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	08/05/2025

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consult with the resident's physician when there was an accident involving the resident which resulted in injury and required physician intervention for 1 (Resident #1) of 4 residents reviewed for notification of changes. LVN-A failed to notify Resident #1's physician for 24 hours when she complained of pain after a witnessed fall on 06-23-25 which resulted in an acute fracture of the left humerus (the long bone in the upper arm) and soft tissue swelling. The noncompliance was identified as Past Non-Compliance IJ. The IJ began on 06/23/25 and ended on 06/26/25. The facility corrected the noncompliance before the survey began. This failure placed dependent residents at risk of not receiving proper care, a decline in health, and pain.Findings included: Record Review of Resident #1's face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Primary insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or experiencing non-restorative sleep), lack of coordination (impaired balance or coordination), muscle weakness (decreased strength in the muscles), Hyperlipidemia (abnormally high levels of lipids in the blood), Rheumatoid Arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), and Unspecified Osteoarthritis (a type of arthritis where the specific location is not identified in the medical record). Record review of Resident #1's significant change in status MDS assessment dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment). Record Review of Resident #1's Care Plan dated 06/25/25 revealed she was at risk for falls due to unsteady gait, poor awareness with visual deficit, altered cognition and poor safety awareness. She was a one person assist with her ADL. Observation of Resident #1 on 07/01/2025 at 12:50 p.m. revealed she resided in the facility's locked unit. Resident #1 was in bed with her left arm in a splint to keep it immobilized. Her bed was in the lowest position (the bed frame was adjusted to be as close to the floor as possible), fall mats were in place and her call light was in reach. Record Review of Resident# 1's progress note dated 06/23/25 reflected that the following note was written by LVN A: Nurse witnessed resident on floor in front of room [ROOM NUMBER], laying on her left side, assessment/observation completed with no verbal c/o pain or discomfort, no acute changes at the time of fall, resident assisted up into w/c via nurse and CNA, VS obtained 128/72, 97.0, 97% RA, 18, 67 stable, supplement given, resident up and walking from sitting in w/c, nurse redirected and assisted resident back to w/c, continued with no signs/symptoms of pain during observation, resident assisted to bed via CNA with no complaints of uncontrolled pain. Record Review of CNA-A's witness statement dated 06/30/2025 reflected that CNA-A stated that Resident #1's fall on 06/23/2025 was caused when Resident #1 was getting up from her seat and she accidentally bumped into a resident that CNA-A was assisting. Record review of Resident #1 shower sheet dated 06/24/25 reflected that she refused her shower on 06/24/25. Shower sheet was signed by CNA-GG. Record review of Resident#1 skin assessment dated [DATE] reflected that there wasn't any alterations in skin integrity noted. The Assessment was conducted by LVN-BB. Record review of Resident #1's progress note dated 06/25/25 reflected that she had mild swelling and warmth to touch to her left arm. The NP was notified, and X-ray was ordered, Tylenol 325 mg 2 tabs was given., vitals recorded and was within range. Rp was notified and care was continued. Resident #1 Physician's order dated 08/14/23 reflected that 2 tablets be given by mouth every 8 hours as needed for Pain. Record review of Resident #1 MAR dated 06/25/25 reflected that she was given 2 tabs of Tylenol 325 mg. Record Review of Resident #1's X-Ray report dated 06/25/25 reflected that she had sustained an Acute fracture across the left humerus neck (broken arm)with subtle displacement of bony edges, overlying soft tissue swelling as noted. Record review of Resident #1's progress note dated 06/30/25 reflected that she had one fall in the past three months. Date, time, and how the fall occurred was not documented in the progress note. In an Interview on 07/02/25 at 10:30 am with the DON, Administrator, and Regional Nurse, all stated that when a resident had a fall Head-to-Toe assessment must be done, the NP, the ADON or DON needs to be notified, and the results of the assessment must be documented. They stated that LVN A did not complete a Head-to-Toe assessment, she failed to notify the facility medical staff, and she also failed to notify the DON. Therefore, due her not following policy, LVN-A was terminated. On 07/02/25 at 11:00 am, an unsuccessful attempt was made to contact LVN-A and CNA-A, but both parties did not answer their phone. In an interview on 07/02/25 at 3:30 PM, the NP stated that she did not receive a call from the facility notifying

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety 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 residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 4 residents reviewed for quality of care. The facility failed to ensure LVN-A adequately assessed, monitored, provided appropriate interventions, and contact the physician immediately when Resident #1 complained of pain after a fall which resulted in an acute fracture of her left humerus (the long bone in the upper arm). The noncompliance was identified as Past Non-Compliance. The IJ began on 06/23/25 and ended on 06/26/25. The facility corrected the noncompliance before the survey began. This failure placed residents who experience falls with injury at risk of not receiving adequate treatment in a timely manner, further injury, and pain.Findings included: Record Review of Resident #1's face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Primary insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or experiencing non-restorative sleep), lack of coordination (impaired balance or coordination), muscle weakness (decreased strength in the muscles), Hyperlipidemia (abnormally high levels of lipids in the blood), Rheumatoid Arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet), and Unspecified Osteoarthritis (a type of arthritis where the specific location is not identified in the medical record). Record review of Resident #1's significant change in status MDS dated [DATE] revealed she had a BIMS score of 3 (severe cognitive impairment). Record Review of Resident #1's Care Plan dated 06/25/25 revealed she was at risk for falls due to unsteady gait, poor awareness with visual deficit, altered cognition and poor safety awareness. Interventions included: Anticipate and meet the resident's needs; Be sure the call light is within reach and encourage the resident to use it for assistance as needed; Ensure resident wears appropriate footwear when ambulating or mobilizing in wheelchair; Keep needed items in reach; and Physical Therapy evaluate and treat as ordered or as needed. Observation of Resident #1 on 07/01/2025 at 12:50 p.m. revealed she resided in the facility's locked unit. Resident #1 was in bed. Resident #1 was in bed with her left arm in a splint to keep it immobilized. Her bed was in the lowest position (the bed frame was adjusted to be as close to the floor as possible), fall mats were in place and her call light was in reach. Record Review of Resident #1's progress note dated 06/23/25 reflected that the following note was written by LVN A: Nurse witnessed the resident on floor in front of room [ROOM NUMBER], lying on her left side. An assessment/observation were completed with no verbal c/o pain or discomfort. The resident was assisted to bed with no complaints of uncontrolled pain. Record review Resident#1 progress note dated 06/25/25 reflected that she had mild swelling and warmth to touch to her left arm. The NP was notified, and X-ray was ordered, Tylenol 325mg 2 tabs was given., vitals recorded and was within range. Rp was notified and care was continued. Record review of Resident#1 progress note dated 06/30/25 reflected that she has had one fall in the past three months. Date, time, and how the fall occurred was not documented in the progress note. Record Review of Resident #1's X-Ray report dated 06/25/25 reflected that she had sustained an Acute fracture (a sudden and complete break in a bone) across the left humerus neck (upper arm) with subtle displacement (broken bone fragments are slightly out of alignment) of bony edges, overlying soft tissue swelling as noted. In an interview on 07/02/25 at 10:00am with the DON, Administrator, and Regional Nurse revealed they all stated that when a resident had a fall that a head-to-toe assessment must be done, the NP must be notified, the ADON, or DON needed to be notified. And the result of the assessment must be documented. They stated that LVN A did not complete a head-to-toe assessment, she failed to notify the facility medical staff, and she also failed to notify the DON. In an interview on 07/02/25 at 3:30PM, the NP stated that she did not receive a call from the facility notifying her that Resident #1 had a fall. She said that if she had been given a call, she would have given an order for Resident#1 according to the result of the assessment. In an interview on 08/11/25 at 11:30am with Resident#1 RP he stated that he was not notified of Resident#1 fall on the 23rd of June until the 25th of June when the facility was getting ready to send her to the hospital. In an interview on 08/05/25 at 11:20am with the ADON he stated that LVN-BB reported to him on 06/25/25 that Resident#1 was experiencing pain in her left arm, The ADON stated that he told LVN-BB to call the NP for an order for an X-ray. The ADON stated that the X-ray was performed and as result of the X-ray Resident#1 was sent to the Hospital. The ADON stated that 06/25/25 was the first time it was reported to him that Resident#1 was having pain. In an interview