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	05/23/2026

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 - Immediate jeopardy to resident health or safety 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 observation, interview, and record review, the facility failed to ensure that the resident received adequate supervision and assistive devices to prevent accidents for 1 of 6 residents (CR #1) reviewed for witnessed falls. The facility failed to ensure 2 staff members remained at bedside on [DATE] during ADL /linen change for CR #1, which resulted in a witnessed fall with major head injury (hematoma [a collection of blood trapped under the skin or inside the body after an injury or damaged blood vessel]), which resulted in hospitalization. CR #1 expired in the hospital on [DATE]. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on [DATE] and ended on [DATE]. The facility corrected the non-compliance before the investigation began. This failure has the potential to place residents at risk for serious harm, hospitalization and death. Findings included: Record review of face sheet dated [DATE] reflected CR #1 was a [AGE] year-old male admitted into the facility on [DATE] and was readmitted on [DATE]. His diagnoses included heart failure (condition where the heart becomes too weak to pump blood through the body properly), thrombocytopenia (condition where a person has a low number of platelets in the blood. Platelets help stop bleeding), intracranial hemorrhage (bleeding inside the skull or brain), hemiplegia (complete paralysis on one side of the body, the person cannot move that side properly), hemiparesis (weakness on one side of the body), and thrombosis of deep veins (blood clots that forms in the deep veins usually in the legs). Record review of CR #1's Annual Minimum Data Set, dated [DATE] revealed he was coded as Severely impaired - never/rarely made decisions. Section GG, which reflects functional abilities, indicated that CR #1 required dependent, two-person assistance for showers, toileting, hygiene, and bed transfers. Record review of CR #1's care plan initiated [DATE] with a revision date of [DATE] indicated CR #1 was at risk for falls related to poor safety awareness and poor balance. Intervention: CR #1 will be Mechanical lift with staff x 2 to assist with transfers. CR #1 required total assistance x 2 staff assistance for ADLs. Record review of CR #1's progress note dated [DATE] at 8:52 p. m., revealed the following documentation by LVN A .called attention to Resident room, nurse and other staff entered, observed resident on floor lying face down. Per staff that witnessed the fall, during the time of changing resident, I crossed his legs and turned him to side to change linens before changing the diaper. In the process, Resident slid from bed to floor face down. Head to toe assessment done, noted raised area to fore face, open skin sites to right arm, resident nonverbal but can response to verbal stimulus by nodding the head. Assisted resident off the floor to bed. Ice pack applied to raised area to fore face, neuro vital initiated and 911 team called at 8:14 p.m. Record review of EMS report dated [DATE] revealed CR#1 was transported to a local hospital due to a witnessed fall and sustained hematoma (a collection of blood trapped under the skin or inside the body after an injury or damaged blood vessel) on the forehead. Record review of the facility's PIR dated [DATE], revealed the alleged incident occurred on [DATE], at approximately 7:45 p.m. Incident category was documented as witnessed fall. Description of allegation revealed CNA L was in the process of changing CR #1's linen on his bed, when CR #1 slid out of bed on the floor. LVN A assessed CR #1 and noted raised area to forehead, and open skin site to right arm. Cold compress (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	placed on the swelling to the forehead; NP was notified and ordered to send CR #1 to emergency room for further evaluation. Further review of the investigation summary revealed CNA L was suspended pending investigation. Interview with DON on [DATE] at 12:26 p.m., he stated that CR #1 experienced a fall while a CNA L was changing the bed linens. The DON stated that CR #1 was care planned as a two-person assist resident for ADLs. The DON stated that only one CNA was present at the time the incident occurred. The DON performed an immediate assessment of the CR #1 following the fall witnessed, emergency medical services were contacted. LVN A then notified CR#1's NP who ordered to send CR #1 to hospital for evaluation. DON further stated that the facility later received notification that CR #1 expired the following day. The DON said he completed in-service training with all staff on fall prevention, two - person assist residents, care plan, and other related topics after the incident on [DATE] through [DATE]. CNA L was suspended, and he had never returned to work at the facility but had completed training on abuse, neglect, and falls prior to the incident. DON said he contacted the hospital for CR #1's medical record, but the hospital had not provided it to them to date. Interview with Administrator on [DATE] at 1:34 pm. She stated that she was informed the CR #1 slid from the bed to the floor while CNA L was changing the bed linens. According to the Administrator, CNA L was reportedly waiting for another staff member to assist because CR #1 required two-person assistance; however, while waiting, CNA L began changing the bed linen. During the process, CR #1 slid from the bed and fell to the floor. The Administrator stated that CNA L immediately called for assistance and nursing staff responded, assessed the resident, contacted emergency medical services, and transferred CR #1 to the hospital for further evaluation. The Administrator stated that the facility subsequently received notification from the hospital that CR #1 expired the following day. The Administrator stated that she reported the incident to the state, suspended CNA L, and started investigation. She said the facility did a QAPI after the incident, and staff had been retrained and in-serviced on two-person ADL care, fall prevention, abuse and neglect. The facility audited the witnessed falls, and all residents who required two-person ADL care with no adverse findings. The Administrator said CNA L never returned to work and had been removed as an employee at the facility. Interview with CNA L on [DATE] at 1:44 p.m., CNA L, stated that he was the staff member providing care to CR #1 on the day of the witnessed fall incident. He stated that during routine rounds he observed that CR #1 required care and noted that CR #1 was care planned as two-person assist resident. He requested assistance from two other CNAs; however, assistance was not immediately available. He stated that while waiting for assistance, he began changing CR #1's bed linen because the linens were soiled. He stated that CR #1's bed was elevated at the time of care and that CR #1 slid from the bed and landed face down on the floor. He further stated that he could not definitively determine whether the resident's head directly struck the floor because the incident happened rapidly. He said that failure to have two staff members present created a risk for CR #1 to fall from the bed. CNA L stated that the potential risks associated with not utilizing two staff members included falls, injuries, worsening of the resident's condition, and possible death. CNA L said he was suspended on [DATE] and had not returned to work since then. He stated that he had completed training on abuse, neglect, and falls prior to the incident. Interview with LVN A on [DATE] at 2:27 p.m., she said she was called by CNA L that CR #1 slid from the bed to the floor. She stated that she responded following notification of the incident; however, she did not witness the actual fall. She performed a head - to - toe assessment on CR #1 and noted that CR #1 had a raised area to the forehead, and an open skin site to the right arm. She notified CR #1's NP who ordered to send CR #1 to emergency room for further evaluation. LVN A stated that CR #1 was care planned as a two-person assist resident. She stated that if only one staff member attempted to assist a resident requiring a two-person assist, the resident would be at risk for falls and possible injury. LVN A said she and all the nurses and CNAs received in-service education related to fall risk residents, abuse, neglect, care plan review prior to resident's care, Kardex (a summary sheet that tells staff the most important things they need to know about a resident at a glance), two -person assistance, and fall prevention (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	using the acronym CHIPS. The in-services were provided by DON, and the most recent in-service occurred on [DATE]. On [DATE], medical record request was sent to Veteran Affair hospital, where the resident expired, but no record had been received to date. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the investigation began.The surveyor confirmed the non-compliance had been corrected by: Interview with Administrator and DON revealed they had identified through their investigation that staff used one-person assistance instead of two-person assistance as stated in the care plan, which caused CR #1 to fall. They implemented training for the nurses and CNAs regarding how to use two-person assistance during ADL care, accessing the care plan/Kardex to determine the resident's individualized care needs, completing fall assessments, implementing fall prevention measures. Record review of the facility in-service dated [DATE] through [DATE] revealed staff were in-serviced on the following topics: Residents at high risk for fall, fall precaution, fall risk factors for residents who are bed bound, review of Kardex and care plan prior to resident care. Fall prevention using the acronyms CHIPS, Abuse and Neglect. Record review of the facility QAPI sign - in sheet meeting held on [DATE] revealed that the following topics were discussed at the meeting: fall prevention, protocol and interventions to minimize and prevent resident falls. Record review of the facility Resident Interview - Safe Survey binder revealed that the facility conducted Residents Safe Survey on 16 residents who were at risk of falling, and residents needing two-person assistance on [DATE] and [DATE] respectfully. Record review of CNA L's personnel file on [DATE] revealed CNA L was suspended on [DATE] and was terminated on [DATE]. During an interview with Resident #5 on [DATE] at 10:56 a.m. Resident #5 stated that she always has two staff members that always assist her with ADLs, repositioning, and transfers because she cannot do it by herself. During interviews on 05/ 21/2026 between 10:27 a.m. through 3:33 p.m., ADON, LVN A, LVN B, LVN C, RN G, RN H, CNA J, CNA K, CNA L, CNA M, and on [DATE] between 12:58 p.m., through 2:53 p.m., LVN D, LVN E, LVN F, RN T, RN U, CNA N, CNA O, CNA P, CNA Q, CNA R, CNA S, were able to state that they were aware of the fall incident involving CR #1 who was care planned for two - person assistance, but one staff provided the care on [DATE], which resulted in CR #1's fall with injury. They stated that if only one staff member attempted to assist a resident requiring a two-person assistance, the resident would be at risk for falls and possible injury. They stated that they had been reeducated regarding the facility's fall prevention interventions. They stated that they had received in-service education related to fall risk residents, abuse, neglect, care plan review prior to resident's care, Kardex, two -person assistance with ADLs, fall prevention using the acronym CHIPS. Observations of two-person in-bed peri-care of Resident #4 on [DATE] at 2:30 p.m., showed no concern, and staff followed appropriate steps to ensure care and resident safety. Observations of two-person in-bed peri-care of Resident #6 on [DATE] at 2:45 p.m., showed no concern, and staff followed appropriate steps to ensure care and resident safety. Record review of facility's policy on Assessing Falls and their Causes with revision date on [DATE] revealed in parts . The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Preparation: 1. Review the resident care plan to assess for any special needs of the residents. The Facility's policy does not really address the issue to provide adequate supervision and assistive devices to prevent accidents.