to the instructions in Section C. Section E. Staff Completing Form: [Regional Reimbursement Consultant]. There were no signatures on the physician attestation on section b and section c. An observation on 05/19/26 at 11:12 AM revealed, Resident #4 appeared well groomed, well-dressed in no immediate distress, seated in a wheelchair in the activity room. She had nail polish on her nails and said she had no issues or concerns with the facility. The resident appeared confused when asked questions about her mental status. In an interview on 05/22/26 at 12:15 PM, the MDS Nurse said she had been in her position for 2 years. She said the PASRR was a required form for new admissions to identify MI or IDD and every resident should get an evaluation regardless of where they were prior to admissions. She said when a resident arrived to the facility, she reviewed the PL1 for accuracy and she entered the PL1 into the system with alerted the assessing entity to come in and evaluate a resident for special services. The MDS Nurse said after entry she was responsible for monitoring for new resident orders or diagnosis that would result in a change in their PL1 status, and any changes should be documented on the form 1012 which provided instructions on the next actions to be taken based on the answers to the questions on the form. She said it was important to monitor the resident to ensure the PL1 remained accurate and if any changes occurred a new PL1 must be completed which would trigger the process of a PE. The MDS Nurse said if a new diagnosis of mental illness was missed, and the PL1 was negative, it would not trigger an evaluation of the residents need for specialized services or necessary care. The MDS Nurse said she was responsible for Resident #4's PL1 and monitoring of the residents diagnoses and since the resident had diagnoses of MDD and schizophrenia she should have had a positive PL1 because mental illness would be checked yes. She said she did not know why Resident #4's PL1 was incorrect, or how her new diagnoses of mental illness was missed. In an interview on 05/22/26 at 12:15 PM, the RRC said she started an audit of PASRR accuracy for all residents the previous week. She said yesterday, 05/21/26, she identified Resident #4's PL1 was incorrect, so she completed the form 1012 which indicated the resident needed a new PL1. The newly completed PL1 was positive so she submitted the new PL1 to notify the mental health authority. Record review of the facility PASRR policy dated 01/20/26 revealed, Purpose- The aim of the PASRR program is to identify residents with Mental Illness (MI), IDD or DD/RC and to ensure they are properly placed, whether in community or in a NF and to ensure they receive the services they require for their MI, or ID/DD. Procedure- The MDS Coordinator or designee will input all other PL1s into the online portal on admission. This includes negative preadmission PL1s, and PL1s for residents who qualify for exempted or expedited status. 2. When it is determined that a PL1 was filled out incorrectly, the MDS Coordinator, Social Worker or designee will reach out to the hospital/responsible case worker and ask them to correct the form. a- If the referring case worker is unwilling/unable to correct the PL1 that contains a potential error, the (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	social worker or designee will complete and submit a form 1012 (MI) or new PL1 (ID/DD). A subsequent positive PL1 will be entered according to 1012 findings (MI). 3. When it is determined that an individual's diagnosis was changed and/or a state surveyor determines the PL1 was incorrect, the social worker or designee will complete and submit a form 1012 (MI). A subsequent positive PL1 will be entered according to 1012 findings. Specialized Services: There are 3 types of Specialized Services that may be provided, the facility is responsible for the coordination of these services. 3. LMHA Specialized Services- a. Skills training b. Medication training C. Psychosocial rehabilitation d. Case management and psychiatric examination.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 8 residents (Resident #4) reviewed for care plan revisions. - The facility failed to ensure Resident #4 care plan was comprehensive and updated to reflect Resident #4's diagnosis of schizophrenia that dated back to 09/13/2021. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. Findings included: Record review of Resident #4's Face Sheet date 05/21/26 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with a primary/principal/admission diagnosis of PVD (a slow progressive circulation disorder where there is reduced blood flow to the legs and feet), additional admission diagnosis of: vitamin deficiency, and asthma (a chronic breathing disease that makes breathing difficult). Other diagnosis included: anxiety disorder with an onset date of 12/30.24; MDD, recurrent, severe with psychotic symptoms with an onset date of 06/202/22 and Paranoid Schizophrenia (disease in which you see and believe things that are not real) with an onset date of 04/01/23. Record review of Resident #4's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 6 out of 15, resident reported feeling down, depressed, or hopeless several days (2-6 days) in the last 2 weeks, rejection of care 1-3 days, and active diagnosis of PVD, dementia, Parkinson's Disease (a progressive brain disorder marked by uncontrolled tremors, muscle stiffness and balance issues), anxiety disorder, depression and schizophrenia. Record review of Resident #4's Care Plan printed 05/21/26 revealed, focus- behavior problem of taking other residents items, intervention- assist Resident #4 to develop more appropriate methods of coping and interactions, encourage the resident to express feelings appropriately. Focus- mood problem r/t disease process, interventions- administer medications as ordered. Focus- impaired cognition/thought r/t to dementia, interventions- administer medications as ordered, keep the residents routine consistent. Focus- use of anti-anxiety medications r/t depression, intervention- administer medications as ordered and monitor for side effects and effectiveness. There was no documented focus area for Resident #4's Schizophrenia diagnosis. Record review of Resident #4's Psychiatric Periodic Evaluation dated 09/13/21 revealed, past medical history: dementia with behavioral disturbances, schizophrenic disorder. [AGE] year-old female with past psychiatric history significant for dementia with behavior disturbances, MDD with psychotic features, and generalized anxiety. An observation on 05/19/26 at 11:12 AM revealed, Resident #4 well groomed, well-dressed in no immediate distress, seated in her wheelchair in the activity room. She had nail polish on her nails and said she had no issues or concerns with the facility. The resident appeared confused when asked questions about her mental status. In an interview on 05/22/26 at 01:27 PM, the DON said a resident's care plan served to recognize issues regarding the resident and make a plan to ensure the facility took care of it. He said the care plan must include all diagnoses, goals and specific interventions and failure to develop an accurate care plan placed resident's at risk of not getting the services they should. The DON said a resident with a new diagnosis of schizophrenia should have their care plan updated by the ADON/DON and ultimately the MDS Coordinator. He could not state what the timeline to complete care plan changes were following a new diagnosis. In an interview on 05/22/26 at 03:00 PM, the MDS Nurse said she was responsible for care plan updates. She said a resident's care plan functioned as a plan of care for the resident and addressed identified behaviors, medications, and diagnosis. The MDS Nurse said failure to update the care plan placed residents at risk of staff not knowing how to provide care for the resident and/or not having their needs met. She said Resident #4's care plan should have addressed her diagnosis of schizophrenia, and she could not provide an answer for why the resident's care plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was inaccurate and did not address her diagnosis of schizophrenia. Record review of the facility policy Care Plans, Comprehensive Person-Centered revised 03/2022 revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (2) any specialized services to be provided as a result of PASARR recommendations. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; d. at least quarterly, in conjunction with the required quarterly MDS assessment. Record review of the facility policy Change in a Resident's Condition or Status revised 04/2025 revealed, 2.A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 7. In addition to notifying the resident and/or representative, the state mental health agency or state intellectual disability agency will be notified within 24hours of a significant change in the mental or physical condition of a resident with a mental disorder or intellectual disability. 9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to provide pharmaceutical services to meet the needs of each resident (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals,) for 1 of 1 medical supply reviewed for medication storage and labeling. The facility failed to ensure the medication room was free from expired medical supplies on 05/22/2026. This failure could place residents at risk of using items that were less effective or risky due to a change in their chemical composition (change of a substance into something else, often making it weaker, useless, or harmful), and could cause infections due to compromised sterile equipment. Findings included: An observation of 200 hall's medication cart and interview on 05/22/2026 at 10:58 a.m., revealed staff stored unopened expired eSwab collection tubes (a system of a liquid-based device for collecting and transporting wound cultures) count 13, all expired on 07/12/2025. In an interview on 05/22/2026 at 11:03 a.m., ADON A A stated she checked the medication room for expired medications and supplies two times every week but overlooked the collection tubes. She stated if staff used expired collection tubes you can get false lab readings. She stated the treatment Nurse, or any nurse could use the collection tubes, they and should check those tubes for expiration before they used them. She stated she should have noticed the expired tubes and discarded them.In an interview on 05/22/2026 11:16 a.m., LVN E stated using expired collection tubes could cause inaccurate lab results. She stated lab staff delivered the collection tubes to the nurses at the nursing station when nurses requested them. She stated she did not check the medication room supplies including the collection tubes for expired items. In an interview on 05/22/2026 at 11:20 a.m., the Treatment Nurse stated when she needed collection tubes she ordered them from the lab, and when lab staff delivered them to her, she stored them in her office and inside the treatment cart. She stated when lab delivered collection tubes to the nurses, nurses stored the tubes inside the medication room. She stated she checked the collection tubes she stored in her office and inside the treatment cart monthly for expiration. She stated she did not check or used the collection tubes nurses stored inside the medication room. The treatment Nurse stated if staff used expired collection tubes, then there could be a risk for infection or false results and tests could be incorrect which could lead to lab did not process the intended test. She stated if the lab processed the test it could lead to incorrect results which could result in incorrect treatment. In an interview on 05/22/2026 at 12:40 p.m., the DON stated he expected ADON A A to check the medication room a couple of times a week. He stated she did random audits every week on medication carts and the medication room for expired items. The DON stated he was unaware staff stored expired collection tubes inside the medication room. He stated he expected the Treatment Nurse and the floor nurses to check the collection tubes for expiration dates every shift and before they used them. The DON stated using expired medical supplies could cause inaccurate laboratory results, improper treatment plans and infections. Record reviews of the facility's policies and procedures revealed the facility did not have a policy on storing medical supplies.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation , interview, and record review, the facility failed to ensure based on the comprehensive assessment of a resident that a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable for 1 of 3 residents (Residents #25) residents reviewed for pressure ulcers. - The facility failed to ensure the pressure redistributing function of Resident #25's air mattress was not interrupted by a fitted sheet on 05/19/26. This failure could place residents at risk of developing, reopening and worsening of pressure ulcers. Findings includedRecord review of Resident #25's Face Sheet dated 05/21/26 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of: type 2 diabetes, and morbid obesity due to excess calories. Record review of Resident #25's Quarterly MDS assessment dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 06 out of 15, lower extremity functional limitations in range of motion on both sides and substantial assistance required to: roll left to right, move from sit to lying, move from lying to sitting on the side of bed. She was totally dependent on staff to stand and transfer, risk of development of pressure ulcers/injuries, and unhealed stage 3 pressure ulcer. Record review of Resident #25's undated Care Plan revealed, focus- impaired physical mobility, intervention- assist resident in performing movements/tasks,. Record review of Resident #25's Wound Assessment Report dated 05/11/26 revealed, a facility acquired stage 3 pressure ulcer to the right buttock that was identified on 11/18/25 had resolved. Record review of Resident #25's Progress Not dated 05/16/26 revealed, the resident had no skin wounds/pressure ulcers. Record review of Resident #25's Order Summary Report dated 05/21/26 revealed- 09/25/25 Pressure relieving mattress to bed. Visual checks every shift-11/13/25 Air Mattress to Bedding: check functionality, normal pressure, correct weight setting every shift. An observation and interview on 05/19/26 at 10:46 AM revealed, Resident #25 in a large bed on an air mattress, with the setting at 450 lbs., in a 25-minute cycle time, alternating pressure, and a fitted sheet on the air mattress. She said she had no current wounds, did not ask for the fitted sheet, and she could not feel the mattress moving up and down, redistributing pressure. In an interview and observation of Resident #25's air mattress on 05/19/26 at 01:44 PM, the Wound Care Nurse said the resident's bed should not have a fitted sheet on because it disrupted the ability of the air mattress to relieve pressure. She said the fitted sheet put residents at risk of skin breakdown. In an interview on 05/22/26 at 01:27 PM, the DON said there should never be a fitted sheet on the air mattress, because the alternating pressure was meant to prevent the development of pressure ulcers, and a fitted sheet disrupted that function. He said when all staff (nurses and CNAs) did rounds with residents, they should have ensured the right sheets were used, but there was no task assigned in the EMR to track it. He said the use of a fitted sheet placed residents at risk of the development or reopening of a healed pressure ulcer. Record review of the facility's policy titled Support Surface Guidelines revised 03/27/25 revealed, Purpose: The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. General Guidelines- 1. Redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. Guidelines for Selecting Appropriate Pressure-Relieving Devices 1. Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed. Interventions/Care Strategies l. Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, static air, alternating air, gel, or air-loss device, when lying in bed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 25 Residents (Resident #16) reviewed for -pharmacy services. - The facility failed to ensure a tube of numbing medicine, Lidocaine and Prilocaine 2.5%/2.5% was not left unattended on Resident #16's bedside table. This failure could place residents at risk of adverse reactions to medications and misappropriation of medications. Findings include:Record review of Resident #16's Face Sheet dated 05/19/26 revealed, a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of: type 2 diabetes, paralysis of both legs and left sided weakness after a stroke (lack of blood flow to the brain), obesity, MDD, anxiety disorder and partial amputation of the left midfoot. Record review of Resident #16's MDS assessment dated [DATE] revealed, moderately impaired cognition as indicated by a BIMS score of 12 out of 15. Record review of Resident #16's undated Care Plan revealed, focus- left forefoot (front of the foot that included all toes but preserved the heel and ankle), Interventions- Complete Treatment as ordered by MD/NP; focus- Wound Management Post-Surgical -General, intervention- Provide wound care per treatment order. Record review of Resident #16's Census list revealed, she admitted on [DATE], transferred to the hospital on [DATE] and returned to the facility on [DATE]. Record review of Resident #16's Order Summary dated 05/19/26 revealed,- Cleanse Left Foot Amputation Site with wound cleanser, pat dry, apply Xeroform, wrap with kerlix, wrap with elastic bandage every day shift every other day for Surgical Site.- Ertapenem (IV antibiotic) Use 1 gram intravenously at bedtime for bacterial blood infection until 06/21/2026.There was no prescription for Lidocaine and Prilocaine 2.5%/2.5%. An observation on 05/19/26 at 10:30 AM revealed, Resident #16 was in bed in no immediate distress. There was an open and in-use tube of Lidocaine and Prilocaine 2.5%/2.5% on her bedside table. Resident #16 said part of her foot was amputated and the medicine in the tube of lidocaine/prilocaine was applied by the nurse to her foot. In an interview on 05/19/26 at 01:38 PM, the Wound Care Nurse said Resident #16 did not have a prescription for Lidocaine/Prilocaine and staff had not administered the prescription numbing medication to her foot. She said the resident asked for the cream to be used, so she asked the wound care doctor, but the doctor refused to prescribe the medication, so she should not have had any. An observation and interview on 05/19/26 at 01:48 with the Wound Care Nurse and Resident #16 revealed, the open and in-use tube of Lidocaine and Prilocaine 2.5%/2.5% was laying her bedside table. Resident #16 said she had the cream since she readmitted from the hospital (05/14/26) and it had been on her table since then. The Wound Care Nurse explained to Resident #16 that she could not have the cream at bedside, and removed the cream from the resident's room. In an interview on 05/22/26 at 01:27 PM, the DON said all medications should be stored in locked carts when not under the supervision of staff and staff were expected to observe rooms for anything inappropriate like medications when they rounded on their residents. He said failure to keep medication under direct supervision of staff could result in inappropriate use or application that placed residents at risk of negative clinical effects. Record review of the facility's policy Medication Labeling and Storage' revised 02/2023 revealed, Policy heading- The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675789	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Arden Wood	8810 Long Point Dr Houston, TX 77055

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facility reviewed for required postings. - The facility failed to post the Daily Staffing Posting in a location visible to all by posting it on the wall on the left side of the building at the entrance to the 200 Hall.- The facility failed to include the name of the facility, and the total number of hours worked by direct care per shift on the Daily Staffing Posting on 05/19/26 to 05/22/26. These failures could affect residents, facility visitors, vendors, and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner. Findings Include: An observation on 05/19/26 at 10:19 AM revealed, a common area/dining area immediately after the lobby with a hall to the left leading to the 100 hall and a hall to the left leading to the 200 hall. The Daily Staffing Posting was attached to the wall leading to the 200 hall, and read date DAILY STAFFING POSTING, Unit one two &three date 05-19-26. The posting included shift times of 6 am- 2 pm, 6 am to 6 pm, 2 pm to 10 pm,6 pm to 6 am and 10 pm to 6 pm. The census 130 and the number of each direct care staff (CNAs, LPNs, RNs) on each shift and total number of each direct care staff category for each day. It did not include the total number or actual hours worked for each type of direct care staff, or the name of the facility. An observation on 05/20/26 at 07:35 AM revealed, a common area/dining area immediately after the lobby with a hall to the left leading to the 100 hall and a hall to the left leading to the 200 hall. The Daily Staffing Posting was attached to the wall leading to the 200 hall, and read date DAILY STAFFING POSTING, Unit one two &three date 05-20-26. The posting included shift times of 6 am- 2 pm, 6 am to 6 pm, 2 pm to 10 pm,6 pm to 6 am and 10 pm to 6 pm. The census 130 and the number of each direct care staff (CNAs, LPNs, RNs) on each shift and total number of each direct care staff category for each day. It did not include the total number or actual hours worked for each type of direct care staff, or the name of the facility. An observation on 05/21/26 at 04:10 PM revealed, a common area/dining area immediately after the lobby with a hall to the left leading to the 100 hall and a hall to the left leading to the 200 hall. The Daily Staffing Posting was attached to the wall leading to the 200 hall, and read date DAILY STAFFING POSTING, Unit one two &three date 05-21-26. The posting included shift times of 6 am- 2 pm, 6 am to 6 pm, 2 pm to 10 pm,6 pm to 6 am and 10 pm to 6 pm. The census 130 and the number of each direct care staff (CNAs, LPNs, RNs) on each shift and total number of each direct care staff category for each day. It did not include the total number or actual hours worked for each type of direct care staff, or the name of the facility. An observation on 05/22/26 at 07:44 AM revealed, a common area/dining area immediately after the lobby with a hall to the left leading to the 100 hall and a hall to the left leading to the 200 hall. The Daily Staffing Posting was attached to the wall leading to the 200 hall, and read date DAILY STAFFING POSTING, Unit one two &three date 05-22-26. The posting included shift times of 6 am- 2 pm, 6 am to 6 pm, 2 pm to 10 pm,6 pm to 6 am and 10 pm to 6 pm. The census 130 and the number of each direct care staff (CNAs, LPNs, RNs) on each shift and total number of each direct care staff category for each day. It did not include the total number or actual hours worked for each type of direct care staff, or the name of the facility. In an interview on 05/22/26 at 11:49 PM, the Staffing Coordinator said she had been in her position for 25 years and her responsibilities included the daily staffing posting and adequate staffing levels. She said the staffing posting must include the type of staff and hours worked, the census, date and the name of the facility. The Staffing Coordinator said the daily staffing posting had been located on the right wall before the 200 hall for as long as she knew, and based on the location of the posting those that went exclusively to the 100 hall would not see the posting. She said the posting did not include the facility name because she must have missed it when she created a new template a few months ago. The Staffing Coordinator said failure to place the staffing posting in a place visible to everyone or have the total number hours actually worked would leave residents and visitors unaware of the staffing for the day. Record review of the facility's policy titled ?Posting Direct Care (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675789	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Arden Wood	8810 Long Point Dr Houston, TX 77055

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Daily Staffing Numbers' revised 08/2022, Policy Statement:Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. 2. Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including, but not limited to: assisting with activities of daily living (ADLs), administering medications, supervising care provided by CNAs, and performing nursing assessments. Medication aides, feeding assistants, hospice staff, private duty aides and administrative staff are not calculated in direct care staffing numbers. Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following: a. The name of the facility; b. The current date (the date for which the information is posted); c. The resident census at the beginning of the shift for which the information is posted;