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	12/02/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 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 residents discharge to an appropriate setting that could meet the resident's needs for 1 of 4 closed record (CR #2) reviewed for discharge in that: 1. The facility discharged CR #2 to a homeless shelter for men where he had difficulties performing his activities of daily living (ADL) and administer and store his medications. This failure could place residents at risk of unsafe discharges, sadness, fear, injury, and death.Record review of CR #2's Facesheet dated 11/11/2025 reflected a [AGE] year-old male who admitted to the facility on [DATE] and discharged on 07/31/2025 to a private home/apartment with no home health services. CR 2#'s diagnosis included hemiplegia (paralysis or weakness of one side of the body affecting the arm, leg, or face) and hemiparesis (one-sided weakness on one side of the body, affecting the arm, leg, or face) following cerebral infarction (the death of brain tissue due to a lack of blood flow) affecting right dominant side, history of falling, hyperlipidemia (high levels of lipids, such as cholesterol and triglycerides, in the blood), homelessness, and pain. Record review of CR #2's undated care plan reflected CR #2 was bowel incontinence related (r/t) immobility Date Initiated: 04/24/2025 and revision on 10/23/2025. Was at risk for falls. Had an actual fall on 06/23/2025, with no injuries Date Initiated: 04/24/2025 and revision on 10/23/2025. Required assistance with ADLs r/t disease date initiated on 04/24/2025. CR #2 had a regular diet, regular texture, thin liquid consistency diet date initiated: 04/24/2025 and revision on 10/23/2025. Record review of CR #2's Comprehensive Minimum Data Set (MDS) dated [DATE] reflected the resident had a Brief Interview for Mental Status (BIMS) score of 06 indicating that the CR #2 had severe cognitive problems, severe cognitive impairment: Section B - Hearing, speech and vision, section B0600 for speech clarity reflected CR #2 had unclear speech/slurred or mumbled words. Section B0700 Makes Self Understood reflected he usually understood, had difficulty communicating some words or finishing thoughts but was able if prompted or given time. Section B0800 reflected he had the ability to understand others and had clear comprehension. Section C - Cognitive Patterns and section C0200 reflected he had the ability to perform temporal orientation (orientate to year, month and day) and oriented the year, missed the month of year by 1 month and provided no answer, for the day of the week. Section C0400 reflected after give three words to remember he was unable to recall the three repeated words. Section GG - Functional Abilities and GG 0115 Functional Limitation in Range of Motion reflected the CR #2 had impairment to his upper extremity one side (shoulder, elbow, wrist, hand) and impairment on lower extremity (hip, knee, ankle, foot). Section covering Functional Abilities, GG0130 - Self-Care and Section GG - Functional Abilities at discharge reflected:CR #2 required substantial/maximal assistance - where helper does more than half the effort during eating. Eating with the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before CR #2. CR #2 was dependent - helper does all of the effort for CR #2's oral hygiene and did not have the ability to use suitable items to clean teeth. CR #2 was dependent - helper does all of the effort for CR #2's toileting hygiene and did not have the ability to maintain perineal hygiene, adjust clothing before and after voiding or having a bowel movement, including wiping the opening but not managing equipment. CR #2 was dependent - helper does all of the effort for CR #2's shower/bathe self and did not have the ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair), including transferring in/out of tub/shower. CR #2 was dependent - helper does all of the effort for CR #2's upper body dressing and did not have the ability to dress and undress above the waists, including fasteners on clothing. CR #2 was dependent - helper does all of the effort for CR #2's lower body dressing and did not have the ability to dress and undress below the waits; including fasteners. CR #2 was dependent - helper does all of the effort for CR #2's placing on/taking off footwear and did not have the ability to put on and take off socks and shoes or other footwear that was appropriate for safe mobility; including fasteners, if applicable. CR #2 was dependent - helper does all of the effort for CR #2's personal hygiene and did not have the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands. Section GG - Functional Abilities - at discharge. GG0170. Mobility (Assessment period was the last 3 days of the stay). Discharge performance: CR #2 required Supervision or touching assistance for sitting to lying: The ability to move from sitting on side of bed to laying flat on the bed with verbal cues and/or touching/steadying and/or contact guard assistance from helper as resident completed activity. (Assistant may be provided thought the activity or intermittently.) CR #2 required Supervision or touching assistance for Lying to sitting on side of

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident with pressure ulcer (injury/bedsore) is skin and tissue damage from prolonged pressure, friction, or shear) receives necessary treatment services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers from developing for 1 of 4 closed record (CR) #1 reviewed for pressure ulcers in that: 1. The facility failed to prevent the development of a pressure ulcers to CR #1's 1-left foot measuring (Length x Width x Depth) 2x2x0 centimeters (cm).2. The facility failed to prevent the development of a pressure ulcers to CR #1's right lateral ankle measuring 1x1x1 cm.3. The facility failed to prevent the development of a pressure ulcers to CR #1's 1-left hip measuring 4x4x0 cm.4. The facility failed to prevent the development of a pressure ulcers to CR #1's-sacrum/sacral (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis) measuring 10x15.5x0 resulting in CR #1 being transferred to a local acute care hospital 10/30/2025. 5. The facility failed to provide CR #1 with a pressure reducing mattress on 10/15/2025 resulting in CR #1 being without the mattress for 15-days resulting in the development of sacrum pressure wound. 6. The facility failed to provide CR #1 with pressure reducing heel boots for 11-days from 10/15/2025 to 10/26/2025 resulting in the resident acquiring. On 11/13/2025 at 02:41 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 11/15/2025 at 06:01 p.m., The facility remained out of compliance with the scope of pattern that was not actual harm with potential for more than the minimal harm that was not an immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures placed residents at risk for further skin breakdown, infections, and pain. Findings included: Record review of CR #1's facesheet dated 11/11/2025 reflected a [AGE] year-old male who admitted to the facility on [DATE] and discharged on 10/30/2025 with medical diagnoses including but not limited to fracture of fourth lumbar vertebra (supporting the upper body and connecting to the pelvis), injury to fourth lumbar (L4): vertebra in the lower back) level of lumbar spinal cord (refers to the nerve roots), traumatic subdural hemorrhage (excessive bleeding from a damaged blood vessel) without loss of consciousness, abrasion of right forearm, abrasion, left lower leg, lumbago with sciatica (a condition characterized by lower back pain that radiates down the buttocks and into one or both legs), and edema (swelling caused by fluid buildup in the body's tissues). Record review of CR #1's undated care plan reflected CR #1 required total assistance for all assistance of daily living (ADLs): (specify) mobility, transfers, dressing, eating, toileting, hygiene/grooming, bathing related to (r/t) clinical diagnosis (as listed above) initiated and revised on 08/17/2025. Goal: CR #1 will have all ADLs met by staff as evidenced by turning and repositioning and safe transfer initiated and revised on 08/17/2025. Interventions/Tasks: CR #1 required assistance with meals initiated on 08/17/2025 and revision on 09/01/2025. Have two-person transfer or mechanical lift as needed initiated on 08/17/2025. Record review of CR #1's hospital discharge records dated 08/04/2025 reflected that CR #1 discharged to the facility for recovery from a fall, head injury subdural hygroma (a collection of cerebrospinal fluid in the brain), fracture injury L4 superior endplate (the top surface of the vertebrate bones) compression fracture with 27 percent (%) loss of vertebral height and 2 millimeters retropulsion (disorder where a person tends to fall backward). Moderate spinal canal stenosis (narrows and puts pressure on the spinal cord) at this level after repeated falls withing a 3-day period beginning on 07/25/2025 while in CR #1's personal residence. Record review of CR #1's Comprehensive Minimum Data Set, dated [DATE] reflected the resident had a Brief Interview for Mental Status (BIMS) score of 03 indicating that the CR #1 had severe cognitive impairment. Section M0100: Determination of the Pressure Ulcer/Injury Risk indicated that a formal assessment instrument/tool and clinical assessment were performed. Section M0150: Risk of Pressure Ulcers/Injuries indicated that the CR #1 was at risk for developing pressure ulcers/injuries. Section M0210: Unhealed Pressure Ulcers/Injuries indicated that the resident had not had one or more unhealed pressure ulcers/injuries. And had not had one or more unhealed pressure ulcers/injuries. Other Ulcers, Wounds and Skin Problems, none were present. M1040: Other Ulcers, Wounds and Skin Problems, none present. Foot problems. None were present. Section M - Skin Conditions M1200: Skin and Ulcer/Injury Treatments: Pressure reducing device for bed. Record review of CR #1's Predicting Pressure Sore Risk Scale assessment effective date: 08/15/2025 at 06:36 p.m. CR #1 was a Low Risk, sensory perception. Ability to respond meaningfully to pressure-related discomfort: No Impairment/Responds to verbal commands. Had no sensory deficit which would limit ability to