STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Sealy	1401 Eagle Lake Road Sealy, TX 77474

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to ensure that residents were given therapeutic diets as prescribed by their physicians in 4 of 8 residents (Resident #1, Resident #2, Resident #3 and Resident # 4). The facility failed to ensure that Resident #1 was given fortified meal plan as ordered by the physician. The facility failed to ensure that Resident #2 was given fortified pudding and fortified meal plan as ordered by the physician. The Facility failed to ensure that Resident #3 was given fortified pudding or ice cream for lunch and dinner as ordered by the physician. The facility failed to ensure that Resident #4 was given fortified pudding/supapudding and fortified meal plan as ordered by the physician. This failure placed all residents to be at risk of weight loss and ultimately malnutrition.Record review of Resident #1's undated face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. His diagnoses included depression (mental health disorder characterized by persistence sadness, loss of interest and low energy), dysphagia (difficulty swallowing), hyperlipidemia (high level of fat in the blood), Gastro esophageal reflux disease (chronic severe form of acid reflux where the acid flows back in the esophagus), hypertension (high level of fat in the blood) and dysphagia following cerebral infarction (difficulty swallowing due to brain damage that controls the swallowing muscles). Record review of Resident #1's quarterly MDS dated [DATE] revealed Section C 0500 coded the Resident's BIMS score as a 4 indicating he was severely impaired for cognition for decision making. Section K:0100 coded the Resident as complaining of pain when swallowing. K0200/K0210 coded the Resident of having no weight loss or weight gain of 5% in the last 30 days. K0520 coded the Resident as on a mechanically altered diet. Record review of Resident #1's physician's order dated 2/19/2026 revealed an order for regular mechanical soft diet, ground texture. Diet order dated 7/18/2025 for fortified pudding BID for malnutrition. Record review of Resident #1's meal ticket dated 4/17/2026 revealed the following: regular diet, mechanical soft diet, fortified pudding cream. Observation of Resident #1's lunch on 4/17/2026 at 12:40pm revealed Resident #1 in the dining room eating. He was self-fed. His meal consisted of potatoes, fish, and hush puppies. There was no fortified pudding. The meal looked exactly like the residents who were served regular meals. Record review revealed Resident #2 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Her diagnoses included Alzheimer (progressive brain disorder that slowly destroys memory), depression (mental health disorder characterized by persistence sadness, loss off interest and low energy), dysphagia (difficulty swallowing), hyperlipidemia (high level of fat in the blood), Gastro esophageal reflux disease (chronic severe form of acid reflux where the acid flows back in the esophagus) and abnormal weight loss (is when you lose more than 10 pounds of your body weight without diet or exercise). Record review of Resident #2's quarterly MDS dated [DATE] revealed Section C 500 coded the resident BIMS score as a 4 indicating she was severely impaired for cognition for decision making. Section K:0100 coded the resident as complaining of pain when swallowing. K0200/K0210 coded the resident of having no weight loss or weight gain of 5% in the last 30 days. K0520 coded the resident as on a mechanically altered diet. Record review of Resident #2's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Avir at Sealy		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Eagle Lake Road Sealy, TX 77474	

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meal ticket dated 4/17/2026 revealed the following: regular diet, mechanical soft diet, fortified pudding/ice cream, fortified enhance food and mighty shake. Record review of Resident #2's physician's order dated 10/13/2025 revealed orders for:Mighty shake 4 oz. 2 times a day lunch and dinnerFortified pudding 4 oz. two times a day for lunch and dinner. Observation of Resident #2's lunch on 4/17/2026 at 12:40pm revealed Resident #2 in the dining room eating. She was self-fed. Her meal consisted of potatoes, fish, and hush puppies. There was no mighty shake, ice cream or fortified pudding. The meal looked exactly like the residents who were served regular meals. Record review revealed dated 4/17/2026 revealed Resident #3 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Her diagnoses included anemia (insufficient healthy red to carry oxygen throughout the body), hypertension (high blood pressure), renal insufficiency (failure to filter waste, balance fluids or regulate blood pressure) Alzheimer's disease (progressive brain disorder that slowly destroys memory), anxiety disorder (mental health disorder characterized by persistence fear of worry), depression (mental health disorder characterized by persistence sadness, loss of interest and low energy), dysphagia (difficulty swallowing) and vitamin D deficiency (when the body lacks sufficient vitamin to keep the body healthy). Record review of Resident #3's quarterly MDS dated [DATE] revealed Section C0500 coded the resident BIMS score as a 3 indicating she was severely impaired for cognition for decision making. Section K:0100 coded the resident as complaining of pain when swallowing. K0200/K0210 coded the resident as having no weight loss or weight gain of 5% in the last 30 days. K0520 coded the resident as on a mechanically altered diet. Record reviews of Resident #3's meal ticket dated 4/17/2026 revealed the following: regular diet, mechanical soft diet, fortified pudding/ice cream and mighty shake. Record review of Resident #3's physician's order dated 10/13/2025 revealed orders for:Mighty shake 4 oz. 2 times a day lunch and dinnerFortified pudding 4 oz. two times a day for lunch and dinner. Observation of lunch on 4/17/2026 at 12:45pm revealed Resident #3 in the dining room eating. She was self-fed. Her meal consisted of cheese sandwich, Juice, milk and water. There was no mighty shake, ice cream or fortified pudding on the tray. Record review revealed Resident #4 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Her diagnoses included depression (mental health disorder characterized by persistence sadness, loss of interest and low energy), dysphagia (difficulty swallowing), hyperlipidemia (high level of fat in the blood), Gastro esophageal reflux disease (chronic severe form of acid reflux where the acid flows back in the esophagus), hypertension (high blood pressure), diabetes (high blood sugar). Record review of Resident #4's quarterly MDS dated [DATE] revealed Section C 500 coded the resident BIMS score as a 00 indicating she was severely impaired for cognition for decision making. Section K:0100 coded as having no swallowing issues. K0200/K0210 coded the resident of having no weight loss or weight gain of 5% in the last 30 days. K0520 coded the resident as on a mechanically altered diet. Record review of Resident #4's meal ticket dated 4/17/2026 revealed the following: regular diet, mechanical soft diet, fortified pudding/ice cream, fortified enhance food and mighty shake. Record review of Resident #4's physician's order revealed orders dated:02/20/2026 for fortified meal plan diet, mechanical soft texture thin consistency.11/24/2025 for super pudding 4 oz. 2 times a day for lunch and dinner. Observation of Resident #4's lunch on 4/17/2026 at 12:40pm revealed Resident #4 in the dining room eating lunch. She was self-fed. Her meal consisted of potatoes, fish, and hush puppies. There was no fortified meal plan or fortified pudding. The meal looked exactly like the residents who were served regular meals. In an interview on 4/17/2026 at 12:43pm with the Dietary Manager, she said she was preparing the fortified pudding. She said she usually served the fortified pudding when residents almost finished their meals. She said she usually added extra butter and sour cream to the potatoes, but she did not add any extra butter and sour cream with the potatoes that day. She said the fortified meal was for residents who were at risk of weight loss. In an interview on 4/17/2026 at 12:47pm with LVN B she agreed that residents who had orders for fortified meals looked exactly like residents with regular meals. She at that point said she (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was going to in-serviced staff on reading the tray ticket to ensure residents were getting what the physicians ordered. Interview on 4/17/26 5:05pm with LVN B she said diets were ordered for a specific reason and the safety of the residents. She said if residents were ordered to eat a specific diet due to health reasons and the safety of the residents and the diets were not given it could cause the residents to lose or gain weight, if it was a modified diet, it could cause the residents to choke. She said the negative outcomes of not following the physician's ordered diet could be choking, excess fluid, weight gain or loss. She also acknowledged it could be detrimental to the safety of the residents and could put residents at risk of excess weight loss or gain. She said when there were changes in the diets they communicated the changes to the kitchen staff immediately. Further interview with LVN B revealed when a diet was ordered by the physician the kitchen receives a communication form that identifies the resident and any changes to the diet. The kitchen keeps the forms and makes the changes accordingly. She said moving forward they will in-service the staff to ensure residents were given the correct diets. She said the nurses would double-check the tickets and the trays before they were given to the residents to ensure they were getting the prescribed diet. Record review of the facility policy and procedures titled Physician Orders dated February 2025 read in part.PurposeThe purpose of this procedure is to establish uniform guidelines in receiving and recording physician's orders to ensure resident receives the necessary care and services.Supervision by a Physician6. Treatment orders: when recording treatment orders, specify the treatment, frequency and duration of treatment.7. Commercial Dietary supplement - when recording orders for commercial dietary supplement specific the type, amount and frequency.