| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/15/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Houston | 2310 S Eldridge Parkway<br>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) |
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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**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 needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 4 residents (Resident #1) reviewed for respiratory care.The facility failed to ensure Resident #1's O2 nasal cannula and water bottle changed every week as ordered by the physician.This failure placed residents at risk for respiratory infections through contamination. Findings included:Record review of Resident #1's face sheet, dated 04/14/26, reflected Resident #1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. She was an [AGE] year-old female diagnosed with COPD (difficulty to breath due to restricted airflow) , obstructive sleep apnea (breathing stop and start during sleep) , acute bronchiolitis (lower respiratory infection) , chronic kidney disease, dementia, major depressive disorder and dysphagia (difficulty to swallow).Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 01 indicating her cognition was severely impaired. Further review revealed he was on oxygen therapy for respiratory issues.Record review of Resident #1's care plan dated 11/26/25 reflected that she was on oxygen therapy via nasal cannula continuously and/or PRN for SOB and the relevant intervention was providing oxygen as ordered by physician.Record review of Resident #1's physician's order reflected : O2: O2 sats every shift and PRN: every night shift. -Start Date-11/23/2025. O2: Change and label water humidification and nasal cannula tubing weekly on Sunday on night shift. -Start Date-11/23/2025During an observation and interview on 04/14/26 at 1:10p.m. of the labels on Resident #1's nasal cannula and the water humidification bottle connected to oxygen tank revealed that they were last changed on 02/23/26.The resident was in bed and stated she did not know or remembered anything related to the oxygen nasal cannula.During an observation and interview on 04/14/26 at 1:35 PM, LVN A removed Resident #1's oxygen nasal cannula and humidifying container. She stated that, as per the physician's order, it was the responsibility of the Sunday night shift nurses to change them every week. She explained that if they were not changed regularly, there was a possibility of microorganism colonization, which could cause serious respiratory and other infections. She also mentioned that it was a mistake by other staff members, as no one verified whether the cannula and water container had been changed by the Sunday night shift nurses, according to the order. She added, it was evident that they had not changed in the past month, even though the order was to change them every Sunday.During an interview on 04/14/26 at 2:30 p.m., RN B stated that she worked in a different hall than Resident #1's . She stated that she had only one resident on oxygen therapy and confirmed that her oxygen nasal cannula tubing was changed on 04/10/26. RN B stated that, as per protocol, the cannula needs to be changed every week or when it was found soiled or nonfunctional. She added that changing the cannula, mask, and humidifier bottle was important to minimize the risk of respiratory infections.During an interview on 04/15/26 at 11:00 a.m. with the DON, she stated that she started working at the facility as the DON one week ago and committed to addressing concerns related to nursing. She said that the oxygen humidifier bottle, nasal cannula, and humidifier mask should be dated and changed weekly, as well as PRN if they were found empty or soiled. She explained that,<br>(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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | although according to the physician's order, it was the responsibility of the night nurses on Sundays, everyone was responsible for ensuring they were changed as per the order. She stated that her plan was for the ADON and DON to make rounds as often as possible to ensure that physician's orders were carried out and that other nursing tasks were up to date. She also mentioned she was not happy that the physician's order was not followed for over a month , as this increased the risk of respiratory infections from soiled equipment.Review of the facility policy Oxygen Administration revised in October 2010 reflected the following: Verify that there is a physician's order for this procedure . Review the physician's orders , facility protocol for oxygen administration .Oxygen /nebulizer tubing/masks to be changed by nursing department weekly and documented in the electronic record. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 6 of 10 residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) reviewed for pharmacy services.The facility failed to administer Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7's medications greater than one hour after the scheduled administration time.This failure placed residents at risk for receiving less than therapeutic benefits from medicationsFindings included:Record review of Resident #2's face sheet, dated 04/15/26, reflected Resident #2 was admitted to the facility on [DATE]. She was a [AGE] year-old female diagnosed with type 2 diabetes, orthostatic hypotension (low blood pressure when standing), peripheral vascular disease(slow peripheral blood circulation) , anxiety disorder, muscle weakness and hypertension.Record review of Resident #2's initial MDS dated [DATE] reflected a BIMS score of 13 indicating her cognition was intact.Record review of Resident #2's care plan dated 04/14/26 reflected that she was on medication for anxiety, depression , anemia , pain from hip fracture and hypertension (high blood pressure). The intervention indicated administering medications as ordered by physician and monitor for side effects . Record review of Resident #2's physicians' orders reflected her medications scheduled at 8a.m were amlodipine Besylate oral tablet 10 MG, linagliptin oral tablet 5 MG, Multivitamin oral tablet, Ferrous Sulfate oral Table oral tablet Delayed Release , Metoprolol Tartrate oral tablet 25 MG and Acetaminophen oral tablet 500 MG.Record review of Resident #2's April 2026 MAR reflected that on 04/15/26 Resident#2's medications scheduled at 8:00am were administered at 11:03am.During an interview on 04/15/26 at 11:30am the RP of Resident #2 stated Resident #2 received medications later than 9 a.m. every now and then. He stated it was not a big issue as none of her medications were time sensitive and no harm occurred because of it. He stated however he preferred the medications administered with time consistency.Record review of Resident #3's face sheet, dated 04/15/26, reflected Resident #3 was admitted to the facility on [DATE]. She was a [AGE] year-old female diagnosed with fracture of unspecified part of neck of left femur (thigh bone), type 2 diabetes, syncope (fainting) and collapse, cardiomyopathies (inability to pump blood by heart muscles) , acute embolism(blockage of lung artery) and thrombosis(formation of blood clots in blood vessels) and pain.Record review of Resident #3's initial MDS dated [DATE] reflected a BIMS score of 14 indicating her cognition was intact.Record review of Resident #3's care plan dated 11/25/25 reflected that she had hypertension, cardiomyopathy, embolism, pain and relevant intervention was giving medications as ordered and monitoring /documenting side effects and effectivenessRecord review of Resident #3's physicians' orders revealed her medications scheduled at 8 a.m. included Aspirin 81 mg oral tablet, Carvedilol 3.125 mg oral tablet, Furosemide 40 mg oral tablet, Liquid Protein 30 ml (once a day), Lisinopril 2.5 mg oral tablet, Pantoprazole Sodium 40 mg delayed-release oral tablet, Calcium 500 + D oral tablet (500 mg calcium - 5 mcg vitamin D), and Acetaminophen 500 mg oral capsule.Record review of Resident #3's April 2026 MAR reflected that on 04/15/26 Resident#3's medications scheduled at 8:00am were administered at 11:20am.During an interview on 04/15/26 at 12:15pm Resident #3 stated Resident #3 received medications later than 9 a.m. She stated she was okay even though they were late, however, preferred to receive them as scheduled. She stated the delay occurred occasionally .Record review of Resident #4's face sheet dated 04/15/26 reflected, Resident #4 was admitted to the facility on [DATE]. He was a [AGE] year-old male diagnosed with cerebral infarction(stroke), obesity, dizziness and giddiness, epilepsy, nausea with vomiting, anxiety disorder, hypertension and , abdominal painRecord review of Resident #4's quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating his cognition was intact.Record review of Resident<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | #4's physicians' orders reflected that his medications scheduled at 8 a.m. and 9 a.m. included Docusate Sodium 100 mg oral tablet, Losartan Potassium 100 mg oral tablet, Isosorbide Mononitrate Extended Release 24-Hour 120 mg oral tablet, Nifedipine Extended Release 24-Hour 90 mg oral tablet, Pantoprazole Sodium 20 mg delayed-release oral tablet, Sertraline HCl 50 mg oral tablet, Spironolactone 25 mg oral tablet, Carvedilol 25 mg oral tablet, Levetiracetam 1000 mg oral tablet, and Hydralazine HCl 50 mg oral tablet. Record review of Resident #4's April 2026 MAR reflected that on 04/15/26 Resident#4's medications scheduled at 8:00am and 9:00am were administered at 10:20am.During an interview on 04/15/26 at 12:15pm Resident #4 stated he received medications everyday and had not noticed what time he received them. He stated, if medications were provided everyday, he was least concerned about the time. He stated the nurses were doing a good job with administering medications.Record review of Resident #5's face sheet dated 04/15/26 reflected Resident #5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. She was a [AGE] year-old female diagnosed with Parkinson's disease, type 2 diabetes, anxiety disorder, hypertension and pain.Record review of Resident #5's quarterly MDS dated [DATE] reflected a BIMS score of 03 indicating her cognition was severely impaired.Record review of Resident #5's care plan dated 02/14/24 reflected that she was taking medications for Depression, Anxiety, seizures, Parkinson's, Diabetes Mellitus, hypertension, Dementia and the relevant intervention was administering medications as ordered and monitoring/documenting for side effects and effectiveness.Record review of Resident #5's physicians' orders reflected that her medications scheduled at 8 a.m. included Amlodipine Besylate 5 mg oral tablet, Cholecalciferol 25 mcg tablet, Lisinopril 10 mg oral tablet, Multivitamin-Minerals oral tablet, Pantoprazole Sodium 40 mg delayed-release oral tablet, Amantadine HCl 100 mg oral capsule, Docusate Sodium 100 mg tablet, Ferrous Sulfate 325 mg oral tablet, Memantine HCl 10 mg oral tablet, Metoprolol Tartrate 25 mg oral tablet, MiraLAX 17 g packet, Risperidone 0.5 mg oral tablet, Valproic Acid oral solution, Venlafaxine HCl 75 mg (250 mg/5 ml), Vitamin C 500 mg oral tablet, and Clonazepam 1 mg disintegrating oral tablet.Record review of Resident #5's April 2026 MAR reflected that on 04/15/26 Resident#5's medications scheduled at 8:00am were administered at 11:07am.Resident #5 was unable to participate in an interview due to her cognitive capacity.Record review of Resident #6's face sheet, dated 04/15/26, reflected Resident #6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. She was an [AGE] year-old female diagnosed with cauda equina syndrome(compressed nerve roots at the bottom of the base of spine), malignant neoplasm (cancerous cell growth) , COPD (breathing difficulty), chronic pain syndrome, anxiety disorders, major depressive disorder.Record review of Resident #6's quarterly MDS dated [DATE] reflected a BIMS score of 06 indicating her cognition was severely impaired.Record review of Resident #6's care plan dated 03/26/26 reflected that resident had pain r/t disease process cauda equina syndrome , chronic pain and she was on anticoagulant, hyperlipidemia(high cholesterol) meds, antidepressant , also medications for dizziness, dementia, hypertension. She was also potential for Respiratory infections/distress, Hypoxia (low oxygen level), SOB, and cough related to DX of COPD. The relevant intervention was administering medication/puffers as ordered and monitoring for effectiveness and side effects.During a record review on 04/15/26 of Resident #6's physicians' orders as of 04/15/26, it was reflected that her medications scheduled at 8 a.m. included Amlodipine Besylate 10 mg oral tablet, Baclofen 10 mg oral tablet, Lidocaine 4% external patch, MiraLAX 17gram powder (per scoop), Sertraline HCl 50 mg oral tablet, Vitamin B12 100 mcg oral tablet, Vitamin D3 50 mcg oral capsule, Apixaban 5 mg oral tablet, Caltrate with D3, Docusate Sodium 100 mg oral tablet, Gabapentin 300 mg oral capsule, Hydrocodone-Acetaminophen 10-325 mg oral tablet, and Pepcid 20 mg oral tablet. Record review of Resident #6's April 2026 MAR reflected that on 04/15/26 Resident#6's medications scheduled at 8:00am were administered at 10:35am.Resident #6 was unable to participate in an interview due to her cognitive capacity.Record review of Resident #7's face sheet, dated 04/15/26, reflected Resident #7 was admitted to the facility on [DATE] . He was a [AGE] year-old male diagnosed with end stage (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | renal disease, shortness of breath, hypertension, bipolar disorder, diseases of liver, chronic kidney disease, restlessness and agitation, COPD and dementia.Record review of Resident #7's initial MDS dated [DATE] reflected a BIMS score of 06 indicating his cognition was severely impaired.Record review of Resident #7's care plan dated 10/18/25 reflected he had performance deficit r/t end stage renal disease, COPD, major Depressive and bipolar Disorder disorders, Respiratory infections/distress, Hypoxia, SOB, and cough related to COPD and Dementia. The relevant intervention was administering medications and monitoring effects and side effects.During a record review on 04/15/26 of Resident #7's physicians' orders as of 04/15/26, it was reflected that his medications scheduled at 8 a.m. included Amlodipine Besylate 5 mg oral tablet, Benztropine Mesylate 1 mg oral tablet, Divalproex Sodium 500 mg delayed-release oral tablet, Memantine HCl 5 mg oral tablet, and Olanzapine 10 mg oral tablet. Record review of Resident #7's April 2026 MAR reflected that on 04/15/26 Resident#7's medications scheduled at 8:00am were administered at 11:35am.Resident #7 was unable to participate in an interview due to his cognitive capacity.Observation and record review on 04/15/26 at 12:20pm, it was revealed that the morning medications of Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7 were administered by MA C.During an interview on 04/15/26 at 12:25 p.m., MA C stated that she worked at the facility as a PRN and started her shift at 6 a.m. on this day. She explained that she knew medications scheduled for 8 a.m. could be administered anytime between 7 a.m. and 9 a.m. She added, nevertheless there were quite a few residents who received their medications after 9 a.m., as she had other commitments and began administering medications later than expected. MA C said that administering medications at the correct time was a fundamental principle of medication administration and was essential to ensure the optimal therapeutic benefit.During an interview on 04/15/26 at 12:30 p.m., LVN A stated that she was the nurse in charge and that MA C was under her supervision. She explained that the hall was often short-staffed, which sometimes led to MAs and LVNs being assigned tasks other than medication administration. She added that this negatively affects the timely administration of medications. LVN A stated she was aware that medication administration should be completed within one hour of the scheduled time. She mentioned that, like on this day and many other days in the past, medications were not always administered on time due to the triaging of nursing tasks shared among LVNs and MAs .LVN A stated she had reported this issue to the previous DON and no actions taken. She added, hopefully the issue would be resolved as the facility had a new DON and administrator and they were aware of the situation.During an interview on 04/15/26 at 12:45 p.m., RN D stated that she worked in a different hall than MA C and was responsible for administering medications in her hall. She reported that residents with 8 a.m. medication schedules had their medications administered well before 9 a.m. RN D said that administering medications on time was important to maximize their benefits. She also noted that some medications were highly sensitive to timing, and it was the responsibility of the medication administrator to ensure they were given promptly.During an interview on 04/15/26 at 1:02 p.m., the NP stated that he did not have any comments regarding medication administration, as it was not part of his responsibilities. When asked whether a delay in administering medications could adversely affect residents, he responded that it depends on the medication and various other factors, and it was not necessarily an issue for all medications. He explained that medication scheduling was not managed by him, so he was unable to comment further. The NP emphasized that ensuring medications were administered on time was the facility's responsibility, and he did not play a role in that process.During an interview on 04/15/26 at 1:45 p.m., the AP stated that she was the primary attending physician for the residents at the facility. She said that some medications were time-sensitive, such as seizure and pain medications, and must be administered as scheduled without delay. She noted that currently, there were no residents on such medications at the facility, so delayed medication administration was not an immediate concern. The AP clarified that the NP works at the facility under her licensure, and both she and the NP were responsible for prescribing medications and determining doses and frequencies. She stated she visited the residents<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | at the facility regularly and observed and verified that none of the residents were negatively impacted with the delay in medication administered if it was happened.During an interview on 04/15/26 at 2:20 p.m., the MD stated that he had heard about the issue regarding the delay in administering morning medications on this day. He emphasized that administering medications on time was very important, regardless of the medication, as residents have different physical conditions and respond differently to treatments. He added that some medications were particularly sensitive and required careful timing. The MD stated that staff at the facility needed additional training and education in this area and affirmed his commitment in ensuring all residents receive quality care.During an interview on 04/15/26 at 12:55 p.m., the DON stated that she had started working at the facility one week prior and getting to know the issues and concerns in the nursing area. She explained that medication administration should follow the physician's orders and that administering medications at the correct time was a key aspect of medication administration principles. She noted that delays could result in next doses being given too early or too late, which might prevent residents from achieving the intended therapeutic effects. She further stated that, in some cases, delayed or mistimed medication administration could cause more harm than benefit. The DON mentioned that some medications were time-sensitive for certain residents and conditions, and the best practice was to follow the facility policy of administering medications within one hour before or after the scheduled time.Record review of the facility policy Administering Medications revised in April 2019 reflected : Medications are administered in a safe and timely manner and as prescribed .Medication administration times are determined by resident need and benefit , not staff convenience .Factors that are considered include:Enhancing optimal therapeutic effect of medication.Medications are administered within one hour of the prescribed time unless otherwise specified ( for example , before and after meal orders). |