STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676066	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Houston	2310 S Eldridge Parkway Houston, TX 77077

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an MDS was completed for a resident and entered MDS data into the facility's assessment software resident's assessment was completed within 7 days after completing the MDS and electronically transmit the MDS data to CMS within and 14 days after completing the MDS, and electronically transmit encoded, accurate, and complete MDS data to the CMS System for a subset of items upon a resident's transfer, reentry, discharge, and death for 1 of 4 discharged residents (CR #2) reviewed for encoding and transmitting resident assessments., in that: - The facility failed to complete and transmit a discharge MDS for CR #2. This failure could place discharged residents at risk of not having a proper discharge and not receiving services post discharge.Findings included: Record review of CR #2's face sheet, dated 09/21/2025, reflected a [AGE] year-old female originally admitted to the facility on [DATE] and was discharged on 09/23/2025. Her medical diagnoses included infection and inflammatory reaction due to nephrostomy catheter, subsequent encounter, acute on chronic systolic (congestive) heart failure (a condition where the heart muscle weakens over time, making it difficult for the heart to pump blood effectively, essential [(primary]) hypertension (high blood pressure), nausea with vomiting, unspecified, gastro-esophageal reflux disease with esophagitis, without bleeding, (gastric reflux occurs when stomach contents flow backward into the esophagus), calculus of kidney (it is a hard, pebble-like deposit made of minerals and salts that forms inside your kidney), encounter for attention to other artificial openings of urinary tract, end stage renal disease, anemia (anemia is a condition where your blood doesn't have enough healthy red blood cells or enough of a key protein called hemoglobin), heart failure (when the heart can't pump enough blood to meet the body's needs.,Record review of Resident #2's Comprehensive MDS, dated [DATE], reflected she had a BIMS of 15, indicating which indicated she was cognitively intact. Resident #2 required substantial assistance with toileting, showering or bathing, lower body dressing. She was coded for right and left nephrostomy tube. (Record review of Resident #2's care plan, captured 09/25/2025, reflected she had an Right Nephrostomy Tube Output Monitor Left Nephrostomy Tube Output. Resident #2 also had a focus area for being on antibiotic therapy due to a urinary tract infection with interventions including which included administering medication as ordered and monitoring/communicating sudden changes in condition and or worsening to the MD/NP (Medical Doctor/Nurse Practitioner).Record review of Resident #2's September MAR , reflected she had Right Nephrostomy Tube Output TID (three time a day) as needed Monitor Left Nephrostomy Tube Output TID as needed have recorded output on 09/14/2025, during night shift (10p-6a) and 09/19/2025 during morning shift (6a-2p).Record review of CR #2's progress notes, dated 9/23/25, revealed reflected CR #2 's left the facility at 11:00 AM alert, orient and stable at time of she left. The resident took all the stuff. Record review of CR #2's MDS Assessment for discharge reflected it was not documented. Interview with the DON(Director of Nurses), on 10/22/25 at 4:15 PM, regarding where CR #2 was discharged to.the DON said CR #2 was discharged home but she was not sure, she would have to checked. On 10/22/2025 at 4:47 PM, the. DON said CR#2 left AMA (against medical advice) and the Social Worker will would upload the discharge home in the PCC (Person -Centered Care) now.Interview with the DON on 10/23/25 at 11:05 AM, she said before a residents leave left AMA, they should do be educated, we getgot a doctor's order for AMA or discharge order,. Get got the AMA form,. ensured there's transportation and the. Social Worker would get involved and set up appropriate out-patient needs. CR#2 wanted to leave; there was a physician order to discharge the resident home. CR #2 had to signed an AMA form, but it was in the SW's office, and she found it in her office and. it should be uploaded to PCC . The DON said an AMA order was entered at 1:00 PM. It looked like the nurse entered the orders after the resident left. Her expectations are were to get an order, but we the facility don't didn't know if they don't didn't have a right to leave. We The staff get got the form signed if the resident wants wanted to leave and we do did education. We The facility cannot could not stop themthe resident. For discharges, the facility don't follow-up by social worker , but it would be nice if someone in corporate to check on them. We hold everyone accountable, and the AMA form should be given to medical records, and they upload everything in PCC and CR #2 was not transmitting in discharge MDS.Interview with the SW (social worker) on 10/23/25 at 10:43 AM, the. SW said if a resident leaves left AMA, she would try to contact them through phone in the chart. If they don't didn't have anybody, she tries tried to contact them. The doctor would be notified, which is was usually communicated by the nurse. She follows followed up with safety, the SW said CR #2 was the one that who

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was 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 (CR #3) reviewed for incontinent care. -The facility failed to ensure CR #3 had her urine output monitored 3/14/2025 and 3/19/2025 as ordered. This failure could place residents at risk for pain, infection, injury, and hospitalization.Record review of CR #3's face sheet, dated 10/23/2025, reflected a [AGE] year-old female originally admitted to the facility on [DATE] and discharged [DATE] to a private home. Her medical conditions included an unspecified fracture of her T5-T6 vertebra (vertebra being the bones forming the backbone) due to pedestrian on foot injured in collision with car, pain, constipation, and traumatic subdural hemorrhage (brain injury caused by head trauma involving the buildup of blood in the brain) without loss of consciousness. CR #3 was discharged on 5/2/2025 to a home. Record review of CR #3's Comprehensive MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated she had high cognitive intactness. CR #3 had impairment of the lower extremity (legs) on both sides. CR #3 required moderate assistance with oral and personal hygiene and was totally dependent with ADLs which included toileting, showering and footwear. CR #3 was total dependence with mobility in bed like lying to sitting and sitting to lying.Record review of CR#3's care plan, reflected she required assistance with ADLs, which included call light within reach and providing ADL care daily. She was on an antibiotic therapy r/t infection for UTI on 4/2/2025 (Macrobid as ordered for 5 days) and 4/18/2025 for UTI (Cipro for UTI for 7 days as ordered), with interventions which included administer medication as ordered. CR #3 also had a focus area of having an indwelling catheter in place r/t urinary retention, with interventions which included assessing for continued need for use of the catheter and perform foley catheter care QS and as needed, encourage her to participate in foley care if able QS and as needed.Record review of CR #3's orders for her foley catheter reflected:-FC size 16 F with 10 cc balloon with an order date of 3/12/2025.-Monitoring FC output with an order and start date of 3/12/2025 and an end date of 4/29/2025.-Cipro oral tablet 250 MG, 1 tablet by mouth two times a day for UTI for 7 days with a start date of 4/19/2025 and an end date of 04/26/2025.-Macrobid Oral Capsule 100 MG, 1 capsule by mouth two times a day for UTI for 5 days, with a start date of 4/22/2025 and an end date of 4/27/2025.Record review of CR #3's hospital records, dated 03/12/2025, reflected she had a catheter 16 fr active order in the hospital.Record review of CR #3's MAR for March 2025 reflected the resident had missing output monitoring for 03/18/2025 for the day shift, 03/19/2025 for the day and evening shift, 03/24/2025 for the evening shift, and 3/27/2025 for the evening shift. Record review of resident's labs, on 03/26/2025, reflected her urine appeared cloudy and her white blood cell count was TNTC (too many to count), which indicated a UTI. On 04/15/2025, her urine appeared cloudy, her white blood cell count was elevated and her red blood cell count was TNTC, which indicated a UTI.Interview with LVN M on 10/22/2025 at 3:14 PM, LVN M said she was not CR #3's nurse but that the urine output should have been monitored and if a resident had a foley catheter she would monitor for urine output. If output was not monitored, residents could develop dehydration and could develop a change in condition and would not be caught. LVN M said she was in-serviced on foley catheters within the last year .Interview with the DON on 10/23/2025 at 11:05 AM, she said output was a measure of dehydration and if a resident's urine output was not monitored and documented the facility would not know what was going on with them and staff could not tell the resident's condition. The nurse manager at the time would have been the one responsible for ensuring nurses documented urine output and nursing management reviewed documentation every morning. Staff were trained on monitoring and documenting resident vitals, which included output. The DON said the facility had a problem entering documents right away and that was something they would work on. Interview with the Administrator on 10/23/2025 at 12:42 PM, he said urine output should have been monitored and if urine output was not monitored, the resident could be retaining fluids and maybe have clogged catheters. Staff would not know the amount of fluid coming in and leaving the resident's body and if fluids were not leaving the resident's body it could be a sign of renal issues. Output needed to be monitored as ordered by the physician. Record review of the facility's policy on change in a resident's condition or status, last revised April 2025, reflected it did not cover accurate documentation in resident records.