STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675791	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Golfcrest	7633 Bellfort Houston, TX 77061

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident's environment remained as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 5 residents reviewed for transfers. Resident #1 was transferred from her motorized wheelchair to the bed with a sit to stand hoyer lift using a sling that was too small to secure around her waist and had a broken buckle. This could place residents who utilize the sit to stand hoyer lift at risk for falls and serious injury. Findings included: Record review of Resident #1's facesheet revealed an eighty-two year old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were dementia, lack of coordination, disorientation, abnormalities of gait and mobility, morbid obesity, and encephalopathy (brain disease or disorder that effects brain function). Record review of Resident #1's MDS (minimum data set) Section C- Cognitive Patterns completed 04/24/25 revealed a BIMS (brief interview mental status) revealed a score of 11 out of 15, signifying moderate impairment. Section G- Functional Status documented that for transfers, Resident #1 required extensive assistance where staff provided weight bearing assistance and was a one-person physical assistance. Record review of Resident #1's care plan revised 04/22/25 documented the following focus areas:* impaired visual function related to glaucoma [TT1] (eye disease that damages the optic nerve) and she was at risk for falls. * ADL self-care performance deficit and detailed that she required partial/moderate assistance during transfers. *On 02/06/25, Resident #1 had a fall with no injury related to lower extremity weakness. During a transfer with a CNA from the bed to her motorized wheelchair, care plan stated her knees went out and she was assisted to sit on the floor. Intervention listed was to consult with PT for strength and mobility. [TT2] In an interview on 06/25/25 at 10:13 am, CNA C stated the facility had a sit to stand hoyer lift that they used to transfer Resident #1 in and out of bed. When they would perform a transfer, aides would tie the belt that secured the resident during a transfer because it could not fit around her due to her size. CNA C [TT3] explained she did not know where they kept this hoyer, but if you looked at the belt, there were several knots in the belt where you can see where it's been tied. She could not give an exact time frame for how long the belt had been broken, but she estimated at least one month. CNA C stated she was worried when Resident #1 would use the sit to stand hoyer because she felt she could slip off and fall. In an observation and interview on 06/25/25 at 1:12 pm, CNA A stated the facility had two traditional mechanical lifts and a sit to stand hoyer lift that was primarily used by Resident #1. She walked the investigator to the sit to stand hoyer life and explained the sit to stand was only utilized by residents who could grab the handle bars. CNA A gave a demonstration on how it was used. She stepped her feet on the platform at the bottom of the machine and grabbed the handles bars. She stated that at her feet, there was a strap that would fasten around both of her legs and there was a strap that would fasten around her lower back/waist. The machine had an up and down button that raised the handle bars up for comfortability as the resident raised from a sitting to standing position. There was a seatbelt attached to a sling that she stated fit around the small of their back and the loops attached to the hooks on the machine. The belt had several knots that had been tied on it. CNA A stated that the knots had been tied on the belt because the belt was too big and the aides were trying to keep it from sliding. When asked if Resident #1 used the belt during transfers, she stated Resident #1 didn't need it because she was able to stand. CNA A could not recall how long the belt on the sit to stand lift had been broken and stated that she had only used it a few times because Resident #1 use to walk more. In an interview on 06/25/25 at 1:46 pm with Resident #1, she stated that when she used the sit to stand lift, she made sure her feet were secured and if they were not, she would ask one of the aides to help her. She explained that there was a burgundy belt attached to the hoyer's sling that was supposed to snap around her, however the buckle was not secured and needed some adjustment and this made her feel unsteady. She explained the aides usually tied it but they needed another belt so that it could be adjusted correctly. She stated that although she was not nervous using the sit to stand lift, she knew that it needed to be fixed. In an observation and interview on 06/25/25 at 2:59 pm, Resident #1 rolled herself into her room accompanied by CNA A and CNA B. Resident #1 lifted her legs out of the leg rests on her motorized wheelchair and placed them on the foot rest of the sit to stand hoyer lift. CNA A removed her glasses and the pouch she was wearing and strapped her legs into the lift. Resident #1 grabbed the handle bars and CNA attempted to fasten the buckle on the sling but it could not fit around Resident #1's body. She tried to buckle it but it would not stay. CNA A finished the transfer with