

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 S Eldridge Pkwy 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident receives adequate supervision for 1 (Resident #1) of 1 reviewed for supervision. The facility failed to provide supervision for Resident #1 when he eloped from the facility on 6/7/2026 between the hours of 9:15 a.m. and 9:40 a.m., when Resident #1 was found by law enforcement outside the perimeter of the facility in the grass. This failure could place all residents at risk of experiencing pain, physical, emotional distress, and possible death. Record Review of Resident #1's chart reveals he was a [AGE] year-old male with a BIMS score of 6, admitted to the facility on [DATE]. Resident #1's primary diagnosis was dehydration. He was also diagnosed with unspecified mood disorder, bipolar, major depression, hyperlipidemia, post traumatic stress disorder, and unspecified dementia. He uses a wheelchair for mobility. He was impaired on both sides, lower extremity ([NAME], knee, ankle, foot) to have functional limitation in range of motion. He requires partial/moderate assistance to walk 10 feet. Record Review of Resident #1's Discharge summary dated [DATE] revealed he was admitted due to being found down with hypotensive (abnormally low blood pressure). Record Review of local temperature website revealed on 06/7/2026 the temperature was from 79 degrees to 84 degrees. Record Review of Resident #1's progress notes dated 6/7/2026 at 12:40 pm reveals Resident #1 was observed outside the back gate lying on the grass by a patrol police, who saw him, pulled over, and called 911. Record Review of Resident #1's progress notes dated 6/7/2026 at 4:35 p.m., Resident #1 returned to the facility, via stretcher by city ambulance. He was alert and oriented x 3. It also reveals the EMS staff stated that he is very alert and ok. Record Review of Resident #1's progress notes dated 6/8/2026 revealed Resident #1 had a BIM's evaluation and an elopement evaluation. Resident #1's BIM was 10. Resident #1's elopement evaluation revealed Resident #1 had low calcium identified per hospital evaluation over the weekend; calcium 8.5 on 6/6 BMP (8.4 on 6/2/ CMP), started calcium carbonate 1 hypocalcemia (low calcium levels in the blood), and continue calcium carbonate indefinitely. Record Review of, In-Service/Training Record of Attendance Sign In-Sheet, dated 06/8/2026 revealed the ADON educated the staff across all disciplines and shifts on topic of: Identification of Residents at risk of elopement, including those with dementia, confusion or wandering behaviors. Reviewing the importance of frequency monitoring, following care plans, maintaining door security measures and immediately reporting unaccounted Residents. Interviews were conducted on 6/18/2026 between 5:35 p.m. and 6:13 p.m. with multiple staff to verify the in-service had been conducted and to validate the staff understanding of the information presented to them. Members of staff was asked what was covered during their in-service. No concerns were found regarding their understanding of requirements, training materials, and expectations. Record Review of Resident #1 care plan dated 6/8/2026 reveals Resident #1 safety will be maintained throughout the next review date, he will not leave the facility unattended through the next review period, and for the facility to identify if there is a certain time of day wandering/elopement attempts occur. Record Review of Resident #1's medication list reveals he was complaint with his medications for the last 30 days. He was prescribed the following medications: Aspirin Oral Tablet Chewable 81 MG (Aspirin), (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated she will report neglect to her Administrator. In an interview on 6/7/2026 at 10:44 a.m. with LVN A, states she has been working at the facility for three months. She stated on 6/7/2026 at 9:55 a.m. the Receptionist came to her and asked her where was Resident #1. She stated she informed her that she did assist Resident #1 with his breakfast around 7:00 a.m. She stated she told her the last time she had seen Resident #1 was about 8:00 a.m., when he was walking without his wheelchair and she took him to his room. She stated she placed Resident #1 in his wheelchair and went to another room where her attention was needed. She stated the DON asked her before 10 a.m., where was Resident #1, she told her the last time she seen him was when she placed him in his wheelchair. She stated the DON told her he was outside with the Resident with the police. She stated the DON asked her how did Resident #1 get outside. She stated she went to the therapist office, asked PT A, to show her where exactly he put the Resident #1 after therapy. She stated PT A took her to the back of court where another Resident was sitting. She stated she looked around the facility looking for his wheelchair tracks because she found mud on his wheelchair. She then printed the face sheet for HPD and he was transporting the Resident to the hospital. She stated she notified the DON. She stated the Resident wife was already at the facility to visit Resident #1. She stated she informed Resident #1's wife of her findings and the wife went to the hospital. She stated she checks on the Residents every two hours, continuous all shift. She stated the facility ensure all Residents are accounted for and none or missing by doing her rounds. She stated the procedure for elopement was to search the inside and out of the building, brown code, notify the DON, Administrator, and follow their instructions. She stated neglect is when you don't care for your patient or know where they are. She stated she would report neglect to the Administrator. In an interview on 6/8/2026 at 11:29 a.m. with PT A he stated he has been working at the facility for three year, only on the weekends. He stated on 6/7/2026 at 8:45 a.m. he took the Resident #1 for therapy. He stated when he got to the Resident #1 he was sitting outside, in the front. He stated when he was taking the Resident back from therapy around 9:15 a.m. and 9:30 a.m. the Resident asked to go back outside. He stated he informed Resident #1 he could not put him in the front of the facility, he stated he would put him in the back covered patio. He stated it was normal practice to put the Residents on the back patio; there was another Resident also outside. He stated when he was doing a treatment with another Resident around 10 a.m., another therapist told him a Resident fell outside and a staff member asked for him. He stated when he arrived outside the EMS was loading Resident #1 into the EMS vehicle and he was found outside the gated area. He stated HPD got Resident #1's face sheet. He stated the protocol for elopement was every staff search inside and outside for the missing Resident and he does not know the administrative part of the procedure. He stated neglect was not providing the Resident with the necessary care to meet the Resident's needs. He stated he will report neglect to the administrator or the DON. In an interview on 6/8/2026 at 12:23 p.m. with Resident #1, he stated he does get enough food to eat, receives his medications, and was not being abused. He stated he could not breathe the other day and went down. He stated he was ok now. He was dressed, groomed, in lobby. In an interview on 6/8/2026 at 12:45 p.m. with the DON, she stated she has been working at the facility for two months. She stated on 6/7/2026 around 9:45 a.m. she was informed that the Resident was headed to the hospital for having low bp and was found outside the perimeter. She stated she came to the facility at 10:40 a.m. on 6/7/2026 and spoke with the Receptionist, she informed her that Resident #1 had walked to the reception desk wanting to go outside to get some fresh air. She stated the Receptionist allowed him outside in front but positioned his chair where she was able to see him from the desk. She stated before Resident #1 went to therapy he did refuse at first, but the Receptionist told him he was going to get him a popsicle and he decided to go. She stated therapy got a wheelchair and Resident #1 went to therapy. She stated after therapy, 911 comes into the facility to inform the staff that a Resident was outside. She stated the 911 told her that a Resident had fell outside with his wheelchair. She stated the nurse was informed and Resident #1 was taken to the hospital for low bp and a little shortness of breath for further evaluation. She stated when she arrived at 10:40 a.m. she talked with (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse and the Receptionist. She stated she talked with the nurse which stated she had talked to the Resident wife. She stated she talked to all the staff and began an investigation. She stated she was in communication with the nurse all day. She stated she informed the nurse to do the change in condition. She stated the Resident arrived back at the facility around 4:00 p.m. on 6/7/2026. She stated she asked the Receptionist and the physical therapy guy to write a statement. She states the staff checks on the Residents at least every two hours but could be more. She stated the nurse and CNA's do their rounds to ensure all Residents are accounted for and none or missing. She stated the protocol for elopement was to notify all staff to search inside and outside in multiple directions, call the local authority, family members and doctors. She stated an example of neglect was when Resident is incontinent and needs to be changed, develop bed sore. She states she reports neglect to the Administrator. She stated she does not think this resident has a history of elopement. She stated the interventions that are put into place to prevent future occurrences of elopement was to keep a closer eye and to ensure the other departments put the Resident back into nursing and not on the patio. When asked why Resident #1 was not supervised, she stated the Resident was not supervised, she stated she cannot answer it, she was asking the same question. She stated it was everyone responsibility, every member of staff which works with a Resident, to ensure that the Residents are supervised. She stated she understands the risk to the Resident if he was not supervised. She stated the risk to the Residents not being supervise was harm or hurting themselves. In an interview on 6/9/2026 at 8:42 a.m. with Patrol Officer with HPD, he stated he has been working with the agency for three and a half years. He stated on 6/7/2025 he was driving around in the morning and seen this older gentleman on the grass. He stated he stopped to ensure the gentlemen did not need any medical assistance. He stated Resident #1 informed him he was walking, got tired, and was just resting. He stated as he was speaking to him, he saw the Resident wheelchair laying a few feet away. He stated he asked Resident #1 if he lived at the facility behind him, he stated yes but was trying to move out. He stated he asked Resident #1 how he was feeling and he stated he was having a hard time breathing. He stated he asked Resident #1 if he could get up he stated he was a little weak, as he was laying on the ground. He stated he stayed with Resident #1 until medical arrived. He stated he asked EMS to get his vitals. He stated when medial arrived, he went inside to ask if Resident #1 lives at the facility. He stated the Receptionist identified that Resident #1 did live at the facility. He stated one of the gates at the facility was broken and it was probably how Resident #1 got out. He stated he talked to PT A which stated he left Resident #1 in the backyard and was the last time he had seen him. He stated PT A did not know he had gotten outside of the facility. He stated he advised the Receptionist that the gate needed to be fixed to prevent other Residents from getting outside of the facility. He stated Resident #1 was transported to the hospital. In an interview on 6/17/2026 at 4:27 pm with Maintenance Director, he states he has been working at the facility off and on for six years. He stated he was aware the gate was broken and had been waiting on the parts for four or five months. He stated the facility is looking for the parts. He stated the board and motors need repair and two boards need to be replace. He stated on 6/7/2026, after the Resident eloped, he went to the gate and closed it, because the Resident eloped out of an open gate. He states he does understand the risk to the Resident if the gate is not fixed or is open without being fixed. He stated the Risk is elopement or accident can occur. He states the facility is monitor the Residents leaving in and out of the building. He stated it is not protocol for Residents to be left alone outside on the back patio unsupervised. In an observation with DON, on 6/18/2026 at 2:40 p.m., the front gate was observed to be closed unable to open. The surveyor strongly shook the gate, it did not open. In an interview on 6/18/2026 at 5:05 p.m. with the DON, she stated the gate was closed on 6/7 and it is not able to be open. She stated she has educated her staff on the importance of bring Resident's back to the nurse after treatments, the elopement process, how to review the importance of frequency monitoring, following care plans, maintaining door security measures, and immediately reporting unaccounted Residents. Record Review of facility policy, Resident Rights, revised February 2021, read in part, (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed, ?be free from abuse, neglect, misappropriation of property, and exploitation.' Record Review of facility policy, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, read in part, revealed ?Residents have the rights to be free from abuse, neglect, misappropriation of resident property and exploration. ?		