

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment describing services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 of 7 residents (Residents #127, 37 and #97) reviewed for comprehensive care plans. 1. The facility failed to care plan Resident #127's dental recommendations on 02/25/2026. 2. Resident #7's care plan did not address her Apixaban to prevent blood clot.3. Resident #97's care plan did not address her Clopidogrel Bisulfate hematological agent.4.Resident #12's comprehensive care plan was not revised to reflect the resident's ongoing refusals of ADLs. Interventions were not evaluated for effectiveness, nor were individualized interventions added to address underlying causes of the resident's refusals, based on the resident's current assessed needs. This failure could lead to residents not having their individual, medical and functional needs identified and cause a physical or functional decline in health.1.Record review of Resident #127's facesheet dated 07/03/2026, reflected he was an [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE] with medical diagnoses including chronic kidney disease, dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life), need for assistance with personal care, muscle wasting and atrophy (reduction in muscle mass), type 2 diabetes mellitus (high blood sugar) and dysphagia (difficulty swallowing).Record review of Resident #127's Quarterly MDS dated [DATE], reflected he had a BIMS score of 5 out of 15, indicating severe cognitive impairment related to thinking and memory. Resident #127 required moderate assistance with oral hygiene. Record review of Resident #127's care plan dated 06/30/2026, reflected he had focus areas of:-Revised on 03/18/2026: Risk for impaired dentition with interventions including to encourage or assist resident in performing oral hygiene after each meal and as needed. The dental exam recommendations were not in the care plan.Record review of Resident #127's dental exam on 02/25/2026, reflected the resident and SW were on the telehealth visit. Resident #127 said he had discomfort when chewing in the back molars and expressed interest in dentures. Resident #127 would be made a priority at the next scheduled visit for a comprehensive evaluation. The document further read, In the interim, the following recommendations and prescriptions are to be implemented into the pt's daily regimen to manage symptoms until direct dental care can be provided:1)Avoid chewing on the left side. A softer food diet may also be considered to reduce functional pressures when chewing.2) Gently brush and thoroughly clean mouth and teeth 2-3 times/day to reduce oral bacteria.3)Warm saltwater rinses for 30 seconds (and spit out) after every meal and throughout the day, as needed, to flush out excess debris and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reduce inflammation.RX1: Amoxicillin 500mg q8hr for 10 daysRX2: 0.12% Chlorhexidine oral rinse; swish for 30 seconds and expectorate (spit out) BID for 14 days.Record review of Resident #127's care plan, reflected he had the following care areas:-Focus: history of dentures, impacted dentition with interventions including needing to be reminded to brush his teeth twice daily. Observation and interview with Resident #127 on 06/30/2026 at 9:08a.m., revealed he was resting in bed and appeared to be well-groomed and comfortable. Resident #127 said he had a dental check-up a while back but wanted to know when his next appointment was because the dentist had more work to do. Resident #127's lower molars on both sides were blackened. Resident #127 said the facility provided a soft diet that was pre-cut so he could eat. He said his teeth did not bother him now and he had no pain.Interview with CNA M on 06/30/2026 at 3:20p.m., she said that Resident #127 was able to brush his own teeth. Resident #127 was quiet and had never complained to her about his teeth. Resident #127 would eat his meals in the dining room.Interview with CNA AJ on 07/01/2026 at 9:25a.m., she said she was an aide for 3 years at this facility. CNA AJ said she assisted Resident #27 with brushing his teeth every day and that she never helped him rinse his mouth with salt water and that Resident #27 was on a soft/puree diet. Interview with the SW on 07/01/2026 at 2:46p.m., the SW said Resident #127 saw a dentist through telehealth and that since his stay was paid through the VA , they would be the one to schedule it for him. The SW said he was last at the hospital in April 2026 for an unrelated complication and when he came back there were no concerns for his teeth.Interview with Resident #127's family member on 07/01/2026 at 3:17p.m., she said she last visited Resident #127 two weeks ago and he was eating well and did not complain about his teeth. The family member said she had no concerns with the care and that Resident #127 had no problems . Interview with MDS A on 07/02/2026 at 3:09p.m., she said that the SW would be the one to update her on dental appointments and the recommendations should have been communicated to the MDS team. MDS A said that there was an IDT that met often and reviewed assessments, sent emails and reviewed appointments. Resident #127 could have had complications in weight loss, infection or sepsis if these recommendations were not added to his orders. 2.Record review of Resident #7's admission face sheet revealed Resident #7 was a [AGE] year-old female who was admitted on [DATE]. Resident #7's diagnoses included essential hypertension (high blood pressure), Type 2 diabetes (high blood sugar) acute embolism and thrombosis of left peroneal vein (blood clot forming deep inside the body usually in the vein), acute embolism and thrombosis of deep vein and unspecified lower extremities (blood clot forming deep inside the body usually in the legs or pelvis), thrombocytopenia (a condition characterized by an abnormally low count of platelets in the blood), peripheral vascular disease (a slow progressive blood disorder that narrows or blocks blood vessels outside the heart or brain), atherosclerosis of native arteries of the right leg (build up of fatty plaque that narrows the arteries and restricts blood flow), acute kidney failure (decreased kidney function), and chronic diastolic congestive heart failure (this happens when the heart muscle becomes stiff and cannot relax normally between beats). Review of Resident #7's annual MDS dated [DATE] revealed she was coded as having a BIMS score of 10 indicating she was moderately impaired cognitively for decision making. She was coded as receiving anticoagulant medication (to help prevent blood clots, potentially leading to a stroke and loss of oxygen to the brain). Record review of Resident #7's Physician's order revealed an order for Apixaban oral tablet 5mg two times a day to prevent blood clot. Record review of Resident #7's care plan dated 5/7/2026 revealed it did not address the anticoagulant medication apixaban. Record review of Resident #7's MAR for June and July 2026 revealed the medication apixaban was given to Resident #7. In an interview on 7/3/2026 at 5:00p.m., the MDS Nurse said she missed doing the service plan. Not updating the care plan to include the anticoagulant apixaban could (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	result in Resident#7 not getting the care and service needed to improve her quality of life. She said she was going to update the care plan to address the anticoagulant.3.Record review of Resident #97's admission face sheet revealed Resident #97 was a [AGE] year-old female who was admitted on [DATE]. Resident #97's diagnoses included chronic venous hypertension (a condition where high blood pressure develops in the leg vein) , Type 2 diabetes (high blood sugar), peripheral vascular disease (a slow progressive blood disorder that narrows or blocks blood vessels outside the heart or brain), atherosclerosis of native arteries of the right leg (build up of fatty plaque that narrows the arteries and restricts blood flow), acute kidney failure (decreased kidney function), and chronic diastolic congestive heart failure (this happens when the heart muscle becomes stiff and cannot relax normally between beats).Review of Resident #97's quarterly MDS dated [DATE] revealed she was coded as having a BIMS score of 10 indicating she was moderately impaired cognitively for decision making. She was coded as receiving antiplatelet medication . Record review of Resident #97's Physician's order revealed an order for Clopidogrel Bisulfates 75mg one time a day for hematological agent .Review of Resident #97's current Care Plan dated 5/7/2026 reflected that her antiplatelet medication was not addressed on her care plan. Record review of the MAR for June and July 2026 revealed the medication Clopidogrel was given to Resident #97. In an interview with MDS A on 7/3/2026 at 5:00pm she confirmed the medication was not care planned. She said she was going to check the reason why it was not addressed on the care plan. She then said the reason it was not done was she was planning to talk to the doctor about the diagnoses. She said she was going to call the doctor. She called the doctor and she was given a more appropriate diagnoses for the medication. She said she just missed following up with the doctor and that was why it was not addressed on the care plan. She said she was going to update the care plan to include the antiplatelet medication. In an interview on 7/3/2026 at 1:05 pm the DON said his expectation of the MDS nurses was to ensure all resident's care areas were addressed in the care plan. He said not addressing the care areas could prevent residents from getting the care and services needed to improve their quality of life. 4. Record review of Resident #12's face sheet, last captured on 7/3/26, reflected a [AGE] year-old female admitted on [DATE] (original admission 1/2/20) diagnosed with acute embolism and thrombosis, hypertension, bipolar disorder, schizophrenia, and unspecified dementia. Record review of the comprehensive care plan dated 4/28/26 for Resident #12 reflected the resident was resistive to care and experienced episodes of refusing care. The interventions addressing ADL refusals were not current despite subsequent annual and quarterly MDS assessments. No evidence was identified that the care plan had been revised to include current goals, individualized interventions, or staff approaches addressing the resident's ongoing refusal of ADLs or promoting maintenance of functional abilities. Record review of the quarterly MDS dated [DATE] for Resident #12 reflected the resident was coded as requiring total assistance for toileting, bathing, upper body dressing, lower body dressing, and personal hygiene. The assessment also reflected that Resident #12 was independent with rolling left and right in bed, always incontinent, did not use a wheelchair or scooter, and was dependent for tub/shower transfers. MDS Section E reflected daily rejection of evaluation and/or care necessary to achieve the resident's health and well-being goals. During an observation and interview conducted with Resident #12 on 6/30/26 at 9:42 a.m., the resident was observed sitting upright in bed watching television. The resident independently operated a television remote control. When approached for interview, the resident stated, I can't answer questions, and declined further interview. During an interview conducted with CNA D on 7/2/26 at 10:35 a.m., it was stated that Resident #12 was physically capable of completing most ADLs independently, including walking, toileting, brushing her teeth, washing her face, and dressing herself. CNA D stated staff routinely (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided total assistance because the resident frequently refused to perform those tasks. CNA D stated she did not know why the resident refused but believed it was related to the resident's mental illness. CNA D said she was unaware of any interventions being used to address Resident #12's refusals. CNA D further stated the resident had experienced physical decline (decreased strength, endurance, and mobility) because she rarely got out of bed or participated in physical activity. During an interview conducted with RN AF on 7/2/26 at 10:48 a.m., it was stated that Resident #12 refused to walk despite being physically able to do so. RN AF stated the resident needed to be assessed to determine the reason for the refusals and acknowledged that no interventions were currently being used to encourage independence. RN AF stated she had never attempted interventions to promote participation in ADLs. She further stated the resident enjoyed snacks and believed they could potentially be used as motivation but had not communicated that information to the MDS nurse. RN AF stated she was unaware of any diagnosis that would physically prevent Resident #12 from completing ADLs independently. During an interview conducted with MDS A on 7/2/26 at 3:25 p.m., it was stated that Resident #12 remained in bed most of the day and refused to participate in activities despite being physically capable of performing most ADLs and ambulating. MDS A stated the facility had not assessed the reason for Resident #12's refusals and could not identify any current interventions to encourage participation or maintain function. After reviewing the care plan, MDS A acknowledged the interventions addressing refusals remained from 2020 through 2022 despite the care plan having been revised in April 2026. MDS A further acknowledged there was no current documentation evaluating the effectiveness of interventions or addressing the resident's continued refusal of ADLs and stated the care plan should have been updated to reflect the resident's current needs. During an interview conducted with SW on 7/3/26 at 11:50 a.m., the SW stated documentation of ADL refusals on the care plan was not considered her responsibility. The SW stated she had not discussed refusal of ADLs with Resident #12 and had not documented or revised interventions related to those refusals. During a follow-up interview conducted with MDS A on 7/3/26 at 12:00 p.m., MDS A stated documentation of the refusals was considered the responsibility of the Social Worker because the refusals were viewed as behavioral concerns. MDS A stated she had instructed the Social Worker to complete progress notes and update the care plan following discussions regarding resident behaviors or care concerns. MDS A acknowledged that some of the goals, interventions, and tasks on the care plan were last revised over five years ago and had not been updated. MDS A further stated that even when interventions continued to be appropriate, the care plan should have been reviewed and updated with current information to ensure it accurately reflected the resident's ongoing needs. Record review of the facility's policies and procedures for Care Plans dated 4/2024 read in part. GENERAL Each resident will have a care plan that is current, individualized and consistent with their medical regimen. POLICY: 3. The comprehensive care plan is developed within 7 days of CAA completion. A member of the IDT will provide the resident and or representative with a summary of the baseline care plan or a copy of the baseline care plan in writing in a language that can be understood and verbally in a language that can be understood. 5. The care plans are developed by the members of the interdisciplinary team based on their assessments and interaction with the residents and/or resident's significant others. 6. The care plans are updated at least every 90 days or with a significant change of resident by the team member initiating the care plan. 7. The resident care plans are kept electronically and accessible to the staff caring for the residents. 8. If a resident is readmitted to the facility, their care plans are reviewed and updated as needed. 9. The care plan consists of the following: a. Problems as identified by reviewing the medical record and discussion with the resident and /or significant others. b. Goals are set in conjunction with the family and resident. Goals are (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	realistic, measurable, behaviorally stated and may be long or short term. Goals should prevent decline or maintain resident function is realistic and appropriate based on the diagnosis.c.Interventions are actions taken to achieve the goal.12These interventions should build on the resident's strengths, be realistic and identify those responsible for the interventions.d.Evaluation of the care plan goals should occur at least every 90 days or with a significant change of the resident. If the goal is continued, a new date of completion should be identified. If the goal has been achieved, it should be discontinued and a new goal, if appropriate, written. If the goal is now unachievable, it should be discontinued and the care plan updated as to why. Record review of the facility's policies and procedures for Care Plans dated 4/2024 read in part. GENERALEach resident will have a care plan that is current, individualized and consistent with their medical regimen.POLICY: 3.The comprehensive care plan is developed within 7 days of CAA completion. A member of the IDT will provide the resident and or representative with a summary of the baseline care plan or a copy of the baseline care plan in writing in a language that can be understood and verbally in a language that can be understood. 5.The care plans are developed by the members of the interdisciplinary team based on their assessments and interaction with the residents and/or resident's significant others.6.The care plans are updated at least every 90 days or with a significant change of resident by the team member initiating the care plan.7.The resident care plans are kept electronically and accessible to the staff caring for the residents.8.If a resident is readmitted to the facility, their care plans are reviewed and updated as needed.9.The care plan consists of the following:a.Problems as identified by reviewing the medical record and discussion with the resident and /or significant others.b.Goals are set in conjunction with the family and resident. Goals are realistic, measurable, behaviorally stated and may be long or short term. Goals should prevent decline or maintain resident function is realistic and appropriate based on the diagnosis.c.Interventions are actions taken to achieve the goal.12These interventions should build on the resident's strengths, be realistic and identify those responsible for the interventions.d.Evaluation of the care plan goals should occur at least every 90 days or with a significant change of the resident. If the goal is continued, a new date of completion should be identified. If the goal has been achieved, it should be discontinued and a new goal, if appropriate, written. If the goal is now unachievable, it should be discontinued and the care plan updated as to why.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for four residents (Resident #114, Resident #122, Resident #50 and Resident #1) out of six residents reviewed for ADLs. The facility failed to provide personal hygiene to Resident #114 which resulted in the resident having long fingernails and dark brown substances under the fingernails. The facility failed to provide personal hygiene to Resident #122 which resulted in the resident having facial hair on her chin. The facility failed to provide personal hygiene to Resident #50, which resulted in the resident having long fingernails and dry, flaky, skin from below both knees to his feet. The facility failed to provide incontinent care to Resident #1 which resulted in the resident having incontinent brief saturated with dry and fresh feces and the two draw sheets had dry brown rings. These deficient practices could have placed residents at risk of skin breakdown and reduced feelings of self-worth. Findings included: 1. Record review of Resident #114's face sheet dated 07/01/26 revealed an [AGE] year-old female was initially admitted on [DATE] and readmitted on [DATE] from the hospital. Resident #114 had diagnoses which included: dementia (a decline in mental abilities), hypertension (when the pressure in the blood vessels is too high), and myocardial infarction (heart attack). Record review of Resident #114's quarterly MDS assessment, dated 05/30/26, revealed the BIMS score was 10, which indicated moderately impaired cognition. Further review of the MDS revealed Resident #114 needed moderate assistance with personal hygiene. Record review of Resident #114's care plan revision on 02/15/26 revealed the resident had an ADL self-care performance deficit related to paraplegia (not able to move lower part of the body). Intervention: dependent on staff for bathing/shower. Personal hygiene; dependent on staff for personal hygiene as required. Record review of Resident #114's progress notes for June 2026 did not reveal Resident #114 refused personal hygiene. During an observation on 06/30/26 at 9:45 a.m., Resident #114's fingernails on both hands were 0.75 cm long and had dark brown substance under her fingernails. During an interview on 06/30/26 at 9:45 a.m., Resident #114 said she wanted her fingernails cut, and she had asked the aides to cut her fingernails, and they would say they would come back, but they did not. Resident #114 said she could not remember which aides she asked. Resident #114 said the aides were supposed to cut her fingernails and clean them on shower days, but the staff had not cut her fingernails for a while, and she could not remember how long it had been. During an interview on 06/30/26 at 9:47 a.m., ADON A said he observed Resident #114's fingernails on both hands were long and had brown substance under her fingernails. He said none of the staff had told him the resident refused to cut or clean her fingernails. ADON A said Resident #114 could scratch herself with the long fingernails and the fingernails could hide germs which could cause infection. He said the aides cut and clean resident fingernails on shower days and as needed. ADON A said if the resident was diabetic the nurse would cut the resident fingernails. During an interview on 06/30/26 at 9:50 a.m., LVN CR said he observed Resident #114's fingernails on both hands were about 0.75 cm long and the fingernails were dirty and he did not notice the fingernails when he made rounds this morning. He said the aides cut and cleaned resident fingernails on shower days and as needed. LVN CR said Resident #114 could transfer germs from the dirty fingernails to her mouth when she ate with her fingers and that could cause infection for the resident and she could open her skin when she scratched her skin. During an interview on 06/30/26 at 9:53 a.m., CNA D said she was Resident #114's aide and today was the first time she worked with the resident, and she did not observe her (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fingernails were dirty and long when she made rounds about an hour ago. CNA D said the resident fingernails are cut and cleaned on shower days and as needed and the aide should report to the nurse if the resident refused care. She said Resident #114 could give herself skin tear unintentionally when she scratched herself and germs from the dirty fingernails could cause infection for the resident. During an interview on 07/01/26 at 8:08 a.m., the DON said Resident #114's fingernails should be cleaned daily and as needed. He said Resident #114 could get infection and could scratch her skin. The DON said the aides are supposed to cut resident's fingernails during shower which was at least three times a week and as needed. The DON said if the aide could not cut the resident fingernails, then the aide would tell the nurse, and the nurse would cut the resident fingernails. The DON said CNA D should also report to the nurse if Resident #114 refused to cut her fingernails and the nurse would try to cut Resident #114's fingernails and if the resident refused then she would document it on the progress note. During an interview on 07/01/26 at 2:20 p.m., the Administrator said her expectation was for the aides to cut resident's fingernails during shower and clean resident fingernails daily during ADL care and as needed. She said long and dirty fingernails can hide germs and it was not sanitary, and residents could scratch themselves. 2 Record review of Resident #122's face sheet dated 07/01/26 revealed a [AGE] year-old female was admitted on [DATE] from the hospital. Resident #122 had diagnoses which included: dementia (a decline in mental abilities), hypertension (when the pressure in the blood vessels is too high), and atrioventricular block (a heart rhythm disorder). Record review of Resident #122's quarterly MDS assessment, dated 05/26/26, revealed section 700 read memory problem. Further review of the MDS revealed Resident #122 needed moderate assistance with personal hygiene. Record review of Resident #122's care plan revision on 03/17/26 revealed the resident had an ADL self-care performance deficit related to pain and muscle wasting. Intervention: resident requires partial/moderate assistance with one staff for personal hygiene. Record review of Resident #122's progress notes for June 2026 did not reveal Resident #122 refused personal hygiene. During an observation on 06/30/26 at 10:17 a.m., Resident #122 had black curled hair on her chin. During an interview on 06/30/26 at 10:17 a.m., Resident #122 said it had been a week or two since the staff had shaved the hair on her chin. She said she did not remember her shower days. Resident #122 said she want her facial hair shaved. During an interview on 06/30/26 at 10:37 a.m., CNA D said she did not notice the facial hair on Resident #122's face, and she had quite a few black curled up hairs on her chin. CNA D said a female resident who did not want facial hair could feel embarrassed, and it was a dignity issue. She said residents are shaved or plucked on shower days and as needed. She said she was not given any report Resident #122 refused care and today was her first day working with the resident. During an interview on 07/01/26 at 8:12 a.m., the DON said the aide should shave Resident #122 on shower days and as needed. He said it was dignity issue if Resident #122 did not want any facial hair. He said Resident #122 would feel bad if she did not want facial hair. During an interview on 07/01/26 at 2:25 p.m., the Administrator said residents are shaved during shower days which were three times a week and as needed. She said a female who did not want facial hair would feel different and uncomfortable and it was a dignity issue. 3. Record review of Resident #50's face sheet dated 07/01/26 revealed an [AGE] year-old male was admitted on [DATE] from the hospital. Resident #50 had diagnoses which included: cerebrovascular disease (condition that affects the blood vessels and blood flow to the brain), hypertension (when the pressure in the blood vessels is too high), and diabetes mellitus (a disease of inadequate control of blood levels of glucose). Record review of Resident #50's quarterly MDS assessment, dated 05/04/26, revealed the BIMS score was 07, which indicated severely impaired cognition. Further review of the MDS revealed Resident #50 needed moderate assistance with personal hygiene. and was dependent on staff (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with ADL care Record review of Resident #50's care plan revised on 02/27/26 revealed the resident had an ADL self-care performance deficit related to current medical situation, weakness, tremors, and weakness. Intervention: Resident required moderate assistance by 1 staff for personal hygiene. Record review of Resident #50's progress notes for June 2026 did not reveal Resident #50 refused personal hygiene. During an observation on 06/30/26 at 10:28 a.m., Resident #50 had right contracted hand with three long nails, and they were about 1.5 cm, and the left hand 5 fingernails were about 1.5 cm long. Resident #50's skin from below the knees to resident's feet was dry and flaky and some of his skin flaked off when he took off his socks. During an interview on 06/30/26 at 10:28 a.m., Resident #50 said he wanted his fingernails cut and the staff said they would get to it, but he did not know which staff. Resident #50 took off his socks, and said his skin was dry and flaky. During an observation and interview on 06/30/26 at 10:35 a.m. ADON A said he observed Resident #50's fingernails were long. ADON A said the aides are supposed to cut the resident's fingernails on shower day and as needed. ADON A said he was not sure if Resident #50 was a diabetic, then the nurses are responsible for cutting his fingernails. He said Resident #50's skin on his legs was dry and flaky and the aides are supposed to apply lotion or cream on shower days and as needed to prevent the skin breakdown. During an interview on 06/30/26 at 11:00 a.m., CNA D said she was Resident #50's aide and she did not notice the resident's fingernails were long on both hands. She said Resident #50 could scratch himself with the long fingernails. She said the resident fingernails were cut on shower days and as needed and the nurse cut diabetic resident fingernails and she was not sure if Resident #50 was diabetic. She said she would tell the nurse if she could not cut the resident's nails and the nurse would cut the fingernails. She said residents are showered three times a week and the aides are responsible for showering and applying lotion or cream on resident skin on shower days and as needed. CNA D said lotion should be applied to the resident skin on shower days and as needed. She said Resident #50's skin was dry and flaking off and could cause skin break down. During an interview on 07/01/26 at 7:42 a.m., the DON said if Resident #50 was not diabetic the aides would cut the resident fingernails on shower days and as needed and the nurses were responsible to cut his fingernails if he was diabetic. The DON said he was not sure if Resident #50 was diabetic and he would find out if he was diabetic. He said Resident #50 could scratch his skin, and it could become infected. The DON said the aides shower the resident three times a week and they should apply cream on resident skin on shower days, and as needed to prevent the resident skin breakdown. He said the nurse does the skin assessment, and the wound care nurse oversees the skin assessment. The DON said the nurse should document the skin assessment if a resident had long fingernails and if resident refused care. During an interview on 07/01/26 at 2:23 p.m., the Administrator said her expectation was for the aides and the nurses to apply lotion or cream on the resident skin on shower day and as needed to prevent Resident #50's skin from being dry which could cause skin break down. During an interview on 07/03/26 at 3:30 p.m., the Corporate Nurse said the facility protocol was for the staff to document the ADL task where the aide will check off that the resident was provided with a shower. She said there was no area on the task for the aide to document that the resident refused to cut his fingernails, have lotion applied, or be shaved. She said the aide would have to tell the nurse and the nurse would document on the progress note that resident refused to cut fingernails, shave or apply lotion on resident skin. The Corporate Nurse also said the nurses do weekly skin assessments and there was no area in the skin assessment for the nurse to document that the resident had long fingernails or had facial hair. 4. Record review of Resident #1's face sheet dated 07/01/26 revealed a [AGE] year-old female was admitted on [DATE] from the hospital. Resident #1 had diagnoses which included: neuromuscular dysfunction of bladder (lack of bladder control caused by nerve damage), (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypertension (when the pressure in the blood vessels is too high), and retention of urine (inability to completely empty the bladder). Record review of Resident #1's admission MDS assessment, dated 05/26/26, revealed the BIMS score was 12, which indicated moderately impaired cognition. Further review of the MDS revealed Resident #1 needed total assistance (dependent on staff) with ADL care. Further review revealed the resident had an indwelling foley catheter. Record review of Resident #1's care plan initiated on 05/22/26 revealed the resident is resistive to care: prefers male nurses related to adjustment to nursing home, and anxiety. Intervention: educate resident/family/caregiver of the possible outcome of not complying with treatment or care. During an observation on 07/01/26 at 3:11 p.m., of foley care and incontinent care provided for Resident #1 by CNA NH and assisted by staffing Coordinator, Resident #1's incontinent brief was saturated with feces, and the incontinent brief had dry and fresh feces. Resident #1's top cover sheet draw sheet, and bed pad had substantial amount feces and dry brown ring. During an interview on 07/01/26 at 3:40 p.m., CNA NH said she was not Resident #1's aide, she was told to go provide foley care for the resident. She said Resident #1's incontinent brief was full of dry and fresh bowel movement. She said the brown rings on the draw sheets and dried bowel movement indicated Resident #1 had not been changed for hours. She said Resident #1 had dry BM stuck on the resident buttocks and inner thigh. CNA NH said aides make rounds every two hours for incontinent care to prevent what happened to Resident #1. During an interview on 07/01/26 at 4:25 p.m. Resident #1 said he could not remember when the staff last changed him. He said he would like to be changed whenever he was dirty. During an interview on 07/01/26 at 4:03 p.m., the DON said the aides are supposed to make rounds every two hours for incontinent care. The DON said if the draw sheets and incontinent brief had brown border , fresh and dry bowel movement on the resident incontinent brief and draw sheet meant Resident #1 had not been changed in more than 2 hours. The DON said if Resident #1 was left on dirty incontinent brief the resident could develop skin break down. During a Telephone interview on 07/03/26 at 3:40 p.m., CNA BT said Resident #1 was her resident on 07/01/26. She said she came to work at 2:00 p.m., and she checked on Resident #1, and she did not notice the resident had any bowel movement. CNA BT said if Resident #1's draw sheets, top sheet had dry BM and brown ring it meant Resident #1 had not been changed for hours. CNA BT said if Resident #1 was left in a dirty incontinent brief the resident could develop skin breakdown. Record review of the facility policy on shaving the resident dated 2001MED - PASS, Inc read in part . the purpose of this procedure is to promote cleanliness and to provide skin care. Interview on 07/03/26 at 3:45 p.m., the corporate nurse said the facility did not have policy on fingernails and skin care. Record review of the facility in service on showers dated 06/02/26 revealed . nail care is to be completed during this time.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 - Some	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 observations, interviews, and record review, the facility failed to ensure the resident environment was as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents for 3 of 8 residents (Residents #57, #71 and #7), 1 of 1 smoking areas, and 2 of 10 rooms (Room B and Room C) observed for accident hazards and environment.1. Resident #57 was observed smoking without supervision on 06/30/2026 and Residents #71 and #7 were observed smoking without supervision on 07/02/2026.2. The smoking area did not have any ashtrays within reach for residents to use.3. Room B's restroom sink's hot water was 115 degrees F on 07/01/2026.4. Room C's restroom sink's hot water was 114 degrees F on 07/01/2026.5. The facility failed to ensure HK Q and Dietary Aide A did not prop open the exit door by the laundry.6. Resident #98's room had damage to the sink faucet and the sheetrock behind the sink and toilet. The failures could result in residents coming into contact with dangerous materials which could place them at risk of injury or death. Resident #57Record review of Resident #57's face sheet dated 07/03/2026, revealed he was a [AGE] year-old male originally admitted on [DATE] with medical diagnoses including systemic lupus erythematosus (a chronic autoimmune disease where the immune system mistakenly attacks healthy tissues, leading to inflammation and damage across various organs), Wernick's encephalopathy (an acute neurological emergency caused by thiamine (vitamin B1) deficiency, characterized by confusion, eye movement abnormalities, and impaired coordination), rheumatoid arthritis, mild cognitive impairment, and tobacco use. Record review of Resident #57's Comprehensive MDS dated [DATE], revealed he had a BIMS score of 12 out of 15, indicating moderate cognitive impairment related to memory and thinking. Resident #57 was coded for having a wheelchair and required total staff assistance for toileting, showering, dressing and personal hygiene. He required moderate assistance for bed mobility, including transferring from bed to chair or chair to bed. Record review of Resident #57's care plan captured on 07/03/2026, revealed he had the following focus area of behavior problem of smoking without staff present (date initiated 06/05/2026 and last revised 07/01/2026) and disregarding the smoking policy, with interventions including anticipating and meeting resident needs, caregivers providing opportunity for positive interaction, attention. Record review of Resident #57's smoking assessment dated [DATE], revealed he had functional limitations which included contracture, muscle weakness, and need for assistance to get from smoking area and could not independently light his cigarette. Resident #57 was also documented as an unsafe, independent smoker due to cognitive impairment and required direct visual supervision while smoking and the facility stored lighters and cigarettes due to company policy. Record review of Resident #57's skin assessments on 06/22/2026 and 06/29/2026, revealed his skin was warm and dry and there were no issues.Observation of a smoke break sign that was near the patio on 06/30/2026 at 9:00a.m. revealed the departments responsible and the smoke times were 9:00a.m., 11:00 a.m., 1: 00p.m., 4:00p.m. and 7:00p.m.Observation and interview on 06/30/2026 at 3:03p.m., revealed Resident #57 was sitting on the patio smoking a cigarette with Resident #99 sitting next to him. Resident #57 said there was not enough staff to help with him and other residents with their smoke breaks. Resident #57 said he was smoking off hours, and that someone had helped him light his cigarette but he did not want to say who that was. Resident #57 denied having a lighter in his possession. Resident #57 said he was alert and able to smoke safely on his own but that other residents who needed supervision did not always get their smoke break because there was no staff (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 - Some	available to assist and sit outside with residents so other residents often went without their breaks. Interview with the Activities Director on 07/01/2026 at 10:47a.m., she said aides were assigned to different smoke break times and that residents smoked outside on 06/30/2026 and she did not know why there was no one out there with Resident #57. The Activities Director said residents who needed assistance were brought out to the patio/smoking area and that no one in the facility was allowed to smoke on their own according to company policy. She said Resident #57 was considered a safe smoker meaning he did not need monitoring, but he would still be at risk of injury and safety concerns. The Activities Director said some of the residents could fall asleep and drop ashes on themselves and some who tried to light their own cigarettes could be hurt by exploding lighters. The Activities Director said the facility should have followed a schedule. Interview with the BOM on 07/01/2026 at 11:50p.m., she said she did not handle smoke breaks. The BOM said everyone knew about Resident #57 going out to smoke on his own and that he was not the only resident to do that. The BOM had told the DON, charge nurses and the Activities Director but they did not do anything about it. The BOM said about a month ago she saw Resident #57 with a lighter around 9:45p.m. when she was headed home. The BOM said that she had not seen Resident #57 or others smoking alone for some time but smoking alone could put residents at risk of a fire starting or injury. Observation and interview with Resident #57 on 07/01/2026 at 12:50p.m., revealed he was lying in bed and said staff did not respect the allotted times for smoking. Resident #57 said that the DON took his lighter from his room on 06/30/2026 in the afternoon. Resident #57 said he did not feel like the facility cared for or respected residents. Interview with the SW on 07/01/2026 at 2:46p.m., she said staff were not supposed to leave residents to smoke on their own and that residents were educated on not being allowed lighters and smoking without supervision. The SW said Resident #57 usually complied with that request. The SW said residents who smoked on their own could light themselves on fire, burn themselves or get heat exhaustion. The SW said nurses explained that to residents but if the residents were alert, they might not always listen. Resident #71 Record review of Resident #71's face sheet dated 07/03/2026, revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] and last re-admitted on [DATE]. She had medical diagnoses including dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life), hypertension (high blood pressure), osteoporosis (bone disease characterized by bone weakness and fragility), need for assistance with personal care, epilepsy (chronic brain disorder characterized by recurring, unprovoked seizures due to abnormal electrical activity in the brain) and nicotine dependence. Record review of Resident #71's Quarterly MDS dated [DATE], revealed she had a BIMS score of 12 out of 15, indicating moderate cognitive impairment related to thinking and memory. Resident #71 required moderate assistance with ADLs such as personal, oral and toileting hygiene, showering and dressing and getting in and out of bed. Record review of Resident #71's care plan captured 07/01/2026, revealed she had a focus area of being a smoker (last revised 02/06/2025) with interventions including being supervised by a visitor or facility staff member at all times, review smoking policy with her as needed or annually with concerns and report smoking related concerns promptly and intervene as appropriate, ensure no oxygen was located in the smoking area while the resident was smoking. Record review of Resident #71's smoking assessment dated [DATE], revealed she was able to understand the facility smoking policy and had functional limitations preventing her from smoking without supervision due to hands shaking a lot when she smoked. Resident #71 was documented as requiring direct visual supervision and the facility stored her lighter and cigarettes. Record review of Resident #71's skin assessments dated 06/16/2026, 06/23/2026, 06/30/2026, revealed she had no concerns with her skin related to smoking. Resident #71 Record (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 - Some	review of Resident #7's face sheet dated 07/03/2026, revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] and last re-admitted on [DATE]. She had medical diagnoses including dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life), hypertension (high blood pressure), polyneuropathy (nerve damage), osteoarthritis (inflammation of joints), muscle wasting and atrophy (muscle mass loss) and nicotine dependence. Record review of Resident #7's Comprehensive MDS dated [DATE], revealed she had a BIMS score of 10 out of 15, indicating moderate cognitive impairment related to thinking and memory. Resident #7 required total assistance with ADLs such as personal, oral and toileting hygiene, showering and dressing and getting in and out of bed. Record review of Resident #7's care plan captured 07/01/2026, revealed she had a focus area of being a smoker and not complying with the smoking facility policy with interventions including encouraging her to comply with the facility smoking facility and ensuring smoking occurs in designated smoking area and review smoking policy with Resident #7 annually and as needed with concerns and report smoking related concerns promptly and intervene as appropriate. Record review of Resident #7's smoking assessment dated [DATE], revealed she was able to understand the facility smoking policy and needed help getting to the smoking area. Resident #7 was unable to light her cigarette and sometimes dropped ashes on herself and sometimes while she was smoking her hands shook frequently. Resident #7 was documented as requiring direct visual supervision and the facility stored her lighter and cigarettes. Record review of Resident #7's skin assessments dated 06/15/2026, 06/22/2026, 06/29/2026, revealed she had no concerns with her skin related to smoking. Observation and interview on 07/01/2026 at 3:16p.m., revealed Residents #71 and #7 were sitting in their wheelchairs and smoking outside on the patio around a single metal grate about 3 feet by 3 feet in a raised cement bed with cracks along the perimeter. CNA CT assisted both residents with lighting their cigarettes. Resident #7's hands appeared to be shaking and she dropped her cigarette on the ground. CNA CT then left with the cigarette box, opened the patio door and left from view for about a minute. A staff member walking by saw the residents sitting outside without staff supervision and called CNA CT, said something and CNA CT walked back into view, opened the patio door and walked back towards the residents with the cigarette box. Resident #7 called out to CNA CT that her cigarette was on the ground and CNA CT picked it up, threw it away, got another cigarette, lit it, and handed it to Resident #7. Resident #71 said that there were no ashtrays accessible to them while smoking because the ones provided were either on the ground far away or nailed to the nearby tree. Resident #71 and Resident #7 were observed throwing the cigarette into the grate and Resident #71 said that with the grate and cement damage it was hard to roll to the different ashtray spots to put out their cigarettes. CNA CT denied that she left the residents unattended and said she went to call staff to help her watch the residents. CNA CT said the residents threw their cigarettes in the grate in the ground and said that could cause the trash or whatever was in the grate to burn. Resident #71 said that she wanted ashtrays to prevent fires. She said they had someone watch over them during smoke breaks. Interview on 07/01/2026 at 7:09p.m., revealed the DON, Administrator, ADON A and ADON B were in the room. All of them denied taking a lighter from a resident on 06/30/2026. The DON said that the facility's policy said residents could not smoke on their own and that it should not have happened. Interview with Medical Records on 07/03/2026 at 9:29a.m., she said Resident #57 was a safe smoker and had a lighter and was able to go to a nearby store to get cigarettes on his own but lately he did not have any cigarettes nor a lighter. Medical Records said staff would try to monitor Resident #57 but missed him smoking alone sometimes. Medical Records said there were no independent smokers in the facility. Medical Records said the facility had two ashtrays that Medical Records would pass around to staff, but she was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 - Some	unsure why the aide did not use an ashtray. Medical Records said if ashtrays were not used residents or their wheelchairs could get burned and even catch fire especially during times of hot weather. Interview with the DON on 07/03/2026 at 10:33a.m., he said Resident #57 did not listen to staff about smoking with supervision and Resident #57 was educated on this multiple times, and staff would have to continue to monitor and redirect. The DON said it was not okay to leave residents unsupervised like in the two observed instances. The DON said supervision for was for safety and to ensure that someone was there to attend to residents. The DON said staff were aware and were educated on not leaving residents to smoke alone and that Residents #57, #7 and #71 should have been supervised. The DON said ashtrays were used to ensure that the ashes did not drop on the ground. 3./4. Record review of the facility's water temperature log revealed the following temperatures for the same 5 rooms (Rooms G, H, J, K and L) in Hall B: - 06/02/2026 111F, 6/4/2026 112F, 06/09/2026 (11 F, 06/12/2026 111F, 06/15/2026 (11 F, 06/16/2026 111 F, 06/17/2026 111 F, 06/18/2026 111 F, 06/24/2026 111 F, 06/25/2026 112 F and 06/26/2026 112F. Observation and interview with CNA AJ on 07/01/2026 at 9:25a.m., the aide said she was an aide for 3 years at the facility. CNA AJ said hot water was used to clean residents in the morning and they might not like having only cold water and she never heard residents complaining about not having hot water. Observation and interview with the Maintenance Director on 07/01/2026 at 11:09a.m., revealed the water temperature of the sink in Room B was 115 F after two minutes, which the Maintenance Director said should be no higher than 110 F. In Room C, the hot water was 114 F. He was aware that his records showed he checked the same five rooms , but he said he never heard of any complaints from staff or residents about the hot water and he checked water temperatures in rooms daily. The Maintenance Director said he did not have records of him checking Rooms B and C. He said he would talk to his corporate counterpart and see what could be done about temperatures out of range. He adjusted the temperature at a central heater which ran through the building, and he tried to adjust it so that all sinks had hot water for use and monitor for relative compliance, but he said he did not check all the rooms for water temperature . The faucet in Room C had an inch long missing chunk of the faucet on the lower left side near the sink bowl, with an unknown white material appearing to ooze out of the gaps in the faucet. There was one gash of missing sheetrock behind the toilet and one gash behind the sink. The Maintenance Director said that the gashes in the wall were not safe for residents and that he was going to have staff work on the faucet. Resident #98 who resided in Room C said she had no issues with the sink or faucet and that she did use it. 5. During an observation and interview on 07/01/26 at 10:20 p.m., with the DON revealed that the exit door by the laundry room was propped open and the door alarm was going off. HK Q wheeled a big gray cart into the facility from the open door. The DON said the door should have been closed as soon as any staff exited the door to prevent residents from eloping and intruders from entering the facility to prevent harm to residents. He said the Maintenance Director was responsible for providing in-services and training for all facility staff. During an observation and interview on 07/01/26 at 10:28 a.m., revealed Dietary Aide A from the kitchen came out of the kitchen and opened the back door and propped it open with a pink basin and went to the dumpster and placed bags of trash. There were resident rooms on the being of the hall way. During an observation and interview on 07/01/2026 at 10:30 a.m., the Housekeeping Supervisor said he could see the back door by the laundry room was propped open with a pink basin. He said the back door should be closed at all times. The Housekeeping Supervisor said the staff should not have left the door open to prevent any resident from leaving the facility, which could put residents in harm's way. He said outsiders could come into the facility and that was not safe for residents. He said there used to be a doorbell for the staff to push when the staff wanted to come (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 - Some	back in, but the doorbell was gone and he did not know what happened to it. The Housekeeping Supervisor did not respond when he was asked if he reported the doorbell not outside the back door was not working or lost. During an interview on 07/01/26 at 11:01 a.m., the Account Manager said the staff should have locked the back door after they left to prevent animals, flies, and people that are not supposed to come into the building. The Account Manager said it was a safety issue because residents could leave the facility without the nursing staff knowing and residents could get hurt if residents left the facility premises. The Account Manager also said unwanted personnel could enter the facility and that could place residents at risk of harm. During an interview on 07/01/26 at 11:15 a.m., Dietary Aide A said he was not supposed to leave the back door open because people from the street could come into the facility and residents could get hurt, or residents could leave the facility unattended which was not safe for residents. He also said animals could also come into the building because the door was propped open. During an interview on 07/01/26 at 11:18 a.m., HK Q said he went outside to throw away trash and he propped the door open, but he should not have because it was a safety issue. HK Q said residents could leave the facility without staff knowing or people who do not work for the facility could come into the facility and residents could get harmed depending on who entered the facility. During an interview on 07/01/26 at 1:59 p.m., the Maintenance Director said the staff were not supposed to prop the exit door open because of safety issues. The Maintenance Director said a resident could wander out of the facility through the open door and that could put residents in harm's way. He also said anybody from the street could come into the facility and that would put everybody inside the facility at risk. He said the back door used to have a bell for the staff to ring and a staff from inside the facility would have to open the door for the staff outside. He did not respond when he was asked how long the doorbell was lost. During an interview on 07/01/26 at 2:08 p.m., the Administrator said her expectation from staff was to close any exit door and when the staff wanted to come back in then the staff would ring the doorbell and a staff inside the facility would open the door for the staff. She said it was a safety issue when the exit door was propped open. She said she was not aware that the doorbell by the exit door by the laundry was lost or not functioning. Record review of the facility's policy titled Safety and Supervision of Residents last revised July 2017, revealed in part, Policy StatementOur facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and ImplementationFacility-Oriented Approach to Safety1. Our facility-oriented approach to safety addresses risks for groups of residents.2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization.3. When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. Resident Risks and Environmental Hazards1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:d. Smoking; .g. Electrical Safety. h. Water Temperatures. The policy did not mention exit doors. Record review of the facility's policy on smoking for residents last reviewed October 2022, it read in part,.3. Smoking is only permitted in designated resident smoking areas, which are located outside of the building.5. Metal containers, with self-closing cover devices, are available in smoking areas. 6. Ashtrays are emptied only into designated receptacles. 7. The resident (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 - Some	will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker or smokeless tobacco user, the evaluate will include:.d) Ability to smoke safety with or without supervision (per a completed Smoking Assessment).12. Any resident with restricted smoking or smokeless tobacco privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking or using smokeless tobacco.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 13%, based on 4 errors out of 30 opportunities, which involved 3 of 7 residents (Residents #48, #53, #138, and #149) and 3 of 4 staff (LVN DM, LVN ED, and LVN CO) reviewed for medication errors, in that: LVN DM failed to administer medication Effer K (Potassium is a vital mineral and electrolyte that carries an electrical charge, allowing the body to function) to Resident #149 according to the physician's order on 6/30/26 -LVN ED failed to administer Refresh tear Ophthalmic solution (used to treat dry eyes) to Resident #138 according to the physician's order.-LVN ED failed to administer Budesonide inhalation (is a locally acting steroid medication used to reduce inflammation and suppress the immune system) to Resident # 53 on 7/1/26. LVN ED initialed the MAR as administered. -LVN CO failed to administer Refresh tear Ophthalmic solution (used to treat dry eyes) to Resident #48 according to the physician's order on 7/1/26These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health Findings include: Resident #149 Record review of Resident #149's face sheet, she was an [AGE] year-old female admitted on [DATE]. Her diagnoses included: shortness of breath, pneumonitis(Inflammation of the lung tissue, usually meaning the tiny air sacs in the lung) due to inhalation of food and vomit, hypoxemia(having too little oxygen in the blood), restlessness and agitation(, mixed hyperlipidemia(high fat in the blood, essential (primary) hypertension(high blood)other intervertebral disc (is a soft, round cushion that sits between the small bones of your spine) displacement, lumbar region(lower back) and muscle wasting and atrophy, and hypokalemia(an abnormally low level of potassium in the blood). Record review of Resident #149's admission MDS dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. Record review of Resident #149's care plan on 6/27/26 revealed in part . diagnosis of hypokalemia . Intervention . give Potassium Chloride medications as ordered. Record review of Resident #149's physician's orders for June 2026 revealed in part: . Potassium Chloride oral packet 10 meq (Potassium Chloride), Give 10 meq by mouth one time a day for hypokalemia. Record review of Resident #149's Medication Administration Record (MAR) dated June 2026 revealed Effer - K 10 meq (Potassium Chloride), Dissolve 1 tablet in 4 ounces water once daily. Pharmacy recommendation had dissolve 10 meq in 4 to 8 ounces water or cold juice and drink slowly Observation on 6/30/26 at 9:10 a.m. revealed LVN DM took Resident #149's Effer - K 10 meq 1 tablet and dissolved it in 4 ounces of water with other medications. Resident #149 drank 2 ounces of the dissolved Effer -K in water. LVN DM discarded the Effer-K. Interview on 6/30/26 at 9:20 a.m. with LVN DM regarding not encouraging Resident #149 to finish the Effer -K medication, revealed LVN DM said he knew Resident #149 was not going to drink the dissolved Effer -K, and Resident #149 always complained of being too full. LVN DM said he had not told the ADON, DON or the doctor about Resident #149 not taking all the Effer-K or changing Effer -K to liquid. LVN DM said Resident #149 could have low potassium in her blood that could affect her heart. Interview with ADON A and DON on 7/1/26 at 2:00PM regarding Resident #149's Effer-K dissolved in water and not able to consume all the medication. DON said they were not aware of it. DON said he was going notify the doctor for start Potassium blood level lab work to be done. The result of Potassium level from the start blood work was low 3.1 MEQ/L. DON said he started in-services to all staff and Effer-K was changed to liquid. Resident #53 Record review of Resident #53's face sheet, revealed she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (a long -term (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lung disease that makes it hard to breathe with (acute) exacerbation (is a sudden, severe flare-up of these symptom- like extra coughing. Record review of Resident #53's quarterly MDS dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. ^ Record review of Resident #53's care plan on 6/27/26 revealed in part . diagnosis of chronic obstructive pulmonary disease with (acute) exacerbation . Intervention . give Budesonide inhalation medications as ordered . ^ Record review of Resident #53's physician's orders for 5/31/2026 revealed in part: Budesonide Inhalation Suspension (Budesonide (Inhalation) 0.5 mg inhale orally one time a day related to chronic obstructive pulmonary disease with (acute) exacerbation. Record review of Resident #53's Medication Administration Record (MAR) dated July 2026, . Budesonide Inhalation Suspension (Budesonide (Inhalation) 0.5 mg inhale orally one time a day and was initialed as given at 9:00AM on 7/1/26. Observation on 7/1/26 at 8:10 a.m. revealed Resident #53 was seen ambulating from the dining , after eating breakfast, to his room. At 8:20 a.m. LVN ED administered 3 medications to Resident #53 by mouth, then moved the medication cart to Resident #138 to administer eye drops. LVN ED did not administer Budesonide (Inhalation) but initialed as given at 9:00AM. Interview with LVN ED on 7/2/26 at 1:30PM about Budesonide (Inhalation) 0.5 mg inhale orally one time a day not given during medication administration on 7/1/26 and was initialed as given at 9:00AM, LVN ED said she thought she gave it. Resident #138 Record review of Resident #138's face sheet, revealed she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included: ^ack of coordination, other abnormalities of gait and mobility, other reduced mobility, dry eye syndrome of unspecified lacrimal gland, muscle wasting and atrophy, not elsewhere classified, left thigh, muscle wasting and atrophy, not elsewhere classified, right thigh, morbid (severe) obesity (excessive weight that could cause serious health complications) due to excess calories, cognitive communication deficit, Record review of Resident #138's annual dated 5/2/26 revealed a BIMS score of 4 indicating severe cognitive impairment. ^ Record review of Resident #138's care plan on 6/27/26 revealed, . Intervention . Artificial Tears Ophthalmic Solution as ordered . ^ Record review of Resident #138's physician's orders for 6/27/2026 revealed in part: Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin Hypromellose Polyethylene Glycol 400) Instill 1 drop in both eyes two times a day for Eye Drop. Observation on 7/1/26 at 8:27 a.m. revealed Resident #138 was lying in bed. LVN ED picked Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin Hypromellose Polyethylene Glycol 400) Instill 2 drops in both eyes. Interview with LVN ED on 7/2/26 at 1:30PM, regarding not administering Artificial Tears Ophthalmic Solution 0.2-0.2-1 % 1 drop in both eyes as ordered by the doctor, LVN ED said she would be careful. LVN ED said she had in-services on medication administration 2 months ago. Resident #48 Record review of Resident #48's face sheet, dated 03/24/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #48 had diagnoses which included: iron deficiency anemias (not having enough healthy red blood cells to carry oxygen to the body's tissues), blurred or impaired vision, anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, unlike normal, temporary stress), hypertension (blood vessels is too high), heart failure (heart does not pump enough blood for the body's needs), hyperlipidemia (abnormally high fat and lipids) and type 2 diabetes mellitus without complication,(a chronic condition where the body cannot effectively use (insulin resistance) or produce enough of it, leading to high blood sugar levels hyperglycemia). ^ Record review of Resident #48's significant change MDS, dated [DATE], reflected the BIMS score was not scored out of 15, which indicated the resident had severe cognitive impairment. Record review of Resident #48's care plan on 6/30/26 revealed . Intervention . Artificial Tears Ophthalmic Solution as ordered . ^ Record review of Resident #48's physician's orders for 6/30/2026 revealed in part: Artificial Tears (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ophthalmic Solution 0.2-0.2-1 % (Glycerin Hypromellose Polyethylene Glycol 400) Instill 2 drop in both eyes three times a day for Eye Drop. Observation on 7/1/26 at 3:27 P.M. revealed Resident #48 was sitting up in bed. LVN CO picked Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin Hypromellose Polyethylene Glycol 400) Instill 1 drops in both eyes. Interview with LVN CO on 7/2/26 at 1:30PM, regarding not administering Artificial Tears Ophthalmic Solution 0.2-0.2-1 % 1 drop in both eyes as ordered by the doctor for Resident #48, LVN CO said he was nervous and he would be more careful. LVN CO said not following physician's order could cause decline in the resident's health. In an interview with the DON and ADON A on 7/2/26 at 5:45 PM, the DON said his expectation for medication administration was for nurses to administer medication as ordered by the physician. The DON said the facility had morning medication pass times for 9:00 a.m.; medications for twice daily were given at 9:00 a.m. and 5:00pm; medications for 3 times daily were given at 9:00 am, 1:00pm and 5:00pm and medications for every 12 hours were given at 9:00 am and 9:00 pm. The DON said he always monitored the staff periodically and the pharmacist also monitored the staff. The DON said the last time the pharmacist monitored staff was in January 2026. During an interview on 7/3/26 at 5:20 p.m., the Administrator said he expected nursing staff to give medications timely, correctly, and according to the physician's orders. Record review of the facility's policies and procedure title Administering Medication dated April 2019 revealed in part. Policy Statement Medications are administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation 1. Only persons licensed or permitted by the state to prepare, administer, and document administration of medications may do so. 4. Medications are administered in accordance with the prescriber's order, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication b. Preventing potential medication or food interaction and c. Honoring resident choices and preferences consistent with his 6. Medication errors are documented, reported and reviewed by QAPI committee to inform process changes. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) 8. If a dosage is believed to be inappropriate or excessive for a resident, or the medication has been identified as having potential adverse consequences for a resident or suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident attending physician or facility medical director to discuss the concern. 22. The individual administering the medication initials the resident MAR or appropriate line after giving each medication before administering the next medication.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure the food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for one of one kitchen reviewed for food and nutrition services. 1. The facility failed to ensure that serving utensils, bowls, and cups with dried food particles and water stains were not stored with clean utensils, bowls and cups. 2. The facility failed to ensure that clean pots and pans were free of grease and food particles. 3. The facility failed to ensure the floor tiles in the dry storage room were in good repair and the floor was free of dust. 4. The facility failed to ensure that food in the freezer was labeled and dated. 5. The facility failed to ensure that kitchen equipment was clean and in good repair. 6. The facility failed to ensure that food was at the correct holding temperature. 7. The facility failed to ensure that staff changed gloves and washed hands while serving ready-to-eat foods. These failures place all residents who ate food prepared by the kitchen at risk of foodborne disease and other illnesses. Findings included: Observation on 06/30/2026 at 9:05 am - 10 am revealed the following: 1. In the dish room were bowls, plates and cups with dried food particles and food stains on them and they were stored with clean bowls, plates and cups. 2. Serving utensils were observed with food particles and water stains on them stored with clean utensils. 3. The oven racks and doors had brown greasy stains and burnt food particles in the oven. 4. There was a nonfunctioning oven, and the racks had an accumulation of a brown greasy substance on them. Observation of the dry storage room on 6/30/2026 at 9:50 am revealed missing tiles on the floor next to the back of the walk-in freezer. Observation on 6/30/2026 at 9:55 am of the walk-in freezer was a plain plastic bag with chicken fried steak that was not labeled or dated. Observation on 07/02/2026 at 12:15 pm of lunch revealed the following: Cold Marinated Mixed vegetables with mayonnaise at 55 degrees F, and Marinated cooked mixed vegetables (carrots, green beans and bell peppers) at 45 degrees F. Their menu items were chilled to 41 F and below. Observation on 7/2/2026 at 12:30 pm revealed [NAME] A touching the counter, picking up a bag with carrots, plating food, and picking up rolls with the same gloves to put on a resident's plate. These activities went on multiple times without gloves changing or hand washing. This was pointed out to the Dietary Manager who instructed [NAME] A to change her gloves and use tongs to pick up the rolls. In an interview with [NAME] A on 7/2/2026 at 12:55 pm regarding changing gloves and touching ready eat food she said she should change gloves between tasks. She said not changing gloves could cause cross contamination. In an interview on 7/3/2026 at 9:50am with the said Dietary Manager she said she was going to ensure that the food in the refrigerator was labelled and dated, and she was going to in-service the staff on foodservice sanitation. She said she would also in-service the staff on food temperature and handling of ready-to-eat foods. She said her expectation of the dietary staff was to follow the cleaning schedule and prepare food in a sanitary manner. In an interview with the Administrator on 7/3/2026 at 1:30pm he said the expectation of the kitchen staff was to ensure that they follow the sanitization policies and procedures and ensure that they will prepare and store food under sanitary conditions and follow the cleaning schedule. He said moving forward they will be doing daily walk-throughs in the mornings after the morning meeting and in the evening after the stand down meeting. Record review of the policy and procedure for Food Policy dated November 2022 read in part. Sanitization Policy Statement The Foodservice areas should be maintained in a clean and sanitary manner. Policy Interpretation and Implementation. 2. All kitchen areas and dining areas should be clean and free from rodent and insect. 3. All utensils, counter tops, shelves, and equipment and maintain in good repairs and from breakage, chips and cracks. 4. All (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	equipment, food contact surfaces and utensils are clean and sanitized using heat and chemicals. 5. Utensils and equipment have been cleaned and sanitized, they should be allowed to air dry. The use of towels or cloth may increase the risk of cross contamination. 10. Ice machine and ice storage containers are drain clean and sanitized. Food Preparation and ServicePolicy Statement: Food and Nutrition services employees prepare, distribute, and service food in a manner that complies with safe food handling practices. Food Distribution and Services.Proper hot and cold temperatures are maintained during food distribution services: Danger Zone means temperature cold food temperature above (41) degrees and hot foods below 135 degrees (F).All food service equipment and utensils will be sanitized according to current guidelines.Food Receiving and Storage:Foods shall be received and stored in a manner that complies with safe food handling practices.Dry Food Storage: Dry foods that are stored in bins are removed are removed from the original packages are labelled and dated.Refrigerator/ Freezer1.All foods stored in the refrigerator or freezer are covered labelled and dated by their used date or discarded. 2.Refrigerators and freezers are kept clean and free of debris.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Belfort Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 10 residents (Resident #150, Resident #53, Resident #48, Resident #138 and Resident #1) and 7 of 11 staff (LVN ED, LVN CO, LVN BK, HK H, CNA NH, Staffing Coordinator and CNA Y). 1.LVN BK failed to ensure that sterile technique was maintained during Tracheostomy care to Resident #150 on 7/1/26. 2.LVN ED failed to wash or sanitize hands between Resident #53 and Resident #138 on 7/1/26. 3.LVN CO failed to wear PPE when assisting Resident #48 and did not discard PPE in the hazardous box on 7/1/26. Resident #48 had EBP posted on the door. 4.The facility failed to ensure the dirty section of the laundry room had hand washing soap, and the basket which contained clean socks was not placed on the floor in the clean section of the laundry.5.The facility failed to ensure HK H used appropriate hand hygiene when she washed her hands.6.The facility failed to ensure CNA NH and Staffing Coordinator followed the appropriate procedure for PPE and hand hygiene during Foley care for Resident #1.7. The facility failed to ensure CNA Y followed the appropriate procedure for PPE and hand hygiene before she exited Room G. These failures could place residents at risk for spread of infection, cross contamination, and decrease in quality of life. 1. Record review of Resident #150's facility admission record dated 06/30/2026 revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #150's medical diagnoses included dysphagia (difficulty swallowing), tracheostomy status (also called a tracheotomy, is a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe (trachea) to help you breathe) and gastrostomy status (a surgical opening into the stomach for nutritional support or gastric decompression). Record review of Resident # 150's admission MDS dated 6/22/26, revealed the BIMS score was blank. Resident was documented to be totally dependent for all ADL's. Observation on 07/01/2026 at 6:04 PM revealed Resident #150 was in bed with audible moist breath sounds. The Respiratory Therapy (RT) was at the bedside observing tracheostomy care, and LVN BK stated the resident was not usually moist and they changed the resident's inner cannula every day. LVN BK set up a clean field on the bedside table, checked the oxygen saturation and it was 99%. LVN BK changed his gloves without washing his hands or using hand sanitizer. He then grabbed the sterile suction catheter kit tray, opened it, then doffed (take off) his clean gloves without washing his hands, picked up the sterile gloves, then picked up normal saline at Resident #150's bedside, and poured it in the tray. LVN BK picked up the suction tubing from the sterile suction kit and connected it to the suction machine at Resident #150's bedside. LVN BK removed the inner canula. LVN BK then used his clean gloved right hand to removed the oxygen mask on Resident #150's trach, then inserted the suction catheter into the tracheostomy tube 2 times. The then used the same gloved hands to open the sterile inner cannula kit and picked up the inner cannula and inserted it. LVN BK picked up Trach Care Kit without changing his dirty gloves. LVN BK opened the sterile Trach Care Kit, using the same dirty gloves picked up the sterile 4x4 gauze and sterile gloves placed on the bedside table. LVN BK, using the same dirty gloves, then picked up a bottle of 100 ml normal saline (NS) covered with plastic wrap. LVN BK then poured the NS on the 4x4 gauze, then opened the sterile gloves without washing his hands or using hand sanitizer don sterile gloved. The sterile gloves LVN BK was trying to put on, got toned, he doff the sterile gloves without washing hands or using hand sanitizer, LVN BK don clean gloves and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opened two sterile Trach Care kit, using the clean gloves. LVN BK picked up the sterile gloves and placed them on the bedside table and doffed his clean gloves without washing his hands or using hand sanitizer. LVN BK tried donning sterile 2 times and it got toned He picked up the 4x4 gauze and cleaned around Resident #150's stoma site with the toned gloves. In an interview with the RT on 7/1/26 at 6:42 PM regarding tracheostomy care she observed LVN BK perform, she said LVN BK should not have touched the inner cannula with a clean glove; he should have suctioned and then should have sanitized his hands or washed his hands, changed his gloves. The RT said LVN BK should have then opened the stuff, peeled the drain, inner cannula and put it out and he should have opened the gauze; and then he should have reached in with sterile gloves and put everything from inside and put it on the sheet and then put it in trash. The RT said LVN BK did not use proper sterile field and that he was nervous. He was putting gloves on. RT said LVN BK had a couple of education sessions, and had Tracheostomy care demonstration with him and LVN BK perform return demonstration. RT said LVN BK should not use dirty gloves inside a sterile Tracheostomy kit. In an interview on 07/1/2026 at 6:52 PM, LVN BK stated he had one training on trach care 6/30/26 and it was been a while since his last trach care training. He said he did wonderful but not excellent. He said trach care was a sterile procedure. He said after removing the stoma (an opening) that's when sterile started. He said he was supposed to wash his hands before doing anything. He said he tried to have a dominant right hand. He said he opened 1 sterile Trach Kit, when he missed a step with one. LVN BK said he had to think he needed to correct and open another one. He believes he did. LVN BK said he didn't use a clean procedure, and he took clean gloves and put sterile items on there. He forgot sterile gloves. He said he should have used his right hand when he did that. He said he had training before. He said he did a training on Friday and another one yesterday (6/30/26) by the RT. He said the RT watched him and she told him he did good. There was tension today. If staff didn't do it the right way, they could have respiratory distress, infection and sepsis. He said he understood when he went from dirty gloves to touch sterile gloves. He said the facility did training before residents came with tracheostomy care, video, with returned demonstration. Record review of the facility policy and procedure entitled Tracheostomy Care-Suctioning, dated, read in part . Policy: The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block the airway. 2. Resident #53 Record review of Resident #53's face sheet, revealed she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe with (acute) exacerbation (a sudden, severe flare-up of these symptom- Like extra coughing)). Record review of Resident #53's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. She needed extensive help from 1 staff with ADLs, and limited assistance with eating. Observation on 7/1/26 at 8:10 a.m. revealed Resident #53 was ambulating from the dining room after eating breakfast to his room. At 8:20 a.m. LVN ED administered 3 medications to Resident #53 by mouth, then moved medication cart to Resident #138 to administer eye drops without washing or sanitizing her hands. Resident #138 Record review of Resident #138's face sheet, she was a [AGE] year-old female admitted on [DATE]. Her diagnoses included: lack of coordination, other abnormalities of gait and mobility, other reduced mobility, dry eye syndrome of unspecified lacrimal gland, muscle wasting and atrophy, not elsewhere classified, left thigh, muscle wasting and atrophy, not elsewhere classified, right thigh, morbid (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(severe) obesity (excessive weight that could cause serious health complications) due to excess calories, cognitive communication deficit, Record review of Resident #138's annual MDS assessment dated [DATE] revealed a BIMS score of 4 indicating severe cognitive impairment. She needed extensive help from 2 staff with ADLs, and limited assistance with eating. Observation on 7/1/26 at 8:27 AM. Resident #138 was lying in bed. LVN ED picked Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin Hypromellose Polyethylene Glycol 400) Instill 2 drops in both eyes. Interview with LVN ED on 7/2/26 at 1:30 PM, regarding not washing hands between Resident #53 and Resident #138. LVN ED said she was nervous and she knew it could cause cross contamination. 3. Resident #48 Record review of Resident #48's face sheet, dated 03/24/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #48 had diagnoses which included: iron deficiency anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues), blurred or impaired vision, anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, unlike normal, temporary stress), hypertension (blood vessels is too high), heart failure (heart does not pump enough blood for the body's needs), hyperlipidemia (abnormally high fat and lipids) and type 2 diabetes mellitus without complication, (a chronic condition where the body cannot effectively use (insulin resistance) or produce enough of it, leading to high blood sugar levels hyperglycemia). Record review of Resident #48's Significant Change MDS, dated [DATE], reflected the BIMS score was not scored, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on staff for bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #48 was incontinent of bladder and bowel. Observation on 7/1/26 at 3:15 P.M. revealed Resident #48 was standing in his room naked. Resident #48 pulled his brief from his waist down to his feet. LVN CO went in Resident #48's room with an EBP sign posted on the door, without donning PPE or wearing gloves and assisted Resident #48 with pulling up the brief and donning his T-shirt. At 4:05 P.M. LVN CO donned PPE and gloves and administered G-Tube feeding, then went to medication cart with the same gloved hands and PPE and picked up Artificial tear eye drop and administered it to Resident #48. LVN CO doffed PPE and gloves at the medication cart trash instead of the hazardous box in Resident #48's restroom. Interview with LVN CO on 7/2/26 at 1:30PM, regarding not wearing PPE and gloves while assisting Resident #48 in his room and not doffing PPE in the hazardous box, he said he was nervous and he forgot. LVN CO said he did have an in-service about PPE usage to prevent infection every month at least bi-weekly. Interview with DON on 7/2/26 at 5:45 PM, regarding expectations for Resident's on EBP during care. DON said his expectation was for all residents with EBP signs posted on their door, the staff were supposed to don PPE before entering their room to perform any care, to prevent infection and wash or sanitize hands in between residents. 4/5. An observation 07/01/2026 10:36 a.m., revealed the dirty section of the laundry room did not have hand washing soap, the soap dispenser was open on the left side of the sink while the sanitizer was on the right side of the wall. HK H walked to the sink in the dirty section of the laundry room and placed her hand under the dispenser on the right and a clear substance tricked onto her hand. Then she turned on the water faucet and washed her hands. After HK H washed her hands, she shook her hands and turned off the faucet with her wet hand, then took a paper towel and dried her hands. During an interview on 07/01/26 at 10:37 a.m., HK H said she had worked for 2 days and there had not been any hand-washing soap in the soap holder. She said she had used hand sanitizer to wash her hands for the past two days, and she was not sure if it was the right way to wash her hands. HK H said she had always turned off the water tap the same way since she started working in the facility with wet hands. She said she had in-service on infection control and it included (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand washing but she could not remember what was educated about how to turn off the water faucet after washing her hand. During an observation on 07/01/26 at 10:40 a.m., the clean side of the laundry revealed a basket filled with socks was placed on the floor. During an interview on 07/01/26 at 10:40 a.m., HK H said there was no space off the floor to place the basket. She said the basket was not supposed to be on the floor because of cross contamination. During an interview on 07/01/26 at 10:45 a.m., Housekeeping Supervisor said the washing area should have soap for staff to wash their hands to prevent cross contamination. He said HK H should not have washed her hands with sanitizer because that was not proper hand washing to prevent cross contamination. He said HK H was supposed to dry her hands with paper towel and dispose of the paper towel and take another dry paper towel to turn off the water faucet to prevent cross contamination. The Housekeeping Supervisor said the basket with socks should not be placed on the floor because of cross contamination, and he asked HK H to place the basket on the lower level of the rack which had clean clothes. HK H placed the basket on the rack, and the basket was touching the clean clothes. The Housekeeping Supervisor said when he asked HK H to place the basket with socks on the rack with clean clothes and the basket touched the clean clothes then the clothes were contaminated, and he was not supposed to ask her to place the basket from the floor with clean clothes and he said it was cross contamination. He said all the clothes and socks would be rewashed.6. Record review of Resident #1's face sheet dated 07/01/26 revealed a [AGE] year-old female who was admitted on [DATE] from the hospital. Resident #1 had diagnoses that included: neuromuscular dysfunction of bladder (lack of bladder control caused by nerve damage), hypertension (when the pressure in the blood vessels is too high), and retention of urine (inability to completely empty the bladder). Record review of Resident #1's admission MDS assessment, dated 05/26/26, revealed the BIMS score was 12, which indicated moderately impaired cognition. Further review of the MDS revealed Resident #1 needed total assistance with ADL care. Further review revealed the resident had an indwelling foley catheter. Record review of Resident #1's care plan initiated on 06/02/26 revealed the resident had 14 French Foley catheter related to Neurogenic bladder. Intervention: Position catheter bag and tubing below the level of the bladder. Record review of Resident #1 order summary report for June 2026 revealed in part . foley catheter 18 French with 10 ML [NAME] DX(diagnosis): neurogenic bladder. During an observation on 07/01/26 at 3:11 p.m., foley care was provided for Resident #1 by CNA NH and Staffing Coordinator. CNA NH changed her gloves three times and she did not sanitize her hands before she donned clean gloves, and on the fourth time she took hand sanitizer from her uniform pocket and after she sanitized her hands, she placed the sanitizer back into her uniform pocket and took gloves from her uniform pocket and continued to provide care for Resident #1's foley care. Staffing Coordinator pulled off the top sheet on Resident#1 before the foley care started and the top sheet had feces on it, and she placed the sheet in the trash bag. She did not remove the dirty gloves but continued to pull wipes from the wipe container and handed them to CNA NH while she provided care for Resident #1. During an interview on 07/01/26 at 3:40 p.m., CNA NH said she changed her gloves three times, but she did not wash or sanitize her hands before she donned clean gloves. CNA NH said she also sanitized her hands with sanitizer from her uniform pocket, and she placed the sanitizer back in her uniform pocket and she contaminated her hands when she placed it back into her uniform pocket. CNA NH said she took gloves from her uniform pocket and donned them and continued to provide care for Resident #1. She said it was infection control issue because it was cross contamination. D During an interview on 07/01/26 at 3:49 p.m., Staffing Coordinator said she should have taken off her gloves and washed her hands and donned clean gloves after she took off Resident #1's top sheet which had feces on it before she took wipes from the clean wipe container and handed (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the wipes to CNA NH who used the wipes to provide foley care for Resident #1. She said she contaminated the wipes because she used dirty gloves and took wipes from the clean packet. She said when she washed her hands, she had to put her hands inside the paper towel holder because the sensor was not working and it was an infection control issue. During an interview on 07/01/26 at 3:53 p.m., the DON said CNA NH should not have used the sanitizer from her uniform pocket or donned gloves from her uniform pocket while she provided foley care Resident #1 because it was cross contamination. The DON said CNA NH should have washed or sanitized her hands before she donned clean gloves to prevent cross contamination. During an observation on 07/01/26 at 3:55 p.m., CNA Y came out from Room G with gloves on and closed the room door with the same gloves on. She walked to the medication cart by the nursing station and removed the gloves and placed them in the trash can attached to the medication cart. CNA Y took gloves from the nursing station without washing or sanitizing her hands. During an interview on 07/01/26 at 3:59 p.m., CNA Y said she should have taken off the gloves and washed her hands before she exited the resident room to prevent the spread of germs. CNA Y said she should have washed her hands after she took off the used gloves before she took clean gloves from the box because of infection control. During an interview on 07/01/26 at 4:02 p.m., the DON said staff should remove gloves in the resident's room and wash or sanitize her hands before leaving the room, to prevent cross contamination and spread of germs. 7. During an observation on 07/01/26 at 3:55 p.m., CNA Y came out from Room G with gloves on and closed the room door with the same gloves on. She walked to the medication cart by the nursing station and removed the gloves and placed them in the trash can attached to the medication cart. CNA Y took gloves from the nursing station without washing or sanitizing her hands. During an interview on 07/01/26 at 3:59 p.m., CNA Y said she should have taken off the gloves and washed her hands before she exited the resident room to prevent the spread of germs. CNA Y said she should have washed her hands after she took off the used gloves before she took clean gloves from the box because of infection control. During an interview on 07/01/26 at 4:02 p.m., the DON said staff should remove gloves in the resident's room and wash or sanitize her hands before leaving the room, to prevent cross contamination and spread of germs. Record review of the facility's policy on Infection Control, undated, read in part, " 5. Gowns and protective apparel 1. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF. Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures.2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from residents or items in their environment to other residents or environment. 6. Resident care equipment and articles.3. Non-invasive resident care equipment is cleaned daily or as need between use by the nursing assistant. 7. Although soiled linen may be contaminated with pathogenic microorganisms, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms. Hygienic and common-sense storage and processing of clean and soiled linen is recommended. "Record review of the facility's Policy and Procedures title Infection Prevention and Control dated December 2023 read in part. Policy Statement: The facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary and comfortable environment and to prevent and manage transmission of disease and infection. Policy Interpretation and Implementation: Infection prevention and control policies and procedures apply to all personnel, consultation, contractors, resident, visitors and volunteers. "The objectives of the infection prevention and control policies and procedures are to: A. ~~~~~ Monitor, detect, investigate and control infections in the facility. B. ~~~~~ Maintain a safe, sanitary and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comfortable environment for resident, personnel, visitors and the general public. C. ~~~~~ Provide evidence-based guidelines for infection prevention and control based on current practices. Record review of the facility policy on handwashing/hand hygiene date MED-PASS, Inc Revised October 2023 read in part.this facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections.administrative practices to promote hand hygiene #3.hand hygiene products and supplies (soap, towel.).indication for hand hygiene 1 a. immediately before touching a resident, 1b. before performing an aseptic task. 1f. before moving from a soiled body site to a clean body site on the same resident, 1g. immediately after glove removal.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 4 of 10 resident rooms reviewed for environment. -Room A had a live roach crawling on the ground near the restroom on 06/30/2026.-Room B had a dead brown bug in the restroom on 07/01/2026. -Resident #23 had two flies flying around and landing on a resident's pillow on 07/01/2026.-Room E had an a/c unit on 07/01/2026, 07/02/2026 and 07/03/2026 which was not allowed under facility policy. These failures could place residents at risk for disease and infection and a decline in their physical health due to pests in the facility. Findings include:Record review of the pest control binder, the following dates had observations of pests:-2/10/2026: gnats in the kitchen and halls-3/12/2026: roaches in one resident room and the room was sprayed. The Kitchen had gnats.-4/8/2026: There were roaches in the administrative offices, beauty salon, and in the microwave. There were small roaches and gnats most likely due to soiled linens being in holding area. There was no live roach activity. There was little black ant activity.-5/21/2026: roaches -5/24/2026: roaches in the front conference room-5/27/2026: roaches and gnats in the front office and one resident room-6/10/2026: there were a lot of flies and roaches in the front office area. There were 4 dead German roaches found in a monitor on the floor and the trap was replaced. There were 2 dead German roaches near the fridge in the conference room. There were two live roaches observed during the visit. Record review of the facility's pest observation log that staff used to document sightings:-03/12/2026: gnats and roaches in a resident room and gnats in all management front offices.-05/08/2026: spiders, roaches and gnats in resident rooms.-05/11/2026: roaches and gnats in the front office.-05/27/2026: roaches in the kitchen and resident rooms.-05/28/2026: roaches and gnats in resident rooms.-06/10/2026: roaches in resident rooms.-06/17/2026: roaches in resident rooms-07/01/2026: spiders and roaches, staff rooms. Observation and interview on 06/30/2026 at 9:08a.m., revealed there was a live roach in Room A. LVN O was called to the room and said she also saw the roach and that she would contact the maintenance department about it so that pest control could come to the facility. Observation and interview on 06/30/2026 at 11:00a.m., revealed Resident #24 was in her room and there were two houseflies and one gnat flying around her head. Resident #24 said she did not know how pests came into the facility, but she did not like it. Resident #24 said the pests were usually around the nurse's station and she's seen them recently and consistently .During an interview with the Activities Director on 07/01/2026 at 10:47a.m., she said she saw roaches the previous week in the front lobby area. She was aware of pest control coming to the facility but did not know the frequency. During the interview the Activities Director noticed a housefly hovering near the window. The Activities Director said the pest issue was ongoing, and she believed flies came in when residents opened the patio door to go outside and smoke. The Activities Director said interventions included calling pest control to come and leave traps outside the building. During an observation and interview with the Maintenance Director on 07/01/2026 at 11:09a.m., he said he saw pests in the facility and that he saw the round bug in Room B. The bug was about an inch long and a half inch wide and appeared to be dead on its back. The Maintenance Director said he did not know what the bug was but that it was June which was pest season. For residents with infested rooms, the Maintenance Director said he would temporarily move residents out of their rooms, spray the rooms, lock the door and then after a day have Housekeeping do deep cleaning along with regular visits from pest control. The Maintenance Director saw a white a/c unit with a plastic extender in the window of Room E, which also had damage and rips in the plastic where there were quarter-inch gaps and direct sunlight entered the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. The Maintenance Director said he will get one of his staff to remove it. The Maintenance Director said he had been at the facility for a few years and never saw the a/c unit being used and that continuing to have the a/c unit could cause a lot of heat to enter the room and that there was enough space in the gaps for bugs to enter. In a later interview with the Maintenance Director on 07/03/2026, he said he was not aware of the policy on having screens on all windows, but he would work on taking the unit out. Observation and interview on 07/01/2026 at 11:42a.m., HK C said she did not see roaches in her hall. HK C went into Resident #123's room and observed two flies on Resident #123's pillow. Resident #123 was not in her room. HK C said that she seldom saw resident rooms needing pest control but when it happened she would tell nursing staff and the facility would temporarily move residents to another room and spray down rooms. Observation of the patio area on 07/01/2026 at 1:42p.m., revealed the door to the smoking area was left open. During an interview with Receptionist A on 07/01/2026 at 2:33p.m., she said she last saw roaches in the building two weeks ago and she would see baby roaches come after pest control. Receptionist A said she thought pests came in when the door was opened for residents on smoke break. If she saw pests, she would report it to someone in the main office so they could call pest control to come. Receptionist A said residents did not complain about pests to her. During an interview with the DON on 07/03/2026 at 10:33a.m., he said the facility had a binder that staff would document pest sightings. Pest Control were called and came to the facility and treated pests promptly. The DON said that while the building was older and the facility had been periodically renovated which meant the pest issue was ongoing, he had seen pests in the building around three times. He said the window in Room E with the a/c unit was used to meet the needs of residents. The DON said he did not want residents to be hurt by the heat and that it was better to have it for heat exhaustion for temporary need. He said the Maintenance Director will work on removing the unit. Record review of the facility's policy on pest control last revised May 2008, it read in part, Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 2. Pest control services are provided by [company name]. 3. Windows are screened at all times. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and support for daily living safely for 2 of 6 residents (Resident #48 and Resident #98) reviewed for resident rights.1. Resident #48's had a missing hot water faucet handle on 06/30/2026. Resident #98's restroom wall and sink were damaged on 07/01/2026. These failures could place residents at risk of injuries, cross-contamination, avoidable infections and a decrease in quality of life. Findings include:1. Record review of Resident #48's face sheet, dated 03/24/26, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #48 had diagnoses which included: iron deficiency anemias (not having enough healthy red blood cells to carry oxygen to the body's tissues), blurred or impaired vision, anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life, unlike normal, temporary stress), hypertension (high blood pressure), heart failure (heart does not pump enough blood for the body's needs), hyperlipidemia (abnormally high fat and lipids) and type 2 diabetes mellitus without complication (a chronic condition where the body cannot effectively use (insulin resistance) or produce enough of it, leading to high blood sugar levels hyperglycemia). ^ Record review of Resident #48's significant change MDS, dated [DATE], reflected the BIMS score was not scored out of 15, which indicated that he had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on staff for bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #48 was incontinent of bladder and bowel. ^ Record review of Resident #48's care plan, dated 4/24/26, reflected Resident #48 had an ADL self-care performance deficit and the goal was the resident would improve current level of function. Observation of Resident #48's room on 06/30/2026 at 9:05a.m. revealed the hot water faucet handle on the left side was missing and the hot water was unable to be turned on. There was an EBP sign outside the door. Interview with Resident #48 on 07/01/2026 at 9:00a.m., the resident did not answer questions about the faucet and changed the subject often. Resident #48 did not appear to have any skin injuries and appeared to be well-groomed and comfortable. Observation and interview with CNA AJ on 07/01/2026 at 9:25a.m., she stated she was an aide for 3 years at this facility. CNA AJ said she did not know about the broken faucet in Resident #18's and #48's room, she just came back to work on 06/30/2026 after a week off. CNA AJ said the missing faucet should have been reported to the nurse who would tell the maintenance department. CNA AJ said hot water was used to clean residents in the morning and they might not like having only cold water and said there were no complaints about not having hot water. Interview with the Maintenance Director on 07/01/2026 at 11:07a.m., he said hot water removed germs and if residents did not wash their hands with hot water and then touched their food and ate it, it could cause residents to become sick. He was not aware of the damaged sink and bathroom wall and he did not have any staff report it on the maintenance log. 2. Observation and interview with the Maintenance Director on 07/01/2026 at 11:09a.m., in Room C , revealed the faucet had an inch long missing chunk on the lower left side near the sink bowl, with an unknown white material appearing to ooze out of the gaps in the faucet. There was one gash of missing sheetrock behind the toilet and one gash behind the sink. The Maintenance Director said that the gashes in the wall were not safe for residents and that he was going to have staff work on the faucet. Record review of the facility's policy titled Safety and Supervision of Residents last revised July 2017, it did not cover how to manage damaged resident equipment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Residents #1) reviewed for incontinent care. The facility failed to ensure Resident #1's Foley catheter bag and tubing was not touching the floor. The facility failed to ensure CNA NH kept Resident #1's Foley catheter bag below Resident #1's bladder level and used appropriate hand hygiene during foley catheter care on 07/01/26. The facility failed to ensure Resident #1 Foley catheter tubing had had Statlock to stabilize the tubing from pulling. The facility failed to ensure CNA H and the Staffing Coordinator used appropriate hand hygiene during foley catheter care for Resident #1 on 07/01/26. These failures could have caused residents to be at risk of infection. Findings included: Record review of Resident #1's face sheet dated 07/01/26 revealed a [AGE] year-old female who was admitted on [DATE] from the hospital. Resident #1 had diagnoses that included: neuromuscular dysfunction of bladder (lack of bladder control caused by nerve damage), hypertension (when the pressure in the blood vessels is too high), and retention of urine (inability to completely empty the bladder). Record review of Resident #1's admission MDS assessment, dated 05/26/26, revealed the BIMS score was 12, which indicated moderately impaired cognition. Further review of the MDS revealed Resident #1 needed total assistance with ADL care. Further review revealed the resident had an indwelling foley catheter. Record review of Resident #1's care plan initiated on 06/02/26 revealed the resident had 14 French Foley catheter related to Neurogenic bladder. Intervention: Position catheter bag and tubing below the level of the bladder. Record review of Resident #1 order summary report for June 2026 revealed in part . foley catheter 18 French with 10 ML [NAME] DX(diagnosis): neurogenic bladder. During an observation on 07/1/26 at 2:59 p.m., revealed that Resident #1's foley bag, privacy bag and tubing were on the floor. During an observation and interview on 07/01/26 at 3:00 p.m., the DON said Resident #1's foley catheter bag, tubing and privacy bag were on the floor because the bed was on the lowest position because the resident was a fall risk. He said it was an infection control issue because if the organism gets into the resident's bladder, it could have caused a UTI (urinary tract infection). He said the staff should have raised the bed up a little bit to prevent the foley form touching the floor. During an observation on 07/01/26 at 3:11 p.m., revealed that Resident #1's foley catheter bag was hung on the bed, but the foley bag, privacy bag and tubing were touching floor. During an observation and interview on 07/01/26 at 3:11 p.m., CNA NH said Resident #1's foley catheter was touching the floor and it was infection control and the resident could get UTI. During an observation on 07/01/26 at 3:11 p.m., revealed foley catheter care was provided for Resident #1 by CNA NH and the Staffing Coordinator. CNA NH placed Resident #1's foley catheter bag on the bed while she provided foley care. She changed her gloves three times and she did not sanitize her hands before she put on a clean gloves, and on the fourth time she took hand sanitizer from her uniform pocket and after she sanitized her hand she placed the sanitizer back into her uniform pocket and took gloves from her uniform pocket and continued to provide care for Resident #1. The Staffing Coordinator pulled off the top sheet on Resident #1 before the foley catheter care started and the top sheet had bowel movement on it. She placed the sheet in the trash bag. She did not remove the dirty glove before she continued to pull wipes from the wipe container and handed them to CNA NH which she was providing care for the resident. During foley catheter care it also revealed Resident #1 did not (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have a safety lock to hold the foley tube in place. During an interview on 07/01/26 at 3:40 p.m., CNA NH said she should not have placed Resident #1's foley catheter bag on the bed because the urine could flow back to the resident's bladder and it could cause infection. She said she also should not place the bag which was on the floor on the bed because of cross contamination. She said she changed her gloves three times, but she did not wash or sanitize her hand before she donned clean gloves. CNA NH said she also sanitized her hand with sanitizer from her uniform pocket, and she placed the sanitizer back in her uniform pocket and she contaminated her hand when she placed her back into her uniform pocket. CNA NH said she took gloves from her uniform pocket and donned them and continued to provide care for Resident #1. She said it was infection control issue because it was cross contamination. CNA NH said Resident #1's foley catheter tubing did not have a sStat lLock to hold the tubing in place, and the foley catheter tubing could be pulled during care, and the foley catheter could be pulled out and it could cause harm to the resident During an interview on 07/01/26 at 3:49 p.m., the Staffing Coordinator said she should have taken off her gloves and washed her hands and donned clean gloves after she took off Resident #1's top sheet which had bowel movement on it before she took wipes from the wipe container and handed the wipes to CNA NH who used the wipes and provided foley catheter care for Resident #1. She said she contaminated the wipes because she used the dirty gloves to take wipes from the clean packet. The Staffing Coordinator said Resident #1's foley catheter was not secured and the foley catheter tubing could pull out during turning and repositioning or during care which could hurt Resident #1. During an interview on 07/01/26 at 402 p.m., the DON said Resident #1's foley catheter should be secured to prevent the foley catheter tubing from pulling during care which could hurt the resident if the foley catheter was pulled. He said the worst case could be the foley catheter could be pulled out of the bladder which could cause serious harm to Resident #1. The DON said CNA NH should not place the foley catheter on the bed during care because the urine could flow back into the resident and it could have caused a UTI for the resident. He said also the foley catheter bag was on the floor and that would transfer the germs from the floor to the resident's linens and the germs could be transferred to the resident which could have caused infection. He said the aide should not have used the sanitizer from her uniform pocket or donned gloves from her uniform pocket because it was cross contamination. Record review of the facility policy on catheter care, urinary care dated 2001 MED-PASS, Inc, updated July 2024 read revealed in part . the purpose of this is to prevent catheter associated urinary tract infection.maintaining unobstructed urine flow #3.the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into urinary bladder. infection control #2b. be sure the catheter tubing and drainage bag are kept off the floor. changing catheter #2. ensure that the catheter remained secured with leg strap to reduce friction and movement at the insertion site. steps in the procedure #2 wash and dry your hands thoroughly. 5. Put on gloves. Record review of the facility policy on handwashing/hand hygiene dated 2001 MED - PASS, Inc. Revised October 2023 read reveaeld in part . indication for hand hygiene #1a .immediately before touching a resident. immediately after glove rem		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, for oxygen therapy for 1 of 1 resident (Resident #150) reviewed for respiratory care. The facility failed to provide tracheal care and suctioning according to professional standards for Resident #150. These deficient practice could result in the residents not receiving the care and services ordered by the physician and a decline in health status and oxygen deprivation. Findings included: Record review of Resident #150's facility admission record dated 06/30/2026 revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #150's medical diagnoses included dysphagia (difficulty swallowing), tracheostomy status (also called a tracheotomy) is a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe (trachea) to help you breathe and gastrostomy status (a surgical opening into the stomach for nutritional support or gastric decompression). Record review of Resident # 150's admission MDS dated 6/22/26, revealed the BIMS score was blank. Resident #150 was totally dependent for all ADL's. Record review of Resident #150's physician's orders for June 2026 with a start date of 6/20/2026 revealed the following orders: -Change Shiley (Shiley inner #4 cannulas that twist to lock in place are reusable) disposable inner cannula every 6 hours and PRN (as needed) for Patent airway. -Change trach tie as needed. -The resident is on Enhanced Barrier Precautions regarding tracheostomy care: Use a gown and gloves for high-contact resident care. Every shift for prevention spread of infection. -Trach care every 6 hours for maintenance/infection prevention. -Tracheal suction every 6 hours for Patent airway. Record review of Resident #150's Treatment Administration Record for June 2026 revealed tracheal suction every 6 hours for patent airway was provided on 6/20/2026. Observation of Resident #150 on 6/30/2026 at 9:00AM, revealed the resident was observed lying in bed with the head at a 30-degree angle. Resident #150's oxygen concentrator read 3.5L/min. Observation on 07/01/2026 at 6:04 PM revealed Resident #150 was in bed with audible moist breath sounds. The Respiratory Therapy (RT) was at the bedside observing tracheostomy care, and LVN BK stated the resident was not usually moist and they changed the resident's inner cannula every day. LVN BK set up a clean field on the bedside table, checked the oxygen saturation and it was 99%. LVN BK changed his gloves without washing his hands or using hand sanitizer. He then grabbed the sterile suction catheter kit tray, opened it, then doffed (take off) his clean gloves without washing his hands, picked up the sterile gloves, then picked up normal saline at Resident #150's bedside, and poured it in the tray. LVN BK picked up the suction tubing from the sterile suction kit and connected it to the suction machine at Resident #150's bedside. LVN BK removed the inner canula. LVN BK then used his clean gloved right hand to removed the oxygen mask on Resident #150's trach, then inserted the suction catheter into the tracheostomy tube 2 times. The then used the same gloved hands to open the sterile inner cannula kit and picked up the inner cannula and inserted it. LVN BK picked up Trach Care Kit without changing his dirty gloves. LVN BK opened the sterile Trach Care Kit, using the same dirty gloves picked up the sterile 4x4 gauze and sterile gloves placed on the bedside table. LVN BK, using the same dirty gloves, then picked up a bottle of 100 ml normal saline (NS) covered with plastic wrap. LVN BK then poured the NS on the 4x4 gauze, then opened the sterile gloves without washing his hands or using hand (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sanitizer don sterile^gloved. The sterile gloves LVN BK was trying to put on, got toned, he^doff^the sterile^gloves^ without^ washing hands or using hand sanitizer, LVN BK^don^clean gloves and opened two sterile Trach Care kit, using the clean gloves. LVN BK picked up the sterile gloves and placed^them on the^bedside^table and doffed his clean^gloves^ without^washing his hands or using hand sanitizer. LVN BK tried donning sterile 2 times and it got toned He^picked^up the 4x4 gauze and^cleaned^around Resident #150's stoma site with the toned gloves.^ In an interview with the RT on^7/1/26^at^6:42^PM^ regarding^tracheostomy care she observed LVN^BK^perform ,^she said LVN^BK^should not have touched the inner cannula with a clean glove; he should have suctioned and then should have sanitized his hands or washed his hands, changed his gloves. The RT said LVN BK should have then opened the stuff, peeled the drain, inner cannula and put it out and he should have opened the gauze; and then he^should have reached in with sterile gloves and put everything from inside and put it on the sheet and then put it in trash. The RT said LVN BK did not use^proper^sterile field and that he was nervous. He was putting gloves on. RT said LVN BK had a couple of education sessions, and had Tracheostomy care demonstration with him and LVN BK perform return demonstration. RT said LVN BK should not use dirty gloves inside a sterile Tracheostomy kit.^~^~In an interview on 07/1/2026^at^6:52^PM, LVN^BK^stated^he had^one training^on trach care 6/30/26 and it was^been a while since his last trach care training.^He^said he^did^wonderful^but not excellent. He said trach care was a sterile procedure. He said after removing the stoma (an opening) that's when sterile started. He said he was supposed to wash his hands before doing anything. He said he tried to have a dominant right hand. He said he opened 1^sterile Trach^Kit,^when^he missed a step with one. LVN BK said he had to think he needed to correct and open another one. He believes he^did.^LVN BK^said he^didn't^use a clean^procedure,^and he took clean gloves and put sterile items on there. He forgot sterile gloves.^~ He said he should have used his right hand when he did that. He said he had training before. He said he did a^training^on Friday and another one yesterday^(6/30/26)^by^the RT.^~He said the RT^watched him and she told him he did good. There was tension today. If staff didn't do it the right way, they could have respiratory distress,^infection^and sepsis. He said he understood when he went from dirty gloves to touch sterile gloves. He said the facility did ^training^before residents came with tracheostomy care, video,^with^returned demonstration.^~~~~~^Record review of the facility policy and procedure entitled Tracheostomy Care-Suctioning, updated 01/2026,revealed in part . Policy: The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Tracheal suctioning is performed by a licensed nurse to clear the throat and upper respiratory tract of secretions that may block the^airway.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents were free of any significant medication errors for 1 of 7 residents (Resident #149) reviewed for medications. -LVN DM failed to administer medication Effer K (Potassium is a vital mineral and electrolyte that carries an electrical charge, allowing the body to function) to Resident #149 according to Physician's order on 6/30/26. Resident #149 did not consume all of the Effer K medication. The failure could place residents with high or low blood pressure at risk of fainting or a stroke due to not getting their blood pressure medication as ordered by their physician. Findings included: Record review of Resident #149's face sheet, revealed she was an [AGE] year-old female admitted on [DATE]. Her diagnoses included: shortness of breath, pneumonitis(Inflammation of the lung tissue, usually meaning the tiny air sacs in the lung) due to inhalation of food and vomit, hypoxemia(having too little oxygen in the blood), restlessness and agitation(, mixed hyperlipidemia(high fat in the blood, essential (primary) hypertension(high blood)other intervertebral disc (is a soft, round cushion that sits between the small bones of your spine) displacement, lumbar region(lower back) and muscle wasting and atrophy, and hypokalemia(an abnormally low level of potassium in the blood). Record review of Resident #149's admission MDS dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. Record review of Resident #149's care plan on 6/27/26 revealed in part . diagnosis of hypokalemia . Intervention . give Potassium Chloride medications as ordered . Record review of Resident #149's physician's orders for June 2026 revealed in part: . Potassium Chloride oral packet 10 meq (Potassium Chloride), Give 10 meq by mouth one time a day for hypokalemia. Record review of Resident #149's Medication Administration Record (MAR) dated June 2026 revealed Effer - K 10 meq (Potassium Chloride), Dissolve 1 tablet in 4 ounces water once daily. Pharmacy recommendation reflected to dissolve 10 meq in 4 to 8 ounces water or cold juice and drink slowly. Observation on 6/30/26 at 9:10 a.m. revealed LVN DM took Resident #149's Effer - K 10 meq 1 tablet and dissolved it 4 ounces of water with other medications. Resident #149 drank 2 ounces of the dissolved Effer -K in water. LVN DM discarded the Effer-K. Interview on 6/30/26 at 9:20 a.m. with LVN DM regarding not encouraging Resident #149 to finish Effer -K dissolved in water. LVN DM said he knew Resident #149 was not going to drink the dissolved Effer -K; Resident #149 always complained of being too full. LVN DM said he had not told the ADON, DON or the doctor about Resident #149 not taking all Effer-K or changing Effer-K to liquid. LVN DM said Resident #149 could have low potassium in her blood that could affect her heart. Interview with the ADON and DON on 7/1/26 at 2:00PM regarding Resident #149's Effer-K dissolved in water and not able to consume all the medication revealed the DON said they were not aware of it. The DON said he was going to notify the doctor to start Potassium blood level lab work to be done. The result of Potassium level from the start blood work was low 3.1 MEQ/L. DON said he started in-services to all staff and Effer-K was changed to liquid. Record review of the facility's policy on medication administration last revised November 2022 revealed in part, Policy Statement Medications are administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation 1. Only persons licensed or permitted by the state to prepare, administer, and document administration of medications may do so. 4. Medications are administered in accordance with the prescriber's order, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 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 all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts (Nurse Cart A) reviewed for medication storage. -Nurse Cart A medication cart had medications that were opened and undated. This failure could place residents at risk of receiving expired medication and improperly stored medications, which could result in delayed healing. Findings include: During an observation on [DATE] at 1:06 pm of Nurse Cart A revealed the following opened medications were not dated when they were opened: The following normal saline and nasal drops were open with no date: a, Sodium chloride 0.65% 2 spray in each nostril a day for dryness of the nose - open not dated b, Fluticasone Propionate Nasal spray 1 spray each nostril twice a day - open not dated c, Sterile 0.9% Normal Saline 100 ml bottle open and date Interview with LVN DM on [DATE] at 1:06 PM said he was not aware when the nasal medications were opened and the resident always refused Fluticasone Propionate Nasal spray 1 spray each nostril twice a day and Sodium chloride 0.65% 2 spray in each nostril a day. LVN DM did not know which nurse open those medications. During an interview on [DATE] at 4:38 p.m., the Director of Nurses (DON) said eye drops opened should have an open date. The DON said the medicines would not be effective for the treatment after 30 days. The nurses were responsible for dating normal saline bottle and nasal drops whenever they were opened. Record review of the facility's policy, not dated, Storage of Medication Purpose: Ensure that medications are stored in a safe, secure and orderly manner. Procedure: 11. multi-dose vials that have been opened or accessed should be dated and discarded within 28 days of opening /initial access unless the manufacturer specifies a shorter or longer date.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Avir at Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 7633 Bellfort Street 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure that food was prepared by a method that conserved nutritive value, flavor, and appearance in one of one kitchen. The facility failed to ensure that carrots, green beans, and green peas for lunch were not left on the stove at a low temperature for 3 hours prior to lunch. This resulted in the green beans and carrots being overcooked and unattractive. This failure could place all residents who ate meals prepared by the kitchen at risk of not getting the nutrients needed to prevent malnutrition and weight loss. Findings Included: Observation on 6/30/2026 at 9:05 am of the stove in the kitchen revealed cooked green beans, carrots, ham and whipped sweet potatoes were on the stove cooking for lunch. There were two pans on the grill, one with pureed green beans and one with pureed ham for lunch. The grill was hot. In an interview on 6/30/2026 at 9:30 am with [NAME] A revealed she was preparing green beans, carrots, ham and whipped sweet potatoes for lunch. Further interview on 7/4/2026 at 9:15 am regarding cooking menu items 2 -3 hours before lunch she said if menu items were cooked too early and placed on the grill to keep hot it would be overcooked. She said when foods were overcooked, they would lose their nutritive value, color and residents could lose weight. In an interview on 6/30/2026 between 11:55 am and 12:30 pm with 3 unidentified residents revealed the green beans tasted good but it was over cooked. Some residents interviewed did not express any food preferences, they said they just ate whatever was served. They said if they did not like what was served, staff would offer them something else from the always available menu. Observation on 7/4/2026 at 9:10 am of the kitchen revealed the following menu items on the stove: green peas and cabbage cooking for lunch. The color of the peas was olive green and the cabbage bright green in color . In an interview on 7/4/2026 at 9:35 am with the Dietary Manager she said overcooked vegetables could be mushy and would not look good. She they could lose their nutritional value and could result in weight loss. She said she would be in-servicing the dietary staff. She said she was going to ensure that vegetables were cooked a few minutes before meal service so it would not be overcooked. She said they would start cooking vegetables around 10:30 am because lunch service starts at 11:30 am. In an interview on 7/4/2026 at 10:00 am with the Foodservice District Manager she said she will be in-servicing the staff on food service sanitation, food preparation and ware washing. She also said she would ensure that all the issues identified in the kitchen were addressed. Record review of the facility's policy and procedures dated October 2017 title Food and Nutrition Services read in part. Policy Statement: Each resident is provided with a nourishing, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.		