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 05/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 S Eldridge Parkway Houston, TX 77077	

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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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one (Resident #93) of five residents reviewed for discharges. The facility failed to safely discharge Resident #93 when she was:1. discharged home on [DATE] by EMS via stretcher, incontinent of bowel and bladder, and unable to ambulate, with no support services from home health.2. discharged without an AMA (This occurs when a patient chooses to leave a hospital or healthcare facility before the treating physician recommends discharge), discharge notice, or notice to the Ombudsman per facility policy. During less than 24 hours after Resident #93 was discharged home she urinated and defecated on herself and was unable to change her clothing and clean her body. Resident #93 was subsequently hospitalized due to CHF exacerbation (a chronic condition where the heart does not pump blood as effectively as it should, causing fluid to back up in the lungs or body) and fluid overload less than 24 hours after discharge from the nursing facility.An IJ was identified on 05/05/2026. The IJ template was provided to the facility on [DATE] at 5:51 PM. While the IJ was removed on 05/08/2026, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.This failure could place residents at risk for serious injury, harm, and/or death due to lack of appropriate supervision.Findings included: Review of Resident #93's face sheet dated 05/05/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included acute on chronic diastolic (congestive) heart failure (a serious, often irreversible condition characterized by a stiff left ventricle failing to relax between beats), acute pulmonary edema (a life-threatening, sudden buildup of fluid in the lung's air sacs (alveoli), causing severe breathing difficulty, air hunger, rapid respiratory failure), other obesity due to excess calories (abnormal or excessive fat accumulation that risks health, caused by an imbalance between calorie intake and expenditure), and non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin(a skin-level chronic wound). Review of Resident #93's admission MDS assessment, dated 03/10/2026, reflected a BIMS score of 15, indicating no cognitive impairment. Section GG Functional abilities admission reflected: 1. Roll left and rights, the ability to roll lying on back left and right side and return to lying on back on the bed - substantial/maximal assistance - helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort2. Sit to lying, the ability to move from sitting on side of bed to lying flat on the bed - dependent- helper does all of the effort, resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity.3. Lying to sitting on side of bed- the ability to move from lying on the back to sitting on the side of the bed with no back support- dependent- helper does all of the effort, resident does none of the effort to complete the activity or, this distance of two or more helpers is required for the resident to complete the activity.4. Set to stand - the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed - Not attempted due to medical condition or safety concerns5. Chair bed to (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	chair transfer: the ability to transfer to and from a bed to a chair (or wheelchair) - not attempted due to medical condition or safety concerns.6. Toilet transfer - the ability to get on and off a toilet or commode - not attempted due to medical condition or safety concerns.7. Tub/shower transfer - the ability to Get in and out of a tower/tub - not attempted due to medical condition or safety concern8. Walk 10 feet: once standing - the ability to walk 10 feet in a room, corridor, or similar space - Not attempted due to medical condition or safety concerns. Urinary continence - always incontinent Bowel continence - always incontinent Height and Weight - 67 inches 396 pounds Number of venous and arterial ulcers (chronic, often painful, lower extremity wounds requiring distinct treatments based on the underlying circulation issue) - oneHigh Risk Drug Classes - diuretic (medications that help the kidneys remove excess salt (sodium) and water from the body through urine. They are primarily used to treat high blood pressure, heart failure, and swelling (edema) by reducing fluid volume in blood vessels)Special Treatments, procedures, and programs - oxygen therapy (a medical treatment providing supplemental oxygen to individuals with low blood oxygen levels (hypoxemia), enabling better organ function, reduced fatigue, and easier breathing)Therapy services - speech-language pathology and audiology services (provide comprehensive assessment, diagnosis, and treatment for communication, hearing, and swallowing disorders), occupational therapy (a healthcare profession that helps people across the lifespan participate in daily activities-or occupations-they want and need to do, especially after injury, illness, or disability), and physical therapy (focused on promoting, maintaining, or restoring health through physical interventions, such as exercise, massage, and education).Discharge planning - no active planning already occurring for resident to return to the community Review of Resident #93's care plan focus dated 03/24/2026 reflected Resident #93 had an ADL self-care performance deficit of Resident #93 was bedfast (confined to bed, typically due to illness, injury, or extreme age, often functioning as a synonym for bedridden) all or most of the time. Resident #93 had a care plan focus dated 03/24/2026 she wished to discharge home after rehabilitation. Resident #93 had a focus dated 03/24/2026 risk for falls related to incontinence, balance issues during transition, impaired range of motion bilaterial lower extremities, diuretic/antihypertensive (class of medications used to treat high blood pressure (hypertension) by reducing vascular resistance, slowing the heart rate, or reducing blood volume) and sleep-aid medications. Resident #93 had a focus dated 03/24/2026 of bowel and bladder incontinence. Resident #93 had a focus of venous/statis ulcer (slow-healing, shallow wounds-often on the lower leg or ankle-caused by poor circulation where blood pools due to damaged vein valves). Resident #93 had a focus dated 03/24/2026 of potential for altered respiratory status/difficulty breathing related to pulmonary edema and respiratory failure. Resident #93 had a focus dated 04/20/2026 of COPD (a progressive, treatable lung disease that causes obstructed airflow, making it hard to breathe). Record review of Physical Therapy Evaluation and Plan of Treatment dated 03/04/2026 reflected frequency 5 times/week 60 days daily certification period 04/04/2026 through 05/02/2026. Objective progress short-term goals:1. Resident #93 will increase bed mobility to CGA (level of assistance where the therapist maintains physical contact (usually light hands or holding a gait belt) with the patient during mobility activities to ensure safety and balance. It indicates a high fall risk, requiring more support than supervision but less than minimal assistance) using bedrail. 2. Resident #93 will increase BLE strength 2+/5 (a muscle is performing slightly above a poor level, but it is still quite weak) in order to return to prior level of functioning abilities and decrease level of assistance from caregivers 3. Resident #93 will increase dynamic level of sitting balance to fair in order to participate in EOB activities 4. Resident #93 will perform standing transfers with substantial/maximal assistance in order to return to prior level functioning abilities Bed Mobility = Dependent; Transfers = not attempted due to medical conditions or safety concerns (recommended [mechanical] lift for safety.); assistive device during transfers = Wheelchair. Review of Resident #93's orders reflected an MD order dated 03/25/2026 for weekly weights: Monday, Wednesday, and Friday. Record review of Resident #93's weights reflected two weights taken by mechanical lift. One on Wednesday 03/04/2026: 396 pounds (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reflected patient will be discharging tomorrow between 2:30 PM and 3:00 PM. Record review nursing progress note dated 05/02/2026 by LVN D reflected Resident discharged home via stretcher, left alert and oriented X4 (patient is fully alert and aware of four key spheres: person (who they are), place (where they are), time (date/time), and situation (why they are there, no respiratory distress noted, medication provided and left with all belongings. Record review of HH Patient Information Sheet for Resident #93 reflected Coordination Notes dated 04/30/2026 please notify facility of decline of HH referral due to insurance denial and 05/01/2026 called facility for social worker informing them of decline of referral for HH at this time. During an interview on 05/05/2026 at 9:15 AM with Resident #93's FM #1 she said Resident #93 told her Resident #93 was going home and FM #1 said she was concerned about Resident #93 being able to take care of herself at home. FM #1 said Resident #93 could not walk. FM #1 said FM #2 was not a care giver for Resident #93. FM #1 said she attempted several times to speak to a social worker at the facility, and no one answered the phone. FM #1 said she finally spoke with the facility receptionist and left a message for the SW to call FM #1, but FM #1 did not receive a return call from a SW. FM #1 said she kept asking Resident #93 who was going to take care of her and Resident #93 said she did not know. FM #1 asked Resident #93 why they were sending her home and Resident #93 said she no longer had any insurance and was free to go home at any time. FM #1 said she heard from FM #2 that Resident #93 arrived home at approximately midnight on Saturday 05/02/2026 and the following morning, on Sunday 05/03/2026, Resident #93 was wearing the same clothing had on when she left the facility and had urinated and defecated and was unable to clean herself. FM #1 said Resident #93 had a friend come to her home and remove Resident #93's soiled clothing and clean her. FM #1 said her friends told Resident #93 she needed to call EMS. During an interview on 05/05/2026 at 10:27 AM with Resident #93's FM #2 he said Resident #93 had been in the hospital since Sunday, 05/03/2026. FM #2 said the facility wanted Resident #93 to leave but he was not sure why they wanted her to leave. He said Resident #93 did not challenge leaving because there was nothing else Resident #93 could do. FM #2 thought the person who wanted her to leave was the SWA. FM #2 said that Resident #93 said she did not feel like she was physically able to take care of herself. FM #2 said Resident #93 could not walk and could not get to the bathroom by herself. FM #2 said she came home then went back to the hospital the next day. FM #2 said Resident #93 was swelling up due to cardiac issues. On 05/05/2026 at 10:45 AM surveyor attempted to contact NP by phone and received a message that NP was out of the office until 05/10/2026. During an interview on 05/05/2026 at 11:26 AM the PTA said he worked with Resident #93, and she had trouble breathing and was a mechanical lift only resident. PTA said SOB was her main issue. PTA said on a good day, using a walker, Resident #93 could take a few steps forward and a few steps backward. PTA A said even rolling Resident #93 on her side was hard and Resident #93 had SOP because of fluid related to CHF. PTA said Resident #93 was not involved in her discharge process, but she was safe to go home with help. PTA said Resident #93 would need some kind of assistance throughout the day to clean her up. PTA said she could sit on the side of the bed. PTA said Resident #93 wanted to go home. During an interview on 05/05/2026 at 12:15 PM with a HH representative from the HH agency listed on Resident #93's 05/01/2026 discharge summary said Resident #93 was not approved by them for HH services. The HH representative said Resident #93's payment for HH was declined because of lack of insurance coverage. During an interview on 05/05/2026 at 12:31 PM with the ADM she said she began working at the facility on 04/17/2026. The ADM said Resident #93 was discharged from the facility on 05/02/2026 and there was no discharge notice and no notice to the ombudsman. During an interview on 05/05/2026 at 1:08 PM with LVN UM she said Resident #93 was discharged from the facility because her insurance was rejected. LVN UM said Resident #93 was she was incontinent and left on a stretcher. LVN UM said she assumed Resident #93 had family to take care of her. During an interview on 05/05/2026 at 1:15 PM with the BOM she said Resident #93 was private insurance and the facility did not follow Medicaid guidelines because Resident #93 had private insurance. She said the facility cannot discharge residents unless they have a safe discharge. The BOM said they did not (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assist Resident #93 with applying for Medicare because Resident #93 did not request Medicaid and Resident #93 was planning to go home. During an interview on 05/05/2026 at 1:26 PM with the SWA he said Resident #93 received a notice of Medicare non-coverage and Resident #93 lost her appeal and he asked Resident #93 if she wanted to go home or go to another facility. Resident #93 said she wanted to go home. The SWA said Resident #93 wanted to appeal the denial of her coverage because she wanted to walk but when her appeal was denied, she had a hospital bed, a wheelchair, and a combination toilet and shower chair for her home. The SWA said he had conversations with Resident #93 stating a skilled nursing home was highly recommended and Resident #93 said she did not want to go to skilled nursing. He said if you cannot walk, a skilled nursing home was recommended. Resident #93 said she had a family member who did not live too far away and he could come check on her and her. The SWA said that between family and HH that would be enough care for Resident #93. The SWA said if Resident #93 did not want to go to a skilled nursing facility, he could not force her. The SWA said he was of course concerned about her falling or hurting herself. The SWA said there was a HH representative whom he touched base with prior to Resident #93 leaving who said Resident #93 would get HH services. The SWA said the representative with HH said everything was fine. The SWA said he did contact Adult Protective Service to make a visit to Resident #93's home. He said Resident #93 was not discharged until her hospital bed, wheelchair, and combination shower chair and bedside toilet were delivered. The SWA said Resident #93 told him she had oxygen at her home already and if Resident #93 needed additional oxygen, the HH agency would provide it. The SWA said the beginning of her being discharged started with Resident #93's insurance company declining her medical coverage for her stay at the facility. The SWA said he did not offer her a Medicaid application. The SWA said Resident #93 paid for her hospital bed, her wheelchair, and combination toilet and shower chair herself. The SWA said as far as he was concerned Resident #93 was fine because she had all her equipment and HH. The SWA said the facility did not have her sign the AMA because the discharge was insurance driven. He said he could have offered her a Medicaid application, but it was too late and bill would have added up for her to have private pay. The SWA said he was the person who handled Resident #93's discharge. The SWA said the insurance company made Resident #93 leave because the insurance company did not approve Resident #93's appeal. During an interview on 05/05/2026 at 1:46 PM the MD said Resident #93 was quite challenging because Resident #93 had issues with CHF and she did not watch her diet. She said her CHF was affecting her breathing and her fluid levels. The MD said Resident #93 was not getting much better and was not making huge strides in therapy. The MD said she recommended long term care. The MD said Resident #93 was taking care of a family member and was insistent on going home. The MD said in no way did she recommend that Resident #93 going home was safe given Resident #93's health issues. The MD said the SW said he would discuss with Resident #93 not going home. The MD said the facility did not have Resident #93 sign an AMA because they have had trouble with getting HH services for residents after a resident has signed an AMA. During an interview on 05/05/2026 at 2:01 PM with Resident #93's FM #2 he said it was very hard to reach the SW when he called the facility. He said the facility had a high turnover of employees and there were 2 or 3 SWs. FM#2 said he left several messages for a SW to call him back and he did not receive a return call. FM #2 said Resident #93 told him she did not want to leave the facility because she wanted to be able to walk before she left. FM #2 said when Resident #93 went home, she had a bed, a walker, and a commode. FM #2 said to his knowledge she had no oxygen at her home. FM #2 said the oxygen that she did receive was given to her from the EMS personnel. FM #2 said he was not going to take care of Resident #93. FM #2 said he was at Resident #93's home when Resident #93 came home. FM #2 said Resident #93 was supposed to have someone in place to give her wound care and change her brief. FM #2 said to his knowledge, nothing was in place and Resident #93 did not have a nebulizer for breathing treatments. FM #2 said he had a full-time job and was not a caregiver for Resident #93. FM #2 said he came over to Resident #93's home on Sunday, 05/03/2026 about 9:30 AM and Resident #93 had urinated and pooped on herself. FM #2 said Resident (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 05/08/2026 at 2:23 PM with the RNC she said an AMA would be necessary if the patient acknowledged and were informed by the facility that it was not safe for them to discharge from the facility. The RNC said if a resident just wanted to leave and the patient did not have a medical release that would be going against medical advice. Record review of facility Transfer or Discharge, Facility-Initiated dated October 2022 reflected once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.Policy Interpretation and Implementation1. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless:1. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility. 2. the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility. 1. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. 2. For a resident who becomes eligible for Medicaid after admission to a facility, the facility will charge a resident only allowable charge under Medicaid. Facility-Initiated Transfer or Discharge Facility-initiated transfer or discharge means a transfer or discharge which the resident objects to or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.In some cases, residents are admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation program, they communicate that they are not ready to leave the facility. In these situations, if the facility proceeds with discharge, it is considered a facility-initiated discharge.Non-Payment as a Basis for DischargeNon-payment for a stay in the facility occurs when the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility and also may apply:1. when the resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or2. after the third-party payer (including Medicare or Medicaid) denied the claim and the resident refused to pay for his/her stay.2. The facility will notify the resident of their change in payment status, and ensure the resident has the necessary assistance to submit any third-party paperwork.3. If the resident continues to need long-term care services, the facility, under the requirements above, will offer the resident the ability to remain, which may include:1. offering the resident the option to remain in the facility by paying privately for a bed;2. providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with S483.10(g)(13), F579, with an explanation that:1. if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and2. if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.4. If a resident's initial Medicaid application is denied but appealed, this suspends non-payment status while the appeal is pending. An Immediate Jeopardy was identified on 05/05/2026 and the Administrator was notified of the Immediate Jeopardy on 05/05/2026 at 5:51 PM and was given a copy of the IJ template and a Plan of Removal (POR) was requested. The facility's POR for Immediate Jeopardy was accepted on 05/07/2026 at 8:30 AM and reflected the following: PLAN OF REMOVAL: Facility Name:Date: 5/5/26The facility failed to ensure a safe discharge for Resident #93 on 05/02/26, which resulted in Resident #1 requiring hospitalization due to CHF exacerbation on 05/03/26. Resident #1 was not discharged with home health in place and confirmed to have all necessary DME's in place prior to discharge. Immediate Action: -The facility immediately contacted resident #1 to inform her that the facility will accept the readmission immediately, or as soon as the hospital deems them ready for transport. Attempted to leave a VM for this resident to return facility's call. Text message sent to resident's personal cell

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 4 of 15 residents (Resident #20, Resident #59, Resident #64 and Resident #102) reviewed for resident rights. The facility failed to ensure CNA B knocked on Resident #20, and Resident #59 and Resident #64's doors when going into the residents' rooms. The facility failed to ensure Resident #102's catheter had privacy cover on it. These failures could place residents at risk of poor self-esteem and feeling like their privacy was being invaded.Findings include: 1. Record review of Resident #20's face sheet, dated 05/05/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20 had diagnoses which included metabolic encephalopathy (brain disease), hypertensive chronic kidney disease (damage to kidneys due to chronic high blood pressure), hyperlipidemia (high cholesterol), hypertension (high blood pressure), weakness, and unsteadiness on feet. Record review of Resident #20's admission MDS assessment, dated 02/23/2026, revealed Resident #20 had a BIMS score of 08, which indicated moderate impairment. Record review of Resident #20's care plan dated 04/17/2026 did not reflect anything about privacy or knocking on the resident's door. During an interview with Resident #20 on 05/05/2026 at 8:09a.m., she said the staff never knocked on the door. She said she would prefer for the staff to knock on the door, especially if the door was closed. 2. Record review of Resident #59's admission sheet, dated 05/05/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #59 had diagnoses which included heart failure, respiratory failure, muscle weakness, gastroesophageal reflux disease without esophagitis (reflux), hypertension (high blood pressure), and sepsis (a life-threatening complication of an infection). Record review of Resident #59's admission MDS assessment, dated 05/06/2026, revealed Resident #59 had a BIMS score of 10, which indicated moderate impairment. Record review of Resident #59's care plan dated 04/17/2026 did not reflect anything about privacy or knocking on the resident's door. During an interview with Resident #59 on 05/05/2026 at 7:49a.m., she said staff do not knock on the door. She said staff were supposed to knock on the door. She said it would be nice if the staff knocked on the door. She said if she was being changed staff would just walk inShe said staff just were not thinking before they entered the room. 3. Record review of Resident #64's face sheet, dated 05/05/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #64 had diagnoses which included protein-calorie malnutrition (inadequate intake of both protein and calories), sepsis (a life-threatening complication of an infection), hypertension (high blood pressure), kidney failure, and alcohol abuse. Record review of Resident #64's admission MDS assessment, dated 04/20/2026, revealed Resident #64 had a BIMS score of 09, which indicated moderate impairment. Record review of Resident #64's care plan dated 04/17/2026 did not reflect anything about privacy or knocking on the resident's door. During an interview with Resident #64 on 05/05/2026 at 8:02a.m., he said staff just walk into his room all the time. He said he would like for staff to knock all the time. He said he got irritated when staff just walked into his room. 4. Record review of Resident #102's face sheet, dated 05/05/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #102 had diagnoses which included hearing loss, pain, hypertension (high blood pressure), hypertension (high blood pressure), cognitive communication deficit (problems with communication), fracture of on rib and pain. Record review of Resident #102's admission MDS assessment, dated 05/06/2026, revealed Resident #102 had a BIMS score of 99, which indicated unable to complete the interview. Record review of Resident #102's care plan dated 05/01/2026 did not reflect anything about the catheter. Observation of Breakfast Hall meal tray's being passed on 05/05/2026 at 7:17a.m., revealed CNA B did not knock on Resident #59's door before (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entering the room. Observation of Breakfast Hall meal tray's being passed on 05/05/2026 at 7:25a.m., revealed CNA B did not knock on Resident #64's door before entering the room. Observation of Breakfast Hall meal tray's being passed on 05/05/2026 at 7:28a.m., revealed CNA B did not knock on Resident #20's door before entering the room.Observations on 05/05/26 at 08:53 AM and 12:48p.m., revealed Resident #102 in bed, asleep and not available for interview. A urinary bag hanging from the side, bottom of Resident #102's bed that had no privacy cover. Urine was exposed and the bag contained urine that was dark orange in color. The urine could be seen from the hallway. During an interview with CNA B on 05/05/2026 at 11:32 a.m., revealed she had been trained on resident rights. She said the policy was staff were to knock on the door before entering. She said knocking was for the resident's privacy. She said all staff were responsible for knocking. She said residents may get upset if staff do not knock. She said the nurses monitored to ensure staff are knocking. She said the nurses monitored by observation. She said she was nervous because the surveyor was there watching her. During an interview with MA F on 05/05/26 at 12:52 p.m., she stated urinary bags were supposed to be hung with a clean privacy bag to cover that was dated. She stated exposed urine affected residents' self-worth and dignity. She stated she did not notice Resident #102's bag as she was a new admit. She stated policy, at any facility, was for a privacy bag to be utilized. She stated she believed the DON would be ultimately responsible for ensuring privacy bags were available and used.During an interview with CNA A on 05/05/26 at 12:58 p.m., he stated privacy bags were supposed to be cleaned and covered, according to facility policy. He stated was over supplies and had to responsibility of making sure they were utilized. He stated the nurse was to be notified in the event the privacy bags were lacking. He stated he had just peeked in Resident #102's room and did not actually go inside because she was asleep. He stated he did not realize she had a urinary bag. He stated the lack of privacy could cause residents shame.During an interview with Central Supply on 05/05/26 at 02:25 p.m., she stated she was responsible for resident supplies. She stated privacy bags came with urinary bags she stated she was unaware Resident #102 did not have a privacy bag. She stated staff were supposed to on into the supply closet and get one if they noticed an exposed urinary bag. She stated when Resident #102 was admitted on [DATE] she had a privacy bag with her urinary bag. She stated facility policy stated privacy covers were a requirement for all urinary bags. She stated the lack of privacy on the urinary bag could have a negative effect on residents in that could be a dignity issue. During an interview with the DON on 05/07/2026 at 5:08p.m., revealed she had been trained on resident right. She said the policy was staff were to knock and wait for the resident to tell them to enter. She said all staff should knock on the resident's door. She said a resident may feel disrespected if staff did not knock. She said the management and charge nurses should be monitoring. She said managementRecord review of the Dignity Policy dated 02/2021 revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 3 of 3 residents (Resident #27, Resident #73, and #85) reviewed for activities. The facility failed to provide Resident #27 with activities he was able to do, failed to offer Resident #73 activities, and failed to provide Resident #85 activities that interested him. This failure could place residents at risk for boredom, depression, and diminished quality of life. Findings include: 1.Review of Resident #27's face sheet dated 05/07/2026 reflected an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included blindness right eye category 5 (total, irreversible blindness, often defined as no light perception) and blindness left eye category 4 (represents a severe visual impairment where the best corrected visual acuity in the eye is worse than 20/200, defined as having only ability to see light rathethan form). Review of Resident #27's Resident Assessment and Care Screening MDS assessment, dated 04/07/2026, reflected a BIMS score of 6, indicating severe cognitive impairment. Section B - Hearing, Speech, and Vision reflected vision highly impaired - sees large print, but not regular print in newspaper/books. Section F - preferences for customary routine activities - F0500 how important is it to you to have books, newspapers, and magazines to read - very important. Review of Resident #27's care plan focus dated 04/16/2026 reflected visual impairment/legally bind related to glaucoma (a group of eye diseases that damage the optic nerve-often due to high eye pressure-leading to permanent, irreversible vision loss or blindness) and eye infection/eye pressure and no focus on Resident #27's care plan for activities. During an interview on 05/08/2026 at 11:49 AM with Resident #27 he said he got bored on the weekends because the facility did not have enough activities especially because they did not have activities to accommodate the blind. Resident #27 said a staff member did take him to play bingo, but he was not provided with a large print bingo card, so he was unable to participate. 2.Review of Resident #73's face sheet dated 05/08/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included displaced comminuted fracture of shaft of right femur (a severe injury where the thighbone is broken into three or more pieces and has shifted out of alignment), atrial fibrillation (the most common treated heart arrhythmia, characterized by a rapid, chaotic, and irregular heartbeat originating in the heart's upper chambers (atria)), and morbid obesity due to excess calories (occurs when calorie consumption consistently exceeds energy expenditure). Review of Resident #73's Resident Assessment and Care Screening MDS assessment, dated 04/30/2026, reflected a BIMS score of 15 indicating no cognitive impairment. Review of Resident #73's baseline care plan dated 04/23/2026 reflected no focus care plan for activities. During an interview on 05/08/2026 12:22 pm with Resident #73 she said she was not asked about activities she would like to do when she was admitted to the facility. She said the first time she received an activity calendar was on 05/08/2026. Resident #73 said no one had come to her room and offered her any activities, like coloring materials or puzzles, she could do in her room. Resident #73 said she was bored. She said when someone came to her room, she talked their ear off because she was so bored. 3.Review of Resident #85's face sheet dated 05/08/2026 reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included central cord syndrome at C3 level of cervical spinal cord (a severe, incomplete cervical spinal cord injury characterized by disproportionately greater motor impairment in the arms/hands than in the legs, often caused by hyperextension injuries in individuals with pre-existing cervical spondylosis), occlusion and stenosis of unspecified meddle cerebral artery (narrowing (stenosis) or blockage (occlusion) of the brain's largest vessel, often due to atherosclerosis or blood clots), and cerebral aneurysm, no ruptured (a (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weak, bulging spot in a brain artery that has not yet leaked or burst). Review of Resident #85's quarterly MDS assessment, dated 03/22/2026, reflected a BIMS score of 9 indicating moderate cognitive impairment. Review of Resident #85's care plan reflected a focus dated 06/19/2024 Resident #85 was dependent on staff for activities. Cognitive stimulation, social interaction related to physical limitations. During an interview on 05/08/2026 at 1:42 PM with Resident #85 he said the facility had asked him what activities he would like. He said they used to play a toss game outside, but they cannot currently locate the game. Resident #85 said they used to have popcorn during movies but have been told they can no longer have popcorn and he does not know why. He said he was currently bored. During an interview on 05/07/2026 at 10:27 AM with the acting AD she said she had been doing the activities at the facility for about two weeks after the previous activity coordinator left. The acting AD stated activities do not start on time which was why the 10:00 AM scheduled activity for aromatherapy and manicures did not occur at that time. She said at 10:00 AM she was going to the residents' room and handed out the amended activities calendar. The acting AD said there was not a lot of involvement in activities because a lot of residents did not have the physical ability to come to the activities. The acting AD said the same 4 or 5 people show up to all the activities. The acting AD said she felt like there were enough activities for the residents. She said she did not have any training in being an activities director and she was not offered any direction from anyone at the facility with the activities. She said she got a lot of help from HR. She said the activities might start on time or might not start on time it just depended, but she had an activity every day. She felt like there were not enough people who were able to participate in activities because of their physical issues or might not have stamina. She said she had a lot of residents who said they were not up to it. During an interview on 05/08/2026 at 10:50 AM with the ADM she said residents should be asked about their activity preferences. She said the AD should be the person to obtain that information from the residents somewhere during the initial phase of the resident's admission. The ADM said the AD should meet with the residents to discuss activities the resident might like. She said she was not sure what the negative effect would be if residents were not offered activities they liked. During an interview on 05/08/2026 at 1:50 PM with the VPC she said she thought it was important to offer residents activities. The VPC said activities were important because they helped with residents' social wellbeing and maybe kept them from being bored. Record review of the facility Activity Programs policy dated June 2018 reflected Activity programs are designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Policy Interpretation and Implementation - 1. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction.2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities.4. Activities are considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive, or emotional health.5. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs.6. Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup, and critique of the programs.7. Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident. Activity programs include activities that promote - self-esteem; comfort; pleasure; education; creativity; success; and independence.8. Activities are not necessarily limited to formal activities being provided only by activities staff. Other facility staff, volunteers, visitors, residents, and family members may also provide the activities.9. All activities are documented in the resident's medical record.10. Activities participation for each resident is approved by the attending physician based on information in the resident's comprehensive assessment.11. Scheduled activities are posted on the resident bulletin board. Activity schedules are also provided (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	individually to residents who cannot access the bulletin board (e.g., bed bound or visually impaired residents).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure storage of drugs and biologicals used in the facility for 2 of 8 medication carts observed for medication storage and labeling. The facility failed to ensure loose medications were removed from the medication carts. This failure could place residents who received medications at risk of not receiving the intended therapeutic effect of the medication. This failure could lead to unsafe and unsecure storage of all medication to reduce, minimize loss, or diversions for all medications.Findings included: Observation on 05/07/2026 at 11:07 a.m., reflected RN B had five loose pills in her medication cart. In an interview on 05/07/2026 at 11:08 a.m., RN B reported the nurses, unit managers, DON, and pharmacy check the medication carts. She reported that the pharmacy checks the medication carts every month. She reported she notified DON and disposed of the loose medications in the sharp's container [specialized, puncture-resistant receptacle used to safely dispose of medical instruments that can cut or puncture the skin, such as needles and syringes]. Observation on 05/07/2026 at 11:30 a.m., reflected RN A had one loose pill in her medication cart. She disposed of the loose pill in the trash can. In an interview on 05/07/2026 at RN A stated, loose pills in the medication cart could cause confusion. She reported that managers and RNs check the medication carts every week for loose medications. Observation on 05/07/2026 at 11:56 a.m., reflected LVN D's medication cart had 1 small, round, blue pill which was loose in her medication cart. There was a bottle of Active Liquid Protein that did not have an open date written on it. In an interview on 05/07/2026 at 12:00 pm, LVN D reported staff will not be able to identify a medication if it is loose in the medication cart. She reported she disposed of loose pills in the pill incinerator. She denied they dispose of loose pills in the sharps container. In an interview on 05/07/2026 at 5:15 pm, DON stated nurses should always clean their medication cart after each shift. She stated, everybody should be responsible for their carts. She reported management checks the medication carts 3-4 times a week. She stated, it is an infection control issue to have loose pills in the medication carts. She reported they expect staff to write the open date on medications. She stated, I am not sure if [Active Liquid protein] is good for 2 weeks. She stated, there is a rationale for writing the open date on medications, but I don't know what the rationale is for writing the open date on Active Liquid protein. In an interview on 05/08/2026 at 2:13 pm, ADM reported staff should check their medication carts to ensure there are not loose pills in their medication carts. She stated, the nurse manager is responsible for rounding and making sure that happens. Review of the facility's administering medications policy with a revision date of 04/2019 revealed medications are administered in a safe and timely manner, and as prescribed. 12. The expiration/beyond use date on the medication label is checked prior to administering [sic]. When opening a multi-dose container, the date opened is recorded on the container.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 serve food and drink that was palatable, attractive, and a safe and appetizing temperature for residents for one (1) of one (1) kitchen reviewed for food and nutrition services. The facility failed to serve warm food to residents. These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life.Findings included: During an interview on 05/05/2026 at 7:01 a.m. Resident #63 stated the food was always cold when he ate in his room. Resident #63 stated that he had to ask staff to warm up his food and bring it back because he could not eat cold food because it did not taste good. During an interview on 05/05/2026 at 7:32 a.m. Resident #91 stated the food was not good and it was served cold. During an observation and interview on 05/05/2026 at 7:35 a.m. and 8:28 a.m. Resident #75 was overhead yelling from her room, where is my breakfast? Can someone bring me my breakfast? My plate is cold. Staff reheated plate and returned it. Resident #75 stated every time her food was brought to her room, the food was cold. Resident #75 stated that staff reheated her plate, and the food came back hard. During an interview on 05/05/2026 at 8:19 a.m. Resident #103 stated that his food usually arrived cold. During an interview on 05/06/2026 at 10:18 a.m. Resident #19 stated the food was always cold. In an observation on 05/06/2026 at 12:18 p.m., the State Survey Team participated in the sampling of the Lunch Meal which included one regular test tray. The lunch tray consisted of beans, spinach, and a meat patty that appeared to be turkey with a gravy on top. When tasted by two state surveyors, all the food on test tray was cold. In an observation on 05/07/2026 at 12:30 p.m., the State Survey Team participated in the sampling of the Lunch Meal which included one regular test tray. The lunch tray consisted of a Philly cheesesteak sandwich, mashed potatoes, red potatoes, green beans and mixed vegetables, a tossed salad, and cheesecake. When tasted by two state surveyors, the green beans and mixed vegetable on the test tray were cold. During an interview on 05/07/2026 at 1:15 p.m., the DA stated she was responsible for putting meal trays on the carts to go to the floors and the food was hot when it came out of the kitchen. The DA had heard from some staff that the food was cold. During an interview on 05/07/2026 at 1:22 p.m., the RD stated that she came to the facility once a week. The RD was aware of some complaints about the food being cold, it had not been often enough for her to do any type of in-service training. The RD stated her expectation would be that hot foods would be served to the residents according to standardized guidelines of 120 . If food was served cold, residents were less likely to eat and then input would be down, which could lead to unexpected weight loss. During an interview on 05/07/2026 at 1:40 p.m. the dietary cook stated he was aware of residents complaining that their food was cold. When that happens, it usually depended on which staff members were working on the floor because some C.N.A work faster than others. His expectation would be that hot food was served hot around 165 degrees, otherwise, it could make residents sick. During confidential resident interviews, nine residents stated that the food was not warm when they received it. During an interview on 05/07/2026 at 6:16 p.m. the ADM stated that her expectation was food would be delivered to residents at a safe and warm temperature according to policy to decrease the risk of infection, bacteria, or contamination. The ADM was unaware of any residents complaining about cold food. Record review of the facility policy titled, Food and Nutrition Services revised October 2017, reflected, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. Record review of the facility policy titled, Food Preparation and Service revised November 2022, reflected, The danger zone for food temperatures is above 41 F and below 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Proper hot and cold temperatures are maintained during food distribution and service.

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 05/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 S Eldridge Parkway Houston, TX 77077	

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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 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 (Resident #7, Resident #32, Resident #95 and Resident #101) of 7 residents reviewed for infection control. ˆ The facility failed to ensure CNA A wore PPE as required for Resident # 32, who was on enhanced barrier precautions. The facility failed to ensure Central Supply wore PPE as required for Resident # 95, who was on enhanced barrier precautions. The facility failed to ensure LVN D followed infection control and prevention by not cleaning the glucometer prior to and after checking Resident #101's blood sugar, and by not cleaning the insulin vial prior to withdrawing a dose. The facility failed to ensure LVN D followed the hand hygiene policy by not properly performing hand hygiene while administering insulin to Resident #101. The facility failed to ensure RN A followed infection control and prevention by not cleaning the glucometer and basket, in which she stored the glucometer supplies, after checking Resident #7's blood sugar and prior to putting it into the medication cart. These failures could place residents at risk for cross contamination and the spread of infection.Findings included: 1. Review of Resident #7's face sheet dated 05/06/2026 revealed a [AGE] year-old female initially admitted to the facility on [DATE]. She re-entered the facility on 04/04/2026 with the following diagnoses: Type 2 diabetes mellitus with hyperglycemia;.Review of Resident #7's MDS assessment dated [DATE] revealed she had a BIMS score of 4 which indicated severely impaired cognition. During an Observation on 05/07/2026 at 11:15a.m., reflected RN A used a small amount of hand sanitizer and rubbed it on the palms of her hands for a few seconds. She checked Resident #7's blood sugar, she failed to clean the glucometer prior to putting it in the medication cart. She used a purple basket to store the glucometer supplies when she entered Resident #7's room and placed it on Resident #7's bedside table. She failed to clean the purple basket prior to putting it in the medication cart.During an interview on 05/07/2026 at 11:17a.m., RN A reported they do sanitize the glucometer before and after each use. She stated, I don't have my sanitizer on the medication cart. She reported not cleaning the glucometer before and after each use can put the resident at risk of getting an infection. She reported she should sanitize her hands with hand sanitizer for at least 20 seconds since she did not wash her hands with soap and water. She reported not sanitizing her hands for 20 seconds could transmit infection. 2. Record review of Resident #32's face sheet, dated 05/07/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included nontraumatic intracerebral hemorrhage (a severe stroke involving bleeding directly into the brain), person injured in a motor-vehicle accident, nontraumatic subarachnoid hemorrhage (spontaneous bleeding in the fluid filled space between the brain and the skull), fractured rib, fractured lower leg, and fractured spine. Record review of Resident #32's admission MDS assessment, dated 04/21/2026, revealed Resident #32 had a BIMS score of 01, which indicated severe cognitive impairment. Record review of Resident #32's care plan dated 05/04/2026 [Resident #32] has actual impairment to skin integrity related to: Right hip closed surgical wound, Trauma to left lower abdominal quadrant, closed midline abdominal surgical wound, trauma to right lower abdominal quadrant. Interventions were use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Further review revealed the care plan did address enhanced barrier precautions. During an observation with Resident #32 on 05/05/2026 at 9:14a.m., Resident #32's room door had an enhanced barrier precautions sign on it. The PPE station right outside Resident #32's door was equipped with only 1 glove and 1 gown. CNA A assisted with removing a brace from her right arm. CNA A did not utilize PPE of any type. During an interview with CNA A on 05/05/2026 at 9:18a.m., he said he had been with the facility nearly 14 years. He said any time there was a PPE station, staff was supposed to utilize the PPE. He said the (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PPE equipment was set up for residents who had a catheter or IV and was not necessarily for conditions. He said the expectation was to put the PPE on any time there was PPE outside the resident's door. He said nurses would usually tell the CNAs which resident had what condition. He said if he did not adequately utilize PPE he could transfer something to another resident, he said he did not know if there was a policy in place. He said his most recent in-service training on infection control was about a couple of weeks ago. He said the DON was responsible for ensuring infection control policies were adhered to 3. Record review of Resident #95's admission sheet, dated 05/07/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #95 had diagnoses which included breast cancer, Asperger's syndrome (a neurodevelopment condition), protein-calorie malnutrition (inadequate intake of both protein and calories), anxiety (feeling of uneasiness or worry), and hypokalemia (low potassium). Record review of Resident #95's admission MDS assessment, dated 03/21/2026, revealed Resident #95 had a BIMS score of 99, which indicated unable to complete interview. Record review of Resident #95's care plan dated 04/06/2026 revealed Staff must use gown and glovesduring high-contact resident care activities that could possibly result in transfer of MDROs (multidrug-resistant organism) to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO. During an observation and interview on 05/05/2026 at 8:00a.m., Resident #95 was yelling from the hall yelling in his room. Enhanced barrier precaution sign was on Resident #95's door. Staff were observed entering the room with no PPE. Central Supply stated Resident #95 had a small wound. She said she was just assisting with pulling Resident #95 up in the bed. She said PPE was required any time patient care was provided to the resident. 4. Review of Resident #101's face sheet dated 05/07/2026 revealed was a [AGE] year-old male admitted to the facility on [DATE]. He had the following diagnosis: Type 2 diabetes mellitus (a chronic condition where the body develops insulin resistance, which is a condition where body cells fail to respond effectively to insulin eventually leading to high blood sugar or type 2 diabetes). Review of Resident #101's physician orders with a start date of 05/01/2026 revealed the following insulin order: Insulin Lispro inject 5 units subcutaneously before meals for high blood sugars. Hold Lispro if BS under 200.During an observation on 05/07/2026 at 11:38a.m., reflected LVN D placed the glucometer supplies in a gray tray. She failed to perform hand hygiene prior to putting gloves on. She failed to clean the glucometer prior to checking Resident #101's blood sugar. She failed to clean the top of the insulin vial prior to withdrawing a dose for Resident #101. She sanitized the palms of her hands for less than 5 seconds, and she failed to spread the hand sanitizer on the back of her hands prior to administering Resident #101's insulin. Resident #101 asked her to empty his urinal, and LVN D failed to properly perform hand hygiene after emptying his urinal. She sanitized the palms of her hands for less than 5 seconds, and she failed to spread the hand sanitizer on the back of her hands. She failed to clean the glucometer or gray tray prior to putting it in the medication cart.During an interview on 05/07/2026 at 12:00 p.m., LVN D reported not cleaning the glucometer prior to and after each use on a resident could cause biohazard transmission due to intermingling with fluids. She reported staff should wipe the insulin vial prior to puncturing it to ensure a clean surface. She reported that staff should sanitize their hands for 15-20 seconds by covering their hands with sanitizer and allowing them to dry. She reported they can also wash for 20 seconds with hot water. During an interview with the DON on 05/07/2026 5:11p.m., she said she had been trained on infection control. She said the policy for PPE was for enhanced barrier precautions meant the staff needed to gown up and glove up and wash hands. She said everyone was responsible to wear PPE if they were going into the resident's room. She said if staff did not wear PPE the facility could have cross contamination and spread different things to other residents. She said the nurse and management team monitored to ensure staff wore PPE. She said the management team and nurses monitored through in-services and observation rounds. She said she did not know why staff were going in rooms without wearing PPE. She said they know they should be wearing the PPE. She (continued on next page)

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 05/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 S Eldridge Parkway Houston, TX 77077	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported that staff should clean the glucometer before and after each use with a resident. She reported that staff should perform hand hygiene or wash their hands prior to entering and after exiting a resident's room. She reported hand hygiene should also be performed in between administering medications to one resident, and prior to administering medications to another resident. She stated, staff should perform hand hygiene for at least 20 seconds to ensure their hands are properly cleaned. She reported the management team and charge nurses were responsible for monitoring hand hygiene by staff. During an interview with the ADM on 05/08/2026 at 9:11a.m., she said she had been trained on infection control she said she had been trained on infection control. she said the policy was that the staff wear PPE special when it was indicated on the resident's door. She said if the resident has a sign on their door for PPE, staff should wear PPE. She said if staff did not wear PPE with those residents staff could spread diseases or other communitive diseases. She said the IP monitored to ensure staff were wearing PPE. She said the IP and management monitored through observation round. She said she did not know why staff were not wearing PPE. In an interview on 05/08/2026 at 2:13 pm, ADM reported the glucometer should have been sanitized prior and after use with a resident. Record review of the Handwashing/Hand Hygiene Policy date 10/2023 revealed The facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for hand hygiene included: a. immediately before touching a resident; b. before performing an aseptic task; c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; and e. after touching the resident's environment. Their procedure for applying alcohol-based hand rubs was 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry. 3. Rub hands together for a minimum of 15 seconds.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences for one (Resident #27) of one residents reviewed for vision impairment. The facility failed to ensure Resident #27 1. Was told what food he was having for breakfast and where it was located on his tray and it was free from cellophane 2. Received large print reading materials This failure could place residents at risk of needs and accommodation being unmFindings Include: Review of Resident #27's face sheet dated 05/07/2026 reflected an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included blindness right eye category 5 (total, irreversible blindness, often defined as no light perception) and blindness left eye category 4 (represents a severe visual impairment where the best corrected visual acuity in the eye is worse than 20/200, defined as having only ability to see light rather than form). Review of Resident #27's Resident Assessment and Care Screening MDS assessment, dated 04/07/2026, reflected the following: *a BIMS score of 6, indicating severe cognitive impairment. *Section B - Hearing, Speech, and Vision reflected vision highly impaired - sees large print, but not regular print in newspaper/books.* Section F - preferences for customary routine activities - F0500 how important is it to you to have books, newspapers, and magazines to read - very important. Review of Resident #27's care plan focus dated 04/16/2026 reflected visual impairment/legally bind related to glaucoma (a group of eye diseases that damage the optic nerve-often due to high eye pressure-leading to permanent, irreversible vision loss or blindness) and eye infection/eye pressure. Further review revealed there was no focus area addressing activities. Observation on 05/05/2026 at 8:30 AM of Resident #27 alone in his room sitting on the edge of his bed with a bedside table in front of him with a meal tray on the bedside table. The meal tray had a bowl of grits mostly empty and spilled on the outside of the bowl, scrambled eggs, a piece of toast, a plastic cup of juice (unknown flavor) covered in cellophane, and a closed plastic container of grape jelly. Observation on 05/08/2026 at 3:50 PM of facility activity calendar attached to a bulletin board in Resident #27's room reflected the calendar was not in large print and Resident #27 was unable to read it. During an interview on 05/05/2026 at 8:30 am with Resident #27 he said when he was served breakfast in the morning and staff bring him his tray, they put it on his bedside table, and leave the room. Resident #27 said staff did not tell him what food was on his plate or where it was on the breakfast tray. Resident #27 said he was trying to eat because he did not want to lose any more weight. He said he was blind and asked the surveyor to tell him where his food was on the tray. When asked if he wanted his juice, he said he did not know he had juice. Resident #27 requested assistance to remove the plastic. Resident #27 said this aggravated him because he was blind. Resident #27 said he tried to be as independent as he could be, and he was the only blind resident in the facility. Resident #27 said that he used a cane and learned after a while how to get to the nurses' station without using a cane. He said when he wanted something and he did not have assistance; he would walk to the nurses' station and ask for help. During a Resident Council meeting held on 05/07/2026 at 1:00 PM Resident #27 said he was told about the resident council meeting, and he asked that a staff member come to his room and take him to the meeting because he did not know where the meeting was going to take place. Resident #27 said a staff member did not come to his room to take him to the meeting and he walked to the nurses' station and asked someone to take him to the meeting. Resident #27 said they dropped off papers for him, but they were not large print and he could not read them. Resident #27 said the facility did not do anything to facilitate blind people. During an interview on 05/07/2026 at 3:18 pm with an OT she said about two months ago Resident #27 told her the aides were dropping off his food and leaving without telling him what food was on his plate, where the food was, or removing the cellophane wrapping. The OT said she spoke to a nurse about it, and it was supposed to be addressed. The OT said she could not remember the name of the nurse she spoke (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with. The OT said the staff was in a hurry and did not take the time to orientate him to his food. The OT said she would get frustrated if she could not see, there was no one to ask, and she was not told where food was on her plate. The OT said Resident #27 went to the dining room for lunch and dinner and there were staff in the dining room to tell him what was on his plate. During an interview on 05/07/2026 at 3:48 pm with LVN UM she said she supervised the nurses. She said Resident #27 had a disorder and saw shadows and things that were not there. LVN UM said staff brought Resident #27 breakfast, they uncovered his food, removed any cellophane, and told him where his food was. LVN UM said he needed this accommodation because of his vision. LVN UM said it would be disheartening to have food placed in front of you and not knowing what it was or where it was. LVN UM said if she were Resident #27 this would be frustrating. During an interview on 05/07/2026 at 4:03 PM with CNA C she said Resident #27 always had breakfast in his room and she told him what he had on his breakfast plate and she told him where his food was. She said he did not need any additional assistance. CNA C said if you did not do something for Resident #27, he would ask you to do it. During an interview on 05/08/2026 at 8:51 AM with the ADM she said Resident #27 was visually impaired. She said she was not sure if Resident #27 received large print reading materials. The ADM said it would be good for Resident #27 to know what was on his plate when he received meals. During an interview on 05/08/2026 at 12:27 PM with LVN F she said the CNAs usually took Resident #27 his breakfast. LVN F said the CNAs told him where his drink was and where the food was on his plate. During an interview on 05/08/2026 with the VPC she said Resident #27's activity calendar should be in large print so he could read it. During an interview on 05/08/2026 at 2:13 PM the RNC said if a resident was visually impaired, they should receive accommodation. The RNC said everyone was responsible for accommodating Resident #27's needs. The RNC said if he could not see his food, it would be frustrating and if someone just presented the food to him and left, she would be frustrated. Record review of facility Accommodation of Needs policy dated March of 2023 reflected Policy Statement our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. Policy Interpretation and Implementation - The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis.In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility. Examples of such adaptations may include:In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the residents' wishes. For example:1. interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity;2. arranging toiletries and personal items so that they are in easy reach of the resident; and3. maintaining hearing aids, glasses, and other adaptive devices for residents.

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 05/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 S Eldridge Parkway Houston, TX 77077	

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a new resident was not admitted with mental illness unless the state mental health authority determined, based on independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission for 2 of 12 residents (Resident #35 and Resident #65) reviewed for PASRR services. The facility failed to ensure a PASRR screening was completed correctly for Resident #35 and for Resident #65. This failure could place residents at risk for not obtaining the services needed to treat their mental health diagnoses. The findings include: 1. Record review of Resident #35's face sheet, dated 05/06/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #35 had diagnoses which included bipolar (extreme mood swings), shortness of breath, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), hypertension (high blood pressure), cerebral infraction (stroke), and need for assistance with personal care. Record review of Resident #35's admission MDS assessment, dated 03/23/2026, revealed Resident #35 had a BIMS score of 99, which indicated unable to complete the interview. The MDS also documented bipolar disorder (extreme mood swings) as active diagnoses. Record review of Resident #35's care plan, dated on 04/07/2026, noted [Resident #35] used psychotropic medications related to behavior management - bipolar and psychosis. The interventions were Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness every- shift. Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Record review revealed of Resident #35's PASRR dated 03/13/2026 revealed mental illness was marked no. During an interview with Resident #35 on 05/05/2026 at 11:12 a.m., Resident #35 would not answer questions about his mental illness. Resident #35 said his care was good. 2. Record review of Resident #65's face sheet, dated 05/06/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #65 had diagnoses which included bipolar (extreme mood swings), major depressive disorder (mental health disorder characterized by persistent depressed mood), schizophrenia (mental health condition that affects everything from how you think, how you feel and how you behave), dysphagia (inability to empty from the throat to the esophagus), hypertension (high blood pressure), and cerebral infraction (stroke). Record review of Resident #65's admission MDS assessment, dated 04/15/2026, revealed Resident #65 had a BIMS score of 13, which indicated intact cognitive response. The MDS also documented bipolar disorder (extreme mood swings), schizophrenia (mental health condition that affects everything from how you think, how you feel and how you behave), anxiety disorder (feeling of uneasiness or worry), and depression as active diagnoses. Record review of Resident #65's care plan, dated on 04/12/2026, noted [Resident #65] uses psychotropic.medications r/t Schizophrenia/Bipolar Disorder The interventions were Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness every- shift. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of (SPECIFY: psychotropic medication drugs being given). Record review revealed of Resident #65's PASRR dated 04/09/2026 revealed mental illness was marked no. Interview attempted with Resident #65 on 05/05/2026 at 9:11a.m., was unsuccessful. During an interview with the MDS Coordinator on 05/07/2026 at 3:55p.m., she said she had been trained on PASRR. She said the policy for PASRR was all residents had to have a PASRR when they were admitted to the facility. She said (continued on next page)

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 05/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was responsible for ensuring the resident had a PASRR. She said they get the PASRR from where the resident admits from. She said the MDS Nurse was responsible for reviewing the PASRR and ensuring it was correct. She said the MDS Nurse was also responsible for submitting all the PASRR in simple (the PASRR system). She said some diagnoses that would trigger a resident as a positive PASRR was mental retardation, Intellectual disabilities, schizophrenia, major depressive disorder and bipolar. She said if a resident had a new qualifying diagnosis the facility would discuss the resident and the new diagnosis in the morning meeting, check the progress notes, and pull a report. She said she was responsible for sending the referral in to the state agency. She said if a PASRR was not marked correctly the facility would not be able to care for the resident or give them the proper treatment they need. She said the DON and ADM monitored to ensure the PASRR was correct. She said the DON did an audit and the team discussed the audit in the morning meeting. She said the Regional Reimbursement Consultant monitored competency. She said the Regional Reimbursement Consultant did a competency check list to ensure everyone was on same processes. She said that Resident #35 and Resident #65 both should have been PASRR positive. She said both residents should have been marked as yes for mental illness. She said she did not know why Resident #35 and Resident #65 were not marked correctly. During an interview with the ADM on 05/08/2026 at 9:20a.m., revealed she had been trained on PASRR. She said the MDS Nurse was responsible for ensuring the resident had a PASRR. She said the PASRR should be done before admission. She said the MDS Nurse should ensure the PASRR was correct. She said residents were screened for PASRR by their medical records and it was determined by the information in their record. She said some diagnoses that would make a resident PASRR positive was schizophrenia, Intellectual disability, and some psychosis. She said the MDS Nurse was responsible for sending the referral to the state designated authority. She said if a resident had a new diagnosis something triggered in the computer system. She said the Regional Reimbursement Nurse monitored to ensure the PASRRs were done correctly. She said the Regional Reimbursement Nurse pulled a report and audits so many PASRRs per week to ensure they were accurate. She said the Regional Reimbursement Nurse monitored competency in PASRR. She said the Regional Reimbursement Nurse did a competency checklist and training. She said if the resident was PASRR positive and was marked incorrectly the resident would not get the resources that they qualified for. She said she did not know why Resident #35 and Resident #65's PASRR was marked incorrectly. Record review of the PASRR Policy dated 01/20/2026 revealed The aim of the PASRR program is to identify residents with Mental Illness, Intellectual Disability or Developmental Disability and to ensure they are properly placed, whether in community or in a Nursing Facility and to ensure they receive the services they require for their Mental Illness, Intellectual Disability or Developmental Disability. When it is determined that a PL 1 was filled out incorrectly, the MDS Coordinator, Social Worker or designee will reach out to the hospital/responsible case worker and ask them to correct the form. If the referring case worker is unwilling/unable to correct the PL 1 that contains a potential error, the social worker or designee will complete and submit a form 1012 or new PL 1. A subsequent positive PL 1 will be entered according to 1012 findings. When it is determined that an individual's diagnosis was changed and/or a state surveyor determines the PL 1 was incorrect, the social worker or designee will complete and submit a form 1012 or new PL 1. A subsequent positive PL 1 will be entered according to 1012 findings.