

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Veterans Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Fallbrook Drive Houston, TX 77038	

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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 24 residents (Resident #1) reviewed for quality of care.- The facility failed to transfer Resident #1 to the hospital by means of emergency services after she was observed to be in pain, had a bruise to the left lower extremity, and her extremity was observed to be out of normal alignment on 3/29/2026 at 12:00pm. Resident #1 was transferred to the hospital at 8:55pm. An Immediate Jeopardy (IJ) was identified on 4/16/26. The IJ template was provided to the facility on 4/16/26 at 10:51am. While the IJ was removed on 4/18/26 at 5:01pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm, with the potential for minimal harm that is not immediate jeopardy, due to the facility's need to finish in-servicing all staff and the need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk for a delay in treatment, pain, and hospitalization. Findings include: 1. Record review of Resident #1's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of unspecified dementia (decline in cognitive function), lack of coordination, unsteadiness on feet, muscle weakness, osteoarthritis (gradual breakdown of cartilage), moderate protein calorie malnutrition, and sarcopenia (loss of muscle mass, strength, and function due to age). Record review of Resident #1's Annual MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15, which indicated severely impaired cognition. The resident had impairment on one side of her lower extremities and was dependent (helper does all of the effort and resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required) for all ADLs. According to the assessment Resident #1 was always incontinent of bowel and bladder. Record review of Resident #1's Care Plan dated 7/18/23 revealed a Focus: Resident #1 was observed lying on the floor on her floor mat, no injuries were noted. 8/25/25- was noted on the side of her bed laying on the floor, on top of fall mat, no injury noted. 11 /23/25- Resident was observed on the floor mat next to her bed. Upon assessment no injury or discomfort noted. 1/25/26- Unwitnessed fall. Writer was called to the patient's room by PCA. Patient was found lying on a floor mat, positioned on the left side with head to dresser and foot towards wall, with active bleeding noted to the left side of the head. Patient was assisted off the floor by three staff members for further assessment. Assessment revealed a laceration to the left side of the head and bruising to the right forehead region, neuros initiated. Interventions included a low bed, monitoring frequently, fall mat, and ensuring personal items were within reach. Focus: Resident #1 had a left tibia (bone in lower leg) fracture, requiring splint placement at this time. Interventions included keeping the call light within reach, responding promptly to the resident, following orders for weight bearing, monitoring/documenting pain, and repositioning as (continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>necessary. Record review of Resident #1's Progress Notes revealed an eInteract SBAR dated 3/29/26 at 12:30pm by LVN A which revealed the resident had a change in condition. The note revealed the resident had discoloration to her skin and pain. LVN A document, LLE noted to be discolored, warm to touch, and patient complained of pain when touch. Extremity observed to be out of normal alignment. The note revealed at 12:10pm LVN A placed a call to NP B and at 12:20pm he called back to order a STAT x-ray of the resident's LLE tibia/fibula (bones of lower leg). Record review of Resident #1's Progress Notes revealed a Nurse's Note dated 3/29/26 at 12:39pm by LVN A that reflected, LLE noted to be discolored, warm to touch, and patient complained of pain. Extremity observed to be out of normal alignment. There was a timeline mentioned on the note that revealed: 12:10pm: LVN A called the provider on call and waited for a call back 12:20pm: NP B called back and ordered the STAT xray 12:30pm: LVN A notified the DON and House Supervisor. Waiting for xray technician 12:40pm: RP notified and informed she would get a call back after results 3:45pm: Xray technician arrived and xray completed 6:40pm: LVN A received a call from the xray company regarding results. Attempted to notify RP. 6:50pm: RP called back and LVN A informed her of xray results 6:55pm: LVN A called provider regarding xray results and waited for a call back 7:00pm: LVN A gave report to oncoming nurse Record Review of Resident #1's x-ray completed to her left leg on 03/29/2026 at 3:50pm revealed findings of displaced fractures (broken bone ends moved out of alignment) to the mid tibia and fibula. Record review of Resident #1's Progress Notes revealed a Nurse's Note dated 3/29/26 at 6:30pm by LVN C that revealed, she received the resident awake and alert with LLE discolored, painful to touch, hot and dry. She documented that the resident also had discoloration to her right and left forearm, had a temperature of 100.4 degrees Fahrenheit, heart rate 109, and at 7:37pm she gave a dose of Tylenol 325mg that was scheduled PRN. Record review of Resident #1's Progress Notes revealed a Nurse's Note dated 3/29/26 at 7:00pm by LVN C that revealed, the PA returned the call and the xray results were given to her. She ordered the resident to be sent to the ER. LVN C notified the RP and at 7:45pm the DON was notified. Record review of Resident #1's Progress Notes revealed an eInteract SBAR dated 3/29/26 at 8:40pm by LVN C that revealed, the resident had a new irregular pulse and the xray showed displaced fractures to the mid tibia and fibula. Record review of Resident #1's Progress Notes revealed a Nurse's Note dated 3/29/26 at 8:40pm by LVN C that a call had been placed to 911 for transfer and at 8:55pm the resident was transferred to the hospital via stretcher with 3 EMS. Record review of a written witness statement dated 3/29/2026 by LVN A, revealed Resident #1 was observed to have swelling, pain, and an extremity that appeared misaligned. Record review of Resident #1's hospital records revealed an admission Note dated 3/26/26 at 9:21pm that reflected she was being treated for a left tibia and fibula fracture. Record review of Resident #1's hospital records revealed a note dated 3/29/26 at 9:42pm by RN M that reflected the resident's leg was supported in a stable position to prevent further injury and deformity, and there was a visible large bruise and edema (swelling) to her left lower leg. Record review of Resident #1's hospital records revealed a note dated 3/29/26 at 10:48pm by MD T that reflected the resident presented with leg bruises and had a tibio-fibular fracture (lower leg) noticed on x-rays. She was put in a trilateral splint (stabilize severe ankle fractures), treated with Fentanyl 25mcg (strong pain medication), and admitted for further treatment. Record review of Resident #1's hospital records revealed an xray of the tibia and fibula report dated 3/29/26 at 11:34pm that reflected, There are acute mildly displaced oblique fractures [slanted break in bone causing misalignment] of the distal [towards feet] tibial and fibular diaphyses [midsection of a bone] with lateral displacement [misalignment to the side] and foreshortening [bone appears shorter]. Record review of Resident #1's Physician Orders as of 4/16/26 revealed the following orders from MD R:- May send to the ER due to abnormal xray of left tib/fib. Ordered on 3/29/26 at 6:02pm.- Eliquis (blood thinner) Oral Tablet 2.5mg, 1 PO BID for prevention of DVT for 30 days. Ordered on 3/31/26 and ends on 4/30/26.- Monitor splint to LLE Qshift to ensure proper placement along with skin check, every shift. Ordered on 4/1/26.- Hydrocodone-Acetaminophen (pain medication) Oral (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Tablet 5-325mg, 1 PO Q6hr PRN, not to exceed 4 tablets in 24hr. Ordered on 4/8/26.- Assess Left Lower Extremity QShift Daily and notify MD of any noted abnormalities Dx: Fx, Every shift for skin assessment. Ordered on 4/9/26.In an observation on 4/14/26 at 9:41am, revealed Resident #1 was lying in bed on her back with her leg propped up on a pillow. She had wedges on both sides of her and a fall mat next to the bed. Resident #1 was on the secure unit and was confused and unable to answer questions when an interview was attempted.In an interview on 4/15/26 at 12:05pm, LVN J said if there was visible trauma to a resident there could be a fracture and that would warrant an immediate transfer to the ER without calling the provider for orders.In an interview on 4/15/26 at 12:12pm, RN G said if the resident had a suspected fracture or their limb was not symmetrical she would send the resident directly to the hospital without calling the provider first.In an interview on 4/15/26 at 12:44pm, NP A said NP B was notified after Resident #1was observed with bruising and pain to her left lower extremity. She said that LVN A documented Resident #1 had an extremity out of normal alignment that was confirmed to be a displaced fracture. She said based on the progress note entered by LVN A, Resident #1 should have been transferred to the hospital by means of emergency services and treatment was delayed. In an interview with LVN A on 4/15/26 at 1:43pm, she said a resident with visible trauma should be sent to the hospital by means of emergency services via 911. She said on 3/29/2026 at 12pm Resident #1 was observed with a left lower extremity that was bruised, swollen, and painful to touch. She said Resident #1's left lower lateral extremity was not symmetrical and had an indentation when compared to the right lower extremity. She said she notified NP B and told him that Resident #1's leg was swollen, bruised, painful, and out of alignment. She said she also requested an x-ray. In a phone interview on 4/15/26 at 2:00pm, NP B said he could not recall Resident #1 or being notified by the facility staff of a change in condition. He said if the nurse documented the left lower extremity was out of normal alignment/misaligned it would lead him to think the left lower extremity was not aligned with the joint and there would be concern for a displaced fracture. He said that change in condition would warrant the resident being transferred to the hospital by emergency medical services via 911. He said that 9 hours was too long to wait with a displaced fracture and treatment was delayed. In an interview with the ADON on 4/15/26 at 3:20pm, the ADON said visible trauma warranted a transfer to the hospital by means of emergency medical services by 911. She said 911 should have been called when the injury was observed. The ADON said Resident #1 was transferred to the hospital at 8:55pm when the trauma was observed at 12:39pm, and treatment was delayed.In an interview on 4/15/26 at 4:25pm, the DON said emergency services should be contacted by means of 911 when an injury could not be managed in house. She reviewed the progress note entered by LVN A and said out of normal alignment meant there was some type of abnormality, but she could not define what that was because she did not see it. She said at 12pm on 3/29/2026 LVN A contacted her and informed her Resident #1 had left lower extremity that was bruised, discolored, warm to touch, and she experienced pain. LVN A told the DON that she notified NP B and he ordered an x-ray. The DON said LVN A also told her Resident #1 had stable, managed pain. The DON said she did not know Resident #1's extremity was out of alignment and she was in pain, otherwise she would have sent the resident straight to the ER. Record review of the facility's policy and procedures on Change in Resident's Condition or Status (revised April 2025) revealed in part: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition. The nurse will notify the resident's attending physician or physician on call when there has been a(an):.discovery of injuries of an unknown source.significant change in the resident's physical/emotional/mental condition.need to transfer the resident to a hospital/treatment center. A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting).Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Communication Form. Unless otherwise instructed by the resident, a nurse will notify the resident's representative. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. An Immediate Jeopardy (IJ) was identified on 4/16/26 and the ADM was notified. The IJ template was provided to the facility on 4/16/26 at 10:51am. The Plan of Removal was accepted on 4/17/26 at 1:40pm. The plan of removal reflected the following: Date: 04/17/2026 [Facility] PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY Summary of Details which lead to outcomes. On April 16, 2026, an annual survey was conducted at [facility], [address]. A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the facility constitute immediate jeopardy to resident health. Problem: Quality of Care (F684) The facility failed to transfer Resident #1 to the hospital by means of emergency services after she was observed to be in pain with a bruise to the left lower extremity that was observed to be out of normal alignment 03/29/2026 at 12:00pm. Resident #1 was transferred to the hospital at 8:55pm. Plan: 1. Medical Director has been notified of the Immediate Jeopardy by the Administrator on 04/16/2026. QAPI was discussed with Medical Director. Medical Director educating NP A and NP B on the importance of transferring residents out to ER when made aware of potential fracture and change of condition. Completion Date: 4/16/26. DON/designee initiated in-service on 04/15/26 with all staff on the following: All staff in-service regarding notification to the charge nurse regarding change of condition for verbal and non-verbal changes in resident. Effective Communication direct line staff to charge nurse, from charge nurse to admin nurse, and Physician/NP on 4/15/26. Completion Date: 4/16/26 Changes in condition will be reported via [EMR] clinical alert. DON/ADON/[ADM]/Charge Nurse are responsible to ensure timely/accurate assessments, MD notification and timely follow up of MD orders/interventions such as transport to higher level of acuity. Monitoring will occur during clinical morning meetings and 24-hour report reviewed by weekend supervisor for resident changes and new orders. 3. Audit initiated of residents who transferred to the ER over the last 90 days for timeliness of treatment and transfer. The Sbar change of condition assessment completed with no negative findings noted. DON completed this audit and review. Completion Date: 4/16/26. DON will initiate one on one education with LVN A regarding change of condition, resident assessment, resident treatment, and documentation; along with notification to physician, nurse admin, and timeliness of transfer to a higher level of care for treatment due to LVN A's communication with nurse admin and NP on 3/29/26. Education will be completed before LVN A's next scheduled shift. Completion Date: 4/16/26 5. Regional Nurse to educate DON regarding daily review of 24-hour report to ensure timeliness of treatment and transfer to a higher level of care. Completion: 04/16/26. All staff who are not working during the time of in-service on Change of Condition and timeliness of transfer to a higher level of care for treatment, will be in-serviced prior to their next scheduled shift. Newly hired staff will receive the in-services during their orientation period. Agency nurses will be in-serviced prior to beginning their shift; initiated 4/16/26. 7. Licensed and certified nursing staff will be given a competency-based quiz on change of condition and communication to charge nurse, from charge nurse to admin nurse, and Physician/NP; initiated 4/16/26. Completion Date: 4/16/26. 8. Monitoring will occur during the clinical morning meeting Monday through Friday by DON/Nurse admin/Designee; weekend supervisor will review the 24 Report for resident changes and new orders. DON will oversee this process and any negative outcomes will be communicated with administrator. 9. Weekend supervisor was in-serviced on monitoring the 24-Hour Report and follow-up on orders i.e., Change of Condition and timeliness of transfer to a higher level of care. Completed: 04/16/26 10. The facility's policy and procedures regarding change of condition was reviewed on 4/15/26. There were no changes made to current policy and procedure. All staff in-service was initiated. Completion Date: 04/16/26 On 4/18/26 a monitoring visit was conducted to ensure the facility was following its POR. The visit revealed: Record review of an email from the Medical Director dated 4/16/26 revealed she submitted guidelines on pain management and residents being transferred to an acute setting for (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>further workup. The Medical Director notified NP A, NP B, and MD R of the guidelines via email. Record review of an in-service revealed the in-service was given to the DON on 4/16/26 by the RNC regarding Changes in Condition: Including any Changes that are Abnormal From Resident's Baseline. Pain Management: Pain is Subjective, Nurse Should Assess for Verbal and Non-Verbal Signs and Symptoms of Pain. If Pain Intervention is Ineffective Notify the MD. Effective Communication: Ensure Nurse's Assessment is Effectively and Accurately Communicated to MD. Storage of Supplies: All Facility Supplies and Equipment to be Stored in Designated Area Not in Resident's Room. Abuse & Neglect: Recognizing and Timely Reporting of Abuse and Neglect. Stop and Watch: Daily Checks of Alerts on [EMR] Dashboard. Record review of a Quality of Care Quiz revealed the quiz was given with 10 questions, and 85 out of 122 staff members had completed it as of 4/18/26. Record review of the Guidelines for Daily Clinical Meeting sheet revealed it was blank so far. Record review of a QAPI Meeting revealed the meeting was held on 4/16/26 at 6:00pm with its board members. The identified concern that was discussed was: the facility failed to escalate care by emergency services after left lower extremity was observed to have obvious deformity leaving the resident in pain for approx. 9 hours. Plan of action: The Medical Director in-serviced the NPs on escalating care to emergency services for potential fractures. Audit completed for all hospital transfers x 90 days. The DON to review 24hr report daily to ensure timeliness of care and treatment, and transfer to the ER if needed. All licensed staff will receive a post-test regarding changes in condition and communication to the Charge Nurse, DON, MD, and RP. Monitoring: The DON to review 24hr report M-F for changes in condition, notification to MD, RP, and as needed timely escalation of care. Record review of an in-service revealed the in-service was given on 4/15/26 and 4/16/26 by the DON regarding the Stop and Watch, Change of Condition, Pain Management, and Communication. There were 68 staff signatures. Record review of staff education revealed the staff were re-educated on the Stop and Watch: Staff are expected to document resident changes and Charge Nurses were expected to monitor for daily alerts in [EMR]. Change of Condition: Staff were expected to report changes that were abnormal for resident's baseline. Record review of staff education revealed the staff were re-educated on Effective Communication: Ensure nurse's assessment was effectively and accurately communicated to the MD/NP and admin nurse. Record review of a Hospital Transfer Audit dated 4/16/26 revealed 27 residents listed between 1/15/26 and 4/16/26. Record review of an in-service revealed the DON had a 1 on 1 in-service with LVN A on 4/17/26 regarding Assessment, Change of Condition, Reporting, Completion of New Orders, Pain Management, and Use of EMS Services. In interviews on 4/18/26 from 10:27am-11:25am, CNA E, Med Aide K, CNA H, CNA K, CNA O, CNA P, Med Aide G, and CNA Q stated they had been in-serviced on changes in condition. They stated they went over if any changes in condition were seen, to report it to the nurse and document. They gave examples of a change in condition like weakness, being incontinent, or any bruised or skin tears. They said if there was a change in condition, like pain, they would ask how much pain the resident was in and they would let the nurse know, and they would keep checking on the resident. They stated they got in-serviced on communication as well so if the nurse did not do anything then they would tell the ADON or DON. They also were able to verbalize what the stop and watch was and where to find it. In interviews on 4/18/26 from 11:56am-12:15pm with LVN H, LVN D, LVN N, and LVN O who all worked the day shift, were able to confirm what a change in condition was, where they would document it, and what they would do if they noticed a change in condition. They also said they were in-serviced about transfers. In an interview on 4/18/26 at 12:20pm the Weekend Supervisor said she was in-serviced on the 24 Hour Report, Changes of Condition, and Timelines of Transfers. She was able to communicate the different types of abuse, who she should report abuse to, and when. The Weekend Supervisor discussed types of changes in condition like changes in breathing, what she would do to assess, and that she would notify the provider. She confirmed that a change in condition was anything different from the resident's baseline. The Weekend Supervisor said she would document the change in condition in the clinical alerts, assessments, and also make a nurse's note. She was able to explain (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observation, interview, and record review the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 24 residents (Resident #1) reviewed for pain.- The facility failed to monitor and address Resident #1's pain on 3/29/26 from 12:00pm to 9:00pm, when the resident was found to have a fracture to her left lower extremity and would say ouch every time she would be turned/repositioned and during incontinence care.An immediate Jeopardy (IJ) was identified on 4/16/2026. The IJ template was provided to the facility on 4/16/2026 at 10:51am. While the Immediacy was removed on 4/18/2026 at 5:01pm, the facility remained out of compliance at a scope of isolated with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures placed residents at risk of increased or unmanaged pain.Findings Include: 1. Record review of Resident #1's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of unspecified dementia (progressive decline in memory), lack of coordination, unsteadiness on feet, muscle weakness, osteoarthritis (cartilage breaks down), moderate protein calorie malnutrition, and sarcopenia (loss of muscle mass, strength, and function due to age).Record review of Resident #1's Annual MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15, which indicated severely impaired cognition. The resident had impairment on one side of her lower extremities and was dependent (helper does all of the effort and resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required) for all ADLs. According to the assessment Resident #1 was always incontinent of bowel and bladder. Resident #1 revealed that her average pain level over the past 5 days was a 4, on a scale from 0-10. The resident was currently on opioids (pain medications) and anticoagulants (blood thinners).Record review of Resident #1's Care Plan dated 7/18/23 revealed a Focus: Resident #1 was on pain medication therapy putting her at risk for having side effects. Interventions included administering analgesics (pain medications) as ordered and monitoring effectiveness, reviewing for pain medication efficacy, and assessing whether the pain intensity was acceptable to the resident. Focus: Resident #1 had a left tibia fracture, requiring splint placement at that time. Interventions included keeping the call light within reach, responding promptly to the resident, following orders for weight bearing, monitoring/documenting pain, and repositioning as necessary.Record review of Resident #1's SBAR dated 3/29/26 at 12:30pm by LVN A revealed she had grimacing - facial grimacing, rigid - fists clenched, knees pulled up, pulling or pushing away, striking out. The SBAR also revealed the resident was repositioned every 2 hours.Record review of Resident #1's Progress Notes revealed a Nurse's Note dated 3/29/26 at 12:39pm by LVN A that revealed, LLE noted to be discolored, warm to touch, and patient complained of pain.Extremity observed to be out of normal alignment. There was a timeline mentioned on the note that revealed the following:12:10pm: LVN A called the provider on call and waited for a call back12:20pm: NP B called back and ordered the STAT xray12:30pm: LVN A notified the DON and House Supervisor. Waiting for xray technician12:40pm: RP notified and informed she would get a call back after results3:45pm: Xray technician arrived and xray completed6:40pm: LVN A received a call from the xray company regarding results. Attempted to notify RP.6:50pm: RP called back and LVN A informed her of xray results6:55pm: LVN A called the provider regarding xray results and waited for a call back7:00pm: LVN A gave report to oncoming nurseRecord Review of Resident #1's x-ray completed on 03/29/2026 (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>at 3:50pm revealed displaced fractures to the mid tibia and fibula (lower leg bones) of the left leg. Record review of Resident #1's Progress Notes revealed a Nurse's Note dated 3/29/26 at 6:30pm by LVN C revealed she received the resident awake and alert with a LLE that was discolored, painful to touch, hot and dry. She documented that the resident also had discoloration to her right and left forearm, had a temperature of 100.4 degree Fahrenheit, heart rate 109, and at 7:37pm she gave the resident a dose of Tylenol 325mg that was scheduled PRN. Record review of Resident #1's March 2026 MAR-TAR revealed on 3/29/26 she received a scheduled Tramadol (pain medication) 50mg at 8:00am and 3:00pm. She was also given PRN Tylenol 325mg at 7:37pm. Record review of Resident #1's SBAR dated 3/29/26 at 8:40pm from LVN C revealed the resident's heart rate was 109 and her temperature was 100.4 degree Fahrenheit on her forehead. Record review of Resident #1's Progress Notes revealed a Nurse's Note dated 3/29/26 at 8:40pm by LVN C that revealed, a call had been placed to 911 for transfer to the ER and at 8:55pm the resident was transferred to the hospital via stretcher with 3 EMS. Record review of a written witness statement dated 3/29/2026 by LVN A, revealed Resident #1 was observed to have swelling, pain, and an extremity that appeared misaligned. Record review of Resident #1's hospital records revealed an admission Note dated 3/26/26 at 9:21pm that revealed she was being treated for a left tibia and fibula fracture. Record review of Resident #1's hospital records revealed a note dated 3/29/26 at 10:48pm from MD T revealed, the resident presented with leg bruises and had a tibio-fibular fracture noticed on x-rays. She was put in a splint, treated with Fentanyl 25mcg, and admitted for further treatment. In an observation on 4/14/26 at 9:41am, revealed Resident #1 was lying in bed on her back with her left leg propped up on a pillow. She had wedges on both sides of her and a fall mat next to the bed. Resident #1 was on the secure unit and was confused and unable to answer questions when an interview was attempted. In an interview on 4/15/26 at 12:44pm, NP A said she was not the NP who took the call and said NP B was notified after the resident was observed with bruising and pain to the left lower extremity. NP A said staff should have turned Resident #1 onto her side of the uninjured leg and left her in that position and not moved her anymore until EMS arrived. In a phone interview on 4/15/26 at 2:00pm, NP B said he could not recall Resident #1 or being notified by facility staff of a change in condition. He said if the nurse documented the left lower extremity was out of normal alignment/misaligned it would have led him to think the left lower extremity was not aligned with the joint, and there would have been a concern for a displaced fracture. NP B said Resident #1 would have been experiencing a high level of pain and would have needed a higher level of care for pain treatment and would have needed to be sent out to the ER. He said that 9 hours was too long to wait with a displaced fracture, and treatment was delayed. In an interview on 4/15/26 at 2:07pm, CNA A said she worked with Resident #1 on 3/29/26 and noticed bruising to her left lower leg when she repositioned her around 11 am for lunch. CNA A stated she went to reposition the resident and Resident #1 complained of pain stating, ouch. The CNA stated she immediately got the unknown nurse to assess the resident. She stated the nurse assessed the resident and then notified the unit nurse. CNA A stated she waited on instructions from the unknown nurse who informed her to keep the resident's leg elevated with a pillow. The CNA stated she continued to reposition the resident every 2 hours and the resident complained of pain every time she repositioned her. CNA A stated the resident also complained of pain when she would do incontinent care on the resident. The CNA stated she reported the resident's pain to the nurse and she thought that the nurse gave the resident medication. In an interview on 4/15/26 at 3:20pm, the ADON said visible trauma warranted a transfer to the hospital by means of emergency medical services by 911. She said the resident would have been in pain. In an interview on 4/15/26 at 4:25pm, the DON said emergency services should be contacted by means of 911 when an injury could not be managed in house. She reviewed the progress note entered by LVN A and said out of normal alignment meant there was some type of abnormality. The DON said Resident #1 should have had a limited amount of repositioning if she was in pain during movement. Record review of the facility's policy and procedures on Pain Assessment and Management (revised January 2025) revealed in part: The purposes of this (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following: Assessing the potential for pain, Recognizing the presence of pain, Identifying the characteristics of pain, Addressing the underlying causes of the pain. Monitoring for the effectiveness of interventions. Cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain are considered when assessing and treating pain. Comprehensive pain assessments are conducted whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. Acute Pain: refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery. Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain. Possible Behavioral Signs of Pain, including: negative verbalizations and vocalizations such as groaning, crying, screaming; facial expressions such as grimacing, frowning, clenching of the jaw, etc.; changes in vital signs. Possible Physiological Signs of Pain, including: increased blood pressure; Tachycardia [high heart rate]. Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition. Assess the resident whenever there is a suspicion of new pain or worsening of existing pain. Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including fractures. Review the resident's treatment record or recent nurses' notes to identify any situations or interventions where an increase in the resident's pain may be anticipated, for example: bathing, dressing, or other ADLs, turning or repositioning. The following are considered when establishing the medication regimen. Administering medications around the clock rather than PRN. Monitor the following factors to determine if the resident's pain is being adequately controlled: The resident's response to interventions and level of comfort over time. Contact the prescriber immediately if the resident's pain or medication side effects are not adequately controlled. This was determined to be an Immediate Jeopardy (IJ) on 4/16/2026. The Administrator was notified on 4/16/2026. The IJ template was provided to the facility on 4/16/2026 at 10:51am. The following Plan of Removal (POR) submitted by the facility was accepted on 4/16/2026 at 8:23pm. The plan of removal reflected the following: Date: 04/16/2026 [Facility] PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY Summary of Details which lead to outcomes. On April 16, 2026, an annual survey was conducted at [facility], [address]. A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the facility constitute immediate jeopardy to resident health. Problem: Pain (F697) The facility failed to treat residents' pain in a timely manner. The facility failed to monitor and address Resident #1's pain on 3/29/26 from 12:00pm to 9:00pm, when the resident was found to have a fracture in her left lower extremity and was in pain every time she was being turned/repositioned and during incontinence care. Resident #1 was assessed on 3/29/26 and sent to the ER for further evaluation. Plan: Initial assessments for current residents for pain were initiated on 4/15/26. Completion date: Completion date: 4/16/26. 1. Medical Director has been notified of the Immediate Jeopardy by the Administrator on 04/16/2026. QAPI was discussed with Medical Director. Medical Director educating NP A and NP B on pain management orders when a new order is needed to address a resident's pain. Completion Date: 4/16/26. 2. DON/Designee initiated in-service on abuse and neglect on 03/29/26. Completion Date: 4/16/26. 3. DON/designee initiated in-service on 04/15/26 with charge nurses on the following: o Pain Management verbal and non-verbal indicators. o Pain Assessment observation form completion. o Notification to physicians when pain medication is ineffective. Completion Date: 4/16/26. 4. DON/Designee initiated in-service on effective (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>communication from direct line staff to charge nurse, from charge nurse to admin nurse, and Physician/NP for all nursing staff. Completion Date: 4/16/26 5. Regional Nurse to educate DON regarding assessing residents for pain after an incident and of sending the resident to the ER for evaluation if in-house Xray cannot be obtained timely. Completion: 04/16/266. DON/designee conducted an audit regarding effectiveness of pain medication for current residents from 4/8/26 to current for active residents. The outcome of the audit reflected residents who are currently on pain management is effective. No additional residents were identified as to not having their pain managed. Completion date: 04/16/26. 7. DON/designee initiated in-service with nurse aides and medication aides on reporting indicators of pain i.e., verbal, or non-verbal to the charge nurse. Completion Date: 4/16/268. Charge nurses, agency nurses/aides, and certified staff who are not working during the in-service on Pain, will be in-service prior to their next scheduled shift. Newly hired staff will receive the in-services during their orientation period. Agency nurses will be in-serviced prior to beginning their shift.9. Licensed and certified nursing staff will be given a competency-based quiz on pain; initiated 4/16/26. Completion Date: 4/16/2610. Monitoring will occur during the clinical morning meeting Monday through Friday; weekend supervisor will review the 24 Report for resident changes and new orders.11. DON initiated in-service with Weekend supervisor on monitoring the 24-Hour Report and follow-up on orders i.e., X-ray, and residents with pain. Completion Date: 04/16/26 12. The facility's policy and procedures were reviewed on 4/15/26. There were no changes made to current policy and procedure. Nursing staff in-service was initiated. Completion Date: 04/16/26The Plan of Removal was confirmed by the IJ monitoring on 4/18/26 as follows:Record review of an in-service revealed the in-service was given by the DON on 3/29/26 at 11:21am on Abuse Policy with 61 staff signatures on it.Record review of ins-services revealed the in-services were given by the DON on 4/15/26 and 4/16/26 on Stop and Watch, Change of Condition, Pain Management, and Communication: Attendees re-educated regarding Stop and Watch communication to Charge Nurse regarding COC, effective pain management to include verbal and non-verbal communication, accurate relaying of information to clinician and there were 78 staff signatures on it.Record review of A Guidelines for Daily Clinical Meeting form revealed it was filled out for resident 3 residents on 4/15/26. One resident was filled out for [EMR] Dashboard: Review ADTs-admission (complete admission checklist) discharges, clinical alerts ABT-SBAR completed, FU UDAs, psychotropic consents, SE/Behavior Monitoring. The two other residents were filled out for [EMR]: Risk Management-All incident/accidents listed under active and 72-FU documentation & FU UDAs ie, fall neuros. Record review of an in-services revealed the in-services were given by the DON on 4/15/26 and 4/16/26 on Stop and Watch, Change of Condition, Pain Management, and Communication and there were 68 staff signatures on it.Record review a Daily Stand Down Meeting form dated for 4/16/26 revealed the attendees were the ADM, DON, ADON, Dietary, and the SW. They discussed any issues with grievances/complaints, events (falls, bruises, skin issues, elopements) since the morning meeting, wounds (new or worsened), new admissions/readmissions, hospital/ER transfers, outstanding self-reports, and (EMR) compliance.Record review of a QAPI Meeting revealed the meeting was held on 4/16/26 at 6:00pm with the board members. The identified concern that was discussed was: Facility failed to treat resident's pain in a timely manner. Plan of action: All staff in-serviced on abuse and neglect. All nurses in-serviced on verbal and non-verbal indicators of pain, pain observation/assessment, and notification to the MD when pain intervention is effective. In-service completed for communication form direct line staff to Charge Nurse for all changes in condition. The RNC in-serviced DON regarding assessing residents for pain after an incident and determining need for transfers to ER if in house x-rays cannot be obtained timely. Monitoring: M-F in daily clinical meeting, RN supposed to review Sat and Sun.Record review of an in-service revealed a one on one in-service given by the RNC on 4/16/26 to the DON revealed training on Change in Condition: Includes any change that is abnormal from resident's baseline. Pain Management: Pain is subjective, Nurse should assess for verbal and non-verbal signs and symptoms of pain. If pain intervention is ineffective (continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>notify the MD. Effective Communication: Ensure nurse's assessment is effectively and accurately communicated to MD. Storage of Supplies: All facility supplies and equipment to be stored in designated areas, not in resident's room. Stop and Watch: Daily Checks of alerts on [EMR] Dashboard. Abuse and Neglect: Recognizing and Timely Reporting of Abuse and Neglect. Record review of a Pain Assessment Quiz with 14 questions revealed 20 of 26 nurses had completed it as of 4/18/26. Record review on 4/18/26 revealed a list of 12 pages of residents currently on Analgesics-Nonnarcotic, 3 pages of residents currently on pain patches, 6 pages of residents currently on opioids, 1 page of residents currently on codeine, and 1 page of residents currently on lyrica for pain. All residents reflected to have effectiveness of their pain medication. Record review on 4/18/26 revealed a Communication Form Log with 8 residents listed dated 4/15/26. In interviews on 4/18/26 from 10:27am-11:25am, CNA E, Med Aide K, CNA H, CNA K, CNA O, CNA P, Med Aide G, and CNA Q stated they had been in-serviced on abuse and neglect, when to report, and who to report to. They were able to verbalize different types of abuse. They said they received in-services about pain management, verbal signs and non-verbal signs, and to ask for a pain scale and report it to the nurse. They were able to verbalize signs of pain in a resident. They also received in-services on communication so if the nurse did not respond then they were to notify the ADON or the DON. They said they had received a quiz on pain as well. In interviews on 4/18/26 from 11:56am-12:15pm with LVN H, LVN D, LVN N, and LVN O who all worked the day shift, were able to confirm different types of abuse, when to report, and who to report to. They confirmed in-services on pain management, verbal and non-verbal cues of pain, how to assess and document, and that they would call the provider for orders if needed or if the pain was not managed. In an interview on 4/18/26 at 12:20pm the Weekend Supervisor said she was in-serviced on the 24 Hour Report, Changes of Condition, and Timelines of Transfers. She was able to communicate the different types of abuse, who she should report abuse to, and when. The Weekend Supervisor discussed types of changes in condition like changes in breathing, what she would do to assess, and that she would notify the provider. She confirmed that a change in condition is anything different from the resident's baseline. The Weekend Supervisor said she would document the change in condition in the clinical alerts, assessments, and also make a nurse's note. She was able to explain what she would do if a resident was experiencing pain, how to assess, and what verbal and non-verbal pain looked like. In an interview on 4/18/26 at 1:00pm, Med Aide Y said she worked from 2pm to 10pm and she was in-serviced on abuse and neglect and was able to give the different types of abuse. She was also able to verbalize when to report abuse and who to report it to. The med aide said she was in-serviced on pain management also, which included verbal and non-verbal cues, and reporting it to the nurse. Record review of an email from the Medical Director dated 4/16/26 revealed she submitted guidelines on pain management and residents being transferred to an acute setting for further workup. The Medical Director emailed NP A, NP B, and MD R of the guidelines via email. In interviews on 4/18/26 from 1:02pm to 3:22pm, CNA D, CNA J, CNA F, CNA C, CNA S, CNA W, CNA I, Med Aide P, and CNA T, who worked from 2pm to 10pm, confirmed they received in-services on abuse and neglect, the different types of abuse, when to report it, and who to report it to. They said they also received in-services on pain regarding how to know if a resident is in pain, what to do if the resident was pain, and who to report it to. They were able to verbalize examples of non-verbal cues of pain. In an interview on 4/18/26 at 3:33pm, LVN A said she had a one on one in-service on communication documentation, stop and watch regarding changes in condition, resident assessments and treatment, and when to transfer a resident out. She also knew what a change in condition was, where to document it, and who to report it to. She also said they had a quiz about changes in condition. The LVN said she also was in-serviced on pain, pain assessment, and what to do if the resident was still in pain. In an interview on 4/18/26 at 3:54pm, the DON said she had a one-on-one in-service on change in condition, reviewing the 24hr report, and timeliness of treatment and transfers. She said she would follow up on any residents with pain and ensuring appropriate interventions were in place. She said 911 was called for residents who were in (continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>immediate distress who were not relieved of their discomfort in house, or if the resident was adamant on being sent out. In an interview on 4/18/26 at 4:00pm, LVN G said she worked from 6:00pm to 6:00am. She said she had in-services on what a change in condition was, where to document it, and what to do if there was a change in condition. She said they had a quiz on changes in condition and was able to give examples. She said they also received in-services on communication. The LVN said she also had an in-service on pain, pain assessment, and what to do if the pain was unmanaged. In an interview on 4/18/26 at 4:22pm, CNA N said she worked 10:00pm to 6:00am. She was able to explain what a change in condition was, where to document it, and who to report it to. She was also able to verbalize what to do if a resident was in pain, who to report it to, and where to document it. In an interview on 4/18/26 at 4:32pm, CNA A said she received a one-on-one in-service regarding a change in condition. She was able to describe what a change in condition was, where to document it, and who to report it to. She said she also received an in-service on communication and who to report to if the nurse did not respond. The CNA was able to describe verbal and non-verbal cues of pain, who to report pain to, and where to document it. In an interview on 4/18/26 at 4:48pm, RN G said she worked 6am-6pm and was in-serviced on abuse and neglect, and pain. She was able to verbalize types of abuse, when to report abuse, and who to report it to. She was also able to verbalize verbal and non-verbal cues of pain, what to do if a resident has pain, where to document pain, and what to do if pain was not managed. The Administrator was informed that the immediacy was removed on 4/18/2026 at 5:01pm. The facility remained out of compliance at a scope of isolated at a severity level of no actual harm that was not immediate due to the facility's need to finish staff training and evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on interview and record review the facility failed to ensure each resident was treated with respect and dignity for 2 of 8 (Resident#4 and #43) residents reviewed for resident rights. The facility failed to ensure that Resident #4's television was programmed to view all channels. The facility failed on 04/14/2026 to ensure Resident #43 was treated with dignity when the facilities training mannequin was stored in the unoccupied bed of the residents room. These failures could place all residents at risk of not being treated with dignity and respect. Findings included: 1. Record review of Resident #4's facesheet revealed a [AGE] year-old woman originally admitted on [DATE]. Admitting diagnoses were generalized anxiety disorder, mood disorder with depressive features, and moderate major depressive disorder. Record review of Resident #4's MDS dated [DATE], under Section C- Cognitive patterns revealed a BIMS score of 12 (moderate cognitive impairment, suggesting occasional mistakes in daily routine). Record review of Resident #4's care plan date initiated 04/27/23 revealed that she received psychology/psychiatry services in the facility. Activities care planned on 7/6/21 revealed that she enjoyed word finds, watching tv, talking on the phone and crocheting. Resident #4 had a history of depression and was at risk for poor mood stability, increased depression, and poor quality of life. Intervention documented to assist with developing a program of activities that were meaningful and of interest and she should be encouraged to engage in activities (crocheting, completing puzzles, reading, and watching tv) frequently to increase mood and cognitive stimulation. In an observation and interview 4/14/26 at 9:10 a.m., Resident #4 was laying in bed with the covers pulled up to her chin and the bedside table positioned over her bed. She stated that whenever there was a storm, it would cut the local TV channels out, but maintenance would come and fix the TV. In a follow up interview and observation on 4/15/26 at 10:13 a.m. with Resident #4, she stated that she felt like when she would ask staff to do things for her, it felt like it took a month of Sunday's to get it done and described herself as feeling low on the totem pole. She explained that every time a storm hit, her tv would go haywire and she asked staff three times for them to fix it, stating that they could do everything for everybody else but not tend to her TV. She showed the surveyor that she could not get channel 2, 13, 11, and the game channel, which were all of the channels she liked to watch. Using the remote to click through the channels, she showed the surveyor that she could get channels like the news but she was not interested. Scrolling through the channels, channel 2,3,8, and 11 were skipped but when they were punched into the remote to go directly there, the channels showed a black and white pixelated screen. Resident #4 stated that she had asked 3 times for maintenance to come and fix those channels but was told that it may take a while because there were visitors in the building. Resident #4 explained that fixing the tv was simple and only required them to reprogram the channels. In an interview and observation on 4/16/26 at 3:35 p.m. with CNA T he was asked to accompany the surveyor into 2 rooms on Hall B to check to see if all the channels on their TV were working. room [ROOM NUMBER] and room [ROOM NUMBER] both had smart TV's that came with several applications for viewing. Inside Resident 4's room, her roommate had the same TV as her, but channels 2,3,8, and 11 showed their normal programming. He stated that it was his first day working with Resident #4 and he had not received any requests for her TV to be fixed. In an interview on 4/17/26 at 1:35 p.m., CNA W stated that Resident #4 had mentioned to her that some of the channels on her TV had stopped working after the storm but she could not recall when that was. She stated that she let Resident #4 know that if she could not get all of the channels, she needed to get with (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avir at Veterans Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Fallbrook Drive Houston, TX 77038	
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>maintenance and he would be able to fix it. CNA W stated that she did not tell maintenance or the nurse on behalf of Resident #4 because it probably slipped her and explained that when Resident #4 voiced this concern, she was busy getting her cleaned up and straightened. In an observation and interview on 4/16/26 at 4:00 p.m. with the EVS Director, he stated that certain channels on the Resident #4's tv had probably been knocked off (stopped working) today when the life safety inspector was in the building and the tv needed to be rescanned. When told that Resident #4 had been having issues with her tv before 4/16/26, he stated that he was not aware and no one had relayed it to him. He explained that when there was a storm, he would have to make rounds to rescan all of the tv's who channels were affected by the storm and who did not have smart tv's. EVS Director was observed walking into Resident #4's room to reset her tv and confirmed that all of her channels were now working. 2. Record Review of Resident #43 face sheet revealed a [AGE] year-old male admitted on [DATE] with a primary diagnosis of vascular dementia, moderate with other behavioral disturbances (significant cognitive impairment due to reduce blood flow to the brain). Record review of Resident #43's Quarterly MDS dated [DATE] revealed BIMS 07, indicating a severe cognitive impairment status in section C. Review of Resident #43's Care Plan undated revealed:Focus: Resident #43 has impaired cognitive function/impaired thought processes r/t (related to) DementiaGoal: Resident #43 will be able to communicate basic needs on a daily basis through the review date.Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs. Use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Cue, reorient and supervise as needed. Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Observation on 04/14/2026 at 10:26am of the room [ROOM NUMBER] with the A bed being unoccupied and the B bed to be occupied by Resident#43. Observation of a training mannequin in the unoccupied bed. Observation of Resident #43 to not be present in the room at the time of the observation. In an interview and observation on 04/14/2026 at 10:27am CNA P stated that training supplies should not be stored in a room that was occupied by a resident. She observed the training mannequin in the unoccupied bed of room [ROOM NUMBER]. She said that the mannequin was usually stored in the DON's office or in an empty room when not being used for training. She said that she did not know who placed the mannequin in the room of Resident#43, why the mannequin was placed in the room, or how long the mannequin had been in the room. She said that she did not know how Resident#43 felt about the mannequin being in the room. She said that she would have the mannequin removed from the room. In an interview and observation on 04/14/2026 at 10:32am with LVN H, who said that CNA P told her about the training mannequin being in the unoccupied bed of room [ROOM NUMBER]. She said that she moved the mannequin back into the office of the DON and she told the DON about the mannequin being in the room if Resident #43. She said that training supplies should not be stored in a room that was occupied by a resident. She said that she did not know who placed the mannequin in the room of Resident#43, why the mannequin was placed in the room, or how long the mannequin had been in the room. She said that she did not know how Resident#43 felt about the mannequin being in the room. In an interview on 04/14/2026 at 10:40am with Resident #43 in the dining hall, he said that the training mannequin had been in his room for two weeks. He said that he has asked multiple times for staff to remove the mannequin from his room. He said that he did not know who placed the mannequin in the room. He said that he went to sleep with a roommate and woke with the mannequin in the room. He said that it felt like a cruel joke, (continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>and he did not know why the staff would think it was funny. He said that when he would ask staff to remove the mannequin, they would laugh at him. He could not remember names of the staff that would have laughed and failed to remove the mannequin, or the dates and times staff would have laughed at him. He said that the facility was his home and he should be treated with dignity and respect in his home. In an interview on 04/14/2026 at 11:25am with Central Supply, who said that training supplies should not be stored in a room that was occupied by a resident. She said that the training mannequin was usually stored in the DON's office or in an empty room when not being used for training. She said that she did not know who placed the mannequin in the room of Resident#43, why the mannequin was placed in the room, or how long the mannequin had been in the room. She said that she did not know how Resident#43 felt about the mannequin being in the room. She said that if Resident #43 asked for the mannequin to be moved it should have been done immediately. She said that the facility was Resident #43's home and he had the right to be treated with dignity. In an interview on 04/14/2026 at 11:28am with the DON, who said that training supplies should not be stored in a room that was occupied by a resident. She said that the training mannequin was usually stored in her office or in an empty room when not being used for training. She said that she did not know who placed the mannequin in the room of Resident#43, why the mannequin was placed in the room, or how long the mannequin had been in the room. She said that she did not know how Resident#43 felt about the mannequin being in the room. She said that if Resident #43 asked for the mannequin to be moved it should have been done immediately. She said that the facility was Resident #43's home and he had the right to be treated with dignity. Record review of the policy titled, Resident Rights, with a revised date February 2021 read in part, Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to: a. a dignified existence; b. be treated with respect, kindness, and dignity;.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 6 residents (Resident #3, Resident #9, and Resident #12) reviewed for comprehensive care plans. 1. The facility failed to provide Resident #3 with comprehensive per-centered care plan to address Activities of Daily Living (ADL). 2. The facility failed to provide Resident #9 with comprehensive per-centered care to address her Contact isolation or Urinary Tract Infection. 3. The facility failed to provide Resident #12 with a comprehensive care plan to address her Contact isolation or Urinary Tract Infection. This failure could place residents at risk of not having personalized plans developed to address their specific care needs. Findings included: 1. Record review of Resident #3's face sheet revealed a [AGE] year old female, with an admission date 08/31/2023, and primary diagnosis of left vertebral artery occlusion and stenosis (blockages or narrowing in this artery, which supplies blood to parts of the brain). Record review of Resident #3's Quarterly MDS dated [DATE] revealed BIMS 09, indicating a moderate cognitive impairment status in section C. In section GG revealed that Resident #3 was triggered as dependent for bathing/showering, partial/moderate assistance for bed mobility, substantial/maximal assistance for dressing, partial/moderate assistance for personal hygiene, substantial/maximal assistance for toilet use, and substantial/maximal assistance for transfers. Record review of Resident #3's undated care plan revealed no focus, goal, or interventions for ADL's to address bathing/showering, bed mobility, dressing, personal hygiene, toilet use, and transfers. In an interview on 04/16/2026 at 2:25pm Resident #3 said that she as able to stand with little assistance from staff, and there was usually one aide in the room when she needed help with transfers, repositioning, toileting, and hygiene. 2. Record review of Resident #9's face sheet revealed she was a [AGE] year old female with an admission date 03/27/2026 with a primary diagnosis of wedge compression fracture of second lumbar vertebra (fracture to spine in the lower back), subsequent encounter for fracture with routine healing. Record review of Resident #9's Quarterly MDS dated [DATE] revealed BIMS 15, indicating a cognitively intact status in section C. In section I revealed that Resident #9 was triggered for Urinary Tract Infection as an active diagnosis. Record review of Resident #9's care plan dated 04/01/2026 revealed the following: The resident was not care-planned for Urinary Tract Infection or Contact Isolation. In an interview on 04/15/2026 at 3:15PM with Resident #9, (prior to entering the room there was signage outside of the room indicating the resident was on contact isolation). The resident stated she was on contact isolation for a Urinary Tract Infection. Resident stated she had started her medication on 4/14/26 and stated her antibiotics would be complete on 4/17/26. Resident #9 reported she had been having issues with UTI prior to being admitted into the facility. 3. Record review of Resident #12's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction caused by underlying systemic illnesses), hypertension (high blood pressure), cirrhosis (scarring of the liver), heart failure (heart does not pump effectively), chronic kidney disease (kidneys are not filtering), acute cystitis (bladder infection with blood in the urine) with hematuria, and asthma. Record review of Resident #12's admission MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15, which indicated moderately impaired cognition. The assessment revealed the resident was always incontinent of bowel and bladder. Record review of Resident #12's Care Plan dated 1/13/26 did not mention her UTI, contact isolation, or antibiotics. Record review on 4/14/26 of Resident #12's April 2026 Physician Orders revealed the following orders from MD R:- Contact Isolation: DX VRE (antibiotic resistant bacteria)/UTI, every shift for 14 days. Recollect UA C&S 48hr after antibiotics complete. Ordered on 4/1/26. In an observation and interview on 4/14/26 at 9:48am, Resident #12 had a sign on (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>her door that said she was on contact isolation. Resident #12 said she was on isolation for a urine infection. Record review of Resident #12's Progress Notes revealed a note from 4/15/26 at 8:35am from MD R that said, .She has completed her antibiotic course, and a follow-up urine culture is pending results. VRE UTI was diagnosed and treated with Macrobid 100 mg (antibiotic) BID, which she completed on 04/12/2026. Her past medical history revealed she had recurrent urinary tract infections and VRE UTI. Under Care Coordination it said, .Continue contact isolation for VRE. In an observation on 4/16/26 at 1:35pm, Resident #12 had a sign on her door that said she was on contact isolation. Resident #12 said no one had mentioned anything to her about discontinuing the isolation. In an interview on 4/16/26 at 3:10pm, MD R said Resident #12 should still be on isolation and it should not have been discontinued. She said she was waiting for the resident's urine culture results to come back to see whether the resident could come off of isolation or not. In an interview on 4/17/26 at 9:55am, the DON said the IDT team updated the care plan. The IDT Team consisted of the MDS Coordinator, SW, Dietary Manager, AD, and the DOR. The DON said the MDS Coordinator did the clinical portion of the care plan. She said acute changes were talked about in the morning meeting and the MDS Coordinator updated the care plan then. The DON said if the care plan was not comprehensive care could be missed. In an interview on 04/17/2026 at 10:58am with MDS Coordinator, she said that all residents should have a comprehensive person centered care plan. She said that without a comprehensive person centered care plan residents may not receive the appropriate care needed. She said that she was a part of the facilities Interdisciplinary Team (IDT), an after the completion of the MDS she is responsible for updating care plan. She said the care-planned could be updated by all clinical staff. She said she was not aware Resident #9's diagnosis had updated but that the resident should be care planned for UTI and Contact isolation. She said that she was not aware that Resident #3's care plan did not include a focus, goal, or interventions for ADL's. She said that any clinical staff that reviewed the care plan could have caught the errors and it was an oversight. In an interview on 04/18/2026 at 3:54pm with the DON, she said residents should have a comprehensive person-centered care plan. She stated when residents' diagnosis were updated it should have been reflected on the resident's care plan. She stated the risk of the resident's care plan not being updated could cause the resident not to receive proper care. Record review of the facility policy titled, Care Plans, Comprehensive Person-Centered, with a revised date March 2022 read in part, Policy Statement. A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The services provided or arranged by the facility, as outlined by the comprehensive care plan, are provided by qualified persons, are culturally- competent and trauma-informed. 7. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals, and preferences for 1 (Resident #4) of 24 residents reviewed for parenteral fluids. Resident #4 had an IV in her L hand that was tender to touch, had redness, and evidence of prurial leakage. IV had not been flushed for 7 days and was not removed per physician's orders. This failure placed residents at risk for a delay in treatment, pain, and hospitalization. Findings Include: Record review of Resident #4's face sheet revealed a [AGE] year-old woman originally admitted on [DATE]. Admitting diagnoses were COPD (ongoing lung condition caused by damage to the lungs), generalized anxiety disorder (overlay anxious), morbid (severe) obesity due to excess calories, need for assistance with personal care, post-traumatic stress disorder (mental health condition triggered by experiencing or witnessing terrifying events), mood disorder with depressive features (persistent sadness, loss of interest, and low energy) and moderate major depressive disorder (persistent daily feelings of sadness, low energy, and loss of interest). Record review of Resident #4's MDS dated [DATE], under Section C- Cognitive patterns revealed a BIMS score of 12 (moderate cognitive impairment, suggesting occasional mistakes in daily routine). Record review of Resident #4's care plan date initiated 4/27/23 revealed that she received psychology/psychiatry services in the facility. Activities care planned on 7/6/21 that she enjoyed word finds, watching TV, talking on the phone and crocheting. Resident #4 had a history of depression and was at risk for poor mood stability, increased depression, and poor quality of life. Intervention documented to assist with developing a program of activities that were meaningful and of interest and she should be encouraged to engage in activities (crocheting, completing puzzles, reading, and watching tv) frequently to increase mood and cognitive stimulation. Resident #4 also could not bear weight, was incontinent of bowels and bladder, and had an altered respiratory status related to sleep apnea. Record review of Resident #4's orders for April 2026 revealed that she on 4/2/26, she was ordered to receive normal saline flush intravenous solution 0.9 % (sodium chloride flush) for 1 liter intravenously. On 4/7/26, a new order was implemented to receive normal saline flush intravenous solution 0.9 % (sodium chloride flush) for 70 milliliters intravenously and was discontinued on 4/10/26. Resident #4 was ordered to drink 2 liters of fluid daily starting on 4/10/26. Record review of Resident #4's NMAR for April 2026 revealed that Resident #4 was ordered to receive Normal Saline Flush Intravenous Solution 0.9 % (Sodium Chloride Flush) with 1 liter intravenously every shift for hyperkalemia (high potassium), until MD reviewed BMP results 4/6/26. The order was started on 4/4/26 and discharged [DATE]. The order was documented as completed for both day shift (6 a.m.) and night shift (6 p.m.). It was last completed by RN G on 4/10/26. Record review of Resident #4's NMAR for April 2026 revealed that Resident #4 was ordered to receive Normal Saline Flush Intravenous Solution 0.9 % (Sodium Chloride Flush) with 70 millers intravenously every day and night shift for abnormal lab fluids continuously until doctor discharged the order. The order was started on 4/7/26 and discharged [DATE]. The order was documented as completed for both day shift (6 a.m.) and night shift (6 p.m.). Record review of Resident #4's progress notes dated 4/9/26 at 10:30 a.m. by the MD revealed staff reported no concerns and noted she ate a lot of fast food and did drink fluids. Resident #4 denied cough, shortness of breath, chest pain, or palpitations. She reported she drank about 1 liter of fluid per day. The patient was instructed that she continued with acute kidney injury due to poor fluid intake. The plan was to continue with normal saline IV fluid hydration; however, the patient preferred to do oral fluid intake. She was encouraged to have at least 2 liters of fluid daily. Given that she was able to drink, will hold off on continuing the normal saline and would repeat a BMP (a blood test that checks the levels of different substances in your blood) in the morning to monitor her acute kidney injury. eGFR (is a measure of how well your (continued on next page)</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>kidneys are filtering waste from your blood) has shown improvement, increasing from 17 to 20 in the last 3 days. Record review of Resident #4's progress note on 4/11/26 at 1:13 a.m. by LVN L revealed that IV normal saline remained on hold at that time. In an observation and interview 4/14/26 at 9:10 a.m., revealed Resident #4 was lying in bed with the covers pulled up to her chin. She held up her left hand and showed the surveyor that she currently had an IV line in her hand. She stated she was given an IV so that she could get extra fluids and she could not get it wet, so she had been getting bed baths instead of showers. In an interview on 4/16/26 at 12:15 p.m. with the MD, she stated that she placed an IV line in Resident #4 about a week ago because she had been having acute and chronic hypokalemia (low potassium in blood serum) and dehydration. The MD stated that reviewing lab work, her kidney function had dropped around 15 which was very low. The MD stated that Resident #4 and herself had a long discussion about her hydration and she stated that she needed more fluids although Resident #4 did not believe the lab results. Resident #4 was started with normal saline and potassium and she let her know she either tried the IV to receive additional fluids or her next step would be to the ER. The MD stated since then her kidneys and potassium levels had been stable and Resident #4 recently stated she wanted to try receiving more fluids orally instead of using the IV. In a follow up observation and interview on 4/17/26 at 10:30 a.m. Resident #4 stated that her IV was changed on 4/10/26 but it had not been changed or flushed since then. She said that the nurse (name unknown) told her that they were keeping the IV line in her hand because they may need to put the IV bag back up so she could get extra fluids but the IV site was a little tender. Observation of the IV revealed that it was inserted in the left hand and was secured with a transparent Tegaderm dressing. At the insertion site, there was visible dried blood beneath the dressing and with noted redness. The surrounding skin also had a yellow discoloration. No date was documented on the bandage. In an interview on 4/17/26 at 11:05 a.m. with LVN D, he stated that he was currently working Hall B and was familiar with Resident #4. He stated that he had not been at work since 4/13/26 and today was his first day back. LVN D stated that during morning assessments, he would assess the residents when he arrived to work at 6 a.m. to check if they were alert, oriented, and aware and he was required to check IV's every day. When asked about Resident #4's IV, he stated that he didn't know if she had an IV because it might have been discharged pending lab work. He stated when checking IV's, he was required to check the date on the bandage to see the last time it was changed, and check for redness, swelling, and infiltration (occurs when intravenous fluid or medication leaks into surrounding tissue instead of the vein, causing swelling, discomfort, and potential tissue damage He stated that IV dressings were typically changed every 7 days or as needed and if the IV was not running, nursing would flush it and ask the doctor if she wanted to discharge it. LVN D stated that flushing the IV should be done once daily and the adverse effects of not flushing the IV could be the risk of it getting clogged, increase risk for infection, a delay in flushing could potentially clot into the body and possibly cause a pulmonary embolism (a blood clot that blocks and stops blood flow to an artery in the lung). During the interview, LVN D was asked to join the surveyor in Resident #4's room to observe the IV line. He stated that he saw redness and evidence of prurial leakage (means that the intravenous fluid or medication has escaped from the vein into the surrounding tissue). In a follow up observation and interview on 4/17/26 at 12:47 p.m., revealed Resident #4 had gauze on her left hand that was secured with paper tape where the IV once was. She stated that nursing removed the IV from her hand a few minutes ago. In an interview on 4/17/26 at 2:15 p.m. with the MD, she stated that she knew Resident #4 still had an IV in her hand because she was dehydrated and had been getting IV fluids so she wanted it to stay in. The surveyor asked her if the IV was infiltrated because Resident #4 had complaints of pain, the injection site was red, warm, tender to touch, and bruised. The MD stated that those symptoms did not mean that the IV was infiltrated and she did not know that Resident #4 had complained of pain. The MD stated she did not know that the IV line had not been flushed since 4/10/26. She stated she did not know why the IV line was still in Resident #4's arm because she verbally informed RN G to remove the IV line on 4/16/26 (not documented in progress (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Veterans Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Fallbrook Drive Houston, TX 77038	
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)		
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>note). The MD stated that when she saw Resident #4 the morning of 4/17/26, the IV site was not warm and she did not have any complaints of pain. In an interview on 4/18/26 at 4:15 p.m., the DON stated that the IV for fluids for Resident #4 had been placed on hold while the MD was waiting on lab work. She stated that although the order was discontinued, the IV should have been flushed daily while they awaited orders from the MD. The DON stated that the harm in leaving an IV in Resident #4's arm without flushing could be irritation and infection. In an interview on 4/18/26 at 4:48 p.m. with RN G, she stated that the last time she worked with Resident #4 was on 4/16/26 and she remembered seeing an IV line in her left hand. She stated that there was an order the previous week to receive fluids by IV but the fluids were to be held. She stated that on 4/16/26, the MD told her to remove the IV but she forgot because there was a lot going on. The DON called her on 4/17/26 and gave her the education on following physician's orders and was told that she needed to have a better system going forward and she should write things down so she would not forget. She stated that she was a new nurse and she took full accountability for what happened and stated that it would not happen again. She stated that she believed she flushed it after 4/10/26, but she did not document it and could not recall if she updated the NMAR. Record review of the facility's policy and procedures on Change in Resident's Condition or Status (revised April 2025) revealed in part: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition. The nurse will notify the resident's attending physician or physician on call when there has been a(an):.discovery of injuries of an unknown source.significant change in the resident's physical/emotional/mental condition.need to transfer the resident to a hospital/treatment center. A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting).Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.Unless otherwise instructed by the resident, a nurse will notify the resident's representative. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. No policy was requested or attained from the facility on the use or Parenteral Fluids.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observation, interview and record review the facility failed to ensure the accurate acquiring, dispensing, receiving, and administering of medications for 1 of 1 medication storage rooms and 3 of 6 (Nurse 100 hall, Nurse 200 hall, and Med Aide 200 hall) medication carts, reviewed for pharmacy services. The facility failed to ensure expired medications were not stored with current medications on the 100 hall Nurse medication cart, 200 hall Nurse medication cart, 200 hall Med Aide medication cart, and medication storage room. These failures could place residents at risk for not receiving the therapeutic benefit of the medication and/or worsening health concerns. Findings included: 1. In an observation on 4/17/26 at 11:20am, there were 5 bottles of expired medications found in the 100 hall nurse medication cart. The expired medications were as follows:- Glucose Control Strips Opened 3/2/26 Expired 4/2/26- Calamine Lotion 6oz Multit-use bottle Expired March 2026- Sodium Chloride Tablets 1 gm Multit-use bottle Expired March 2026- Bisacodyl Suppository 10mg Expired 4/1/26 In an interview on 4/17/26 at 11:20am, LVN O said the medications in the 100 hall nurse medication cart should be checked for expiration at the beginning of the shift. He said expired medication was a medication error and the medications could be less effective. 2. In an observation on 4/17/26 at 11:24am, there was one bottle of expired Saline Nasal Spray 1.5oz found on the 200 hall nurse medication cart. It was opened on 3/9/26 and expired on 4/9/26. In an interview on 4/17/26 at 11:24am, LVN D said he tried to check the 200 hall nurse medication cart every shift, but that did not always happen. He said the expired medication could be less effective. 3. In an observation on 4/17/26 at 12:04pm, there were 10 bottles of expired eye drops, ranging in expiration dates from January 2026 to April 20226 on the 200 hall med aide cart. In an interview on 4/17/26 at 12:15pm, Med Aide F said she checked her 200 hall med aide cart once a month. She said eye drops were good for 30 days after opening. The Med Aide said expired eye drops could cause an eye infection or not be as effective. 4. In an observation on 4/17/26 at 11:45am, one bottle of Insulin Lispro 100u/ml was found expired in the medication storage room refrigerator. The Insulin had been opened on 2/8/26 and expired on 3/8/26. In an interview on 4/17/26 at 11:42am, the DON said she expected staff to check the cart at the beginning of their shift for expired medications and the medication storage room should be checked daily as well. She said opened eye drops, nose sprays, and Insulin were only good for 30 days after opening because bacteria could get inside and they could be less effective. Record review of the facility's policy and procedure on Medication Labeling and Storage (revised February 2023) read in part: .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observations, interviews and record review, the facility failed to ensure residents have the right to request, refuse, and or discontinue treatment and to formulate an advance directive for 1 (Resident #80) of 24 residents whose records were reviewed for advance directives.- The facility failed to have Resident #80's code status on file from admission ([DATE]) through [DATE].This failure could place residents at risk for not having their end of life wishes honored. The findings included:Record review of Resident #80's undated face sheet revealed she was an [AGE] year old female who admitted to the facility on [DATE] with diagnoses of injury of right lower leg, orthostatic hypotension (blood pressure drops when standing), pain in right ankle and joints of right foot, dementia (progressive decline in memory), anemia (low iron), chronic kidney disease (kidneys do not filter), afib (irregular heart rate), rheumatoid arthritis (autoimmune disease of joints), acute kidney failure, and fracture of right lower leg. The code status was blank on the face sheet.Record review of Resident #80's Baseline Care Plan dated [DATE] revealed the code status was blank.Record review of Resident #80's admission MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15, which indicated normal cognition.Record review of Resident #80's Care Plan dated [DATE] revealed a Focus: Resident #80 desires to have a full code status (Initiated: [DATE]). The interventions included ensuring the staff were aware of the resident's advanced care planning decisions and keeping the face sheet, order, and profile information updated as needed.Record review performed on [DATE] of Resident #80's [DATE] Physician Orders revealed no advanced directives ordered or code status anywhere in the resident's chart.In an observation on [DATE] at 3:00pm, the code cart did not have a code book.In an interview on [DATE] at 3:04pm, CNA M said they did not have a code book. The code status of residents was only listed in the EMR.In an interview on [DATE] at 3:10pm, MD R said if there was not a code status listed on a resident and the resident suddenly was unresponsive, the staff would perform a full code until they could find out what the code status was.In an interview on [DATE] at 8:53am, Med Aide F said the code status was if the resident was going to be resuscitated or not. She said she would look on the resident's orders to see what the code status was. Med Aide F said if the code status was not in the orders she would look in the resident's physical chart that was at the nurse's station. She said if the order was not located anywhere, then she would call the MD for an order. She said if a resident became unresponsive and there was no code status, she would perform CPR until further notice.In an interview on [DATE] at 8:55am, LVN D said he would check the resident's orders or face sheet for the code status order. He said the admitting nurse put the code status in and got the information from the medical records. LVN D said the code status was usually on the first pages of the medical records. He said if he had a new resident, he would look to see what their code status was but otherwise he only kept track of the DNRs. The nurse looked in the orders for Resident #80 and saw an order for the code status that was entered on [DATE]. He said if a resident became unresponsive and he did not see a code status on them he would perform CPR until further notice.In an interview on [DATE] at 10:01am, the DON said a code status told them if the resident wishes were to have CPR or be a DNR. She said she would look in the orders to find the resident's code status, and the code status was only in the orders. The DON said the code status was entered by the admitting nurse. She said if a resident became unresponsive staff checked the EMR for their code status and then either performed CPR or not. The DON said if there was not a code status, staff would perform CPR until a code status could be determined. She said the admission nurse (continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>probably forgot to put the code status in, and said it could cause a delay in the care. The DON said either she or the IDT team reviewed admission checklists for completeness so she was unsure how that happened. In an interview on [DATE] at 2:45pm the MDS Coordinator said they got information for resident's care plans from their charts. She said if the code status was not in the chart, she would ask around to see where the order was. She said she was not the one who entered Resident #80's code status on her Care Plan, and it was her co-worker that came in the evenings. The MDS Coordinator said when she looked for the code status of residents she looked in the EMR, the medical records, and the physical chart. Record review of the facility's policy and procedure on admission Assessment and Follow Up: Role of the Nurse (revised [DATE]) read in part: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. Determine if the resident has existing advance directives. If so, initiate the process of obtaining a copy for the medical record. If not, provide the resident with information on his/her rights to have advance directives and initiate the process of establishing them. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The following information should be recorded in the resident's medical record. Orders obtained from the physician. Record review of the facility's policy and procedure on Advance Directives (revised [DATE]) read in part: The resident has the right to formulate advance directives to convey decisions about end-of-life ahead of time. Advance directives are honored in accordance with state law and facility policy. Advance directives include the following documents: Directive to Physicians & Family or Surrogates; Medical Power of Attorney; Out of Hospital- Do Not Resuscitate (OOH-DNR); Statutory Durable Power of Attorney; and Declaration for Mental Health Treatment. Upon admission the Social Service Director/designee will determine if the resident has any advance directives in place and will provide the residents and/or the resident representative (RP) with written information regarding advance directives. Advance directives that have been completed, will be copied and uploaded into the resident's electronic health record (EHR) and the EHR will be updated to reflect whether or not the resident has executed any advance directive. The admitting charge nurse will obtain an order for code status. In the absence of an OOH-DNR, the nurse will obtain an order for a Full Code Status and enter into the EHR. If OOH-DNR is present, the charge nurse will obtain an order for Do Not Resuscitate (DNR) and will enter the order into the EHR. Social Service Director/designee will meet with the newly admitted resident or RP within 72 hours of admission to orally review and discuss the written information referenced above. and to verify the code status of the resident. The Social Service Director (SSD)/designee will complete an Advance Care Planning plan of care and indicate the resident's choice regarding advance directives and code status. The social worker/designee will also ensure that. An order for code status is reflected in the EHR which will read either Full Code or Do Not Resuscitate based on the resident's advance directives. SSD/designee will review all advance directives in the quarterly care plan meetings.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 1 (Resident #85) of 22 residents reviewed for sanitary conditions. The facility failed to clean and disinfect a mud brown smudge with a solid consistency from the wall inside of Resident #85's room for 3 days. The failure could place residents at risk of sickness and infection. Findings included: Record review of Resident #85's face sheet revealed an [AGE] year-old man was initially admitted on [DATE]. Admitting diagnoses were diverticulosis of the large intestine, COPD (ongoing lung condition caused by damage to the lungs), Crohn's Disease of large intestine (is a chronic inflammatory bowel disease that affects the gastrointestinal tract), hemorrhage (bleeding from a damaged blood vessel) of anus and rectum, hemorrhoids (swollen veins in the anus and lower rectum), and slow transit constipation. His face sheet revealed a Full code status. Record review of Resident #85's MDS dated [DATE], under Section C- Cognitive patterns revealed a BIMS score of 9 (moderate cognitive impairment, suggesting occasional mistakes in daily routine). Record review of Resident #85's care plan initiated on 8/20/23 revealed that he required assistance with ADL's and his functional abilities due to impaired cognitive cognition and he was incontinent of bowels and bladder. On 4/18/26, the care plan was updated to include Resident #85 had a behavior problem of smearing BM everywhere on his side of his room and would try to clean it up at times but would still smear it everywhere. In an observation and interview on 4/14/26 at 9:20 a.m., Resident #85 was observed standing on his side of the room near the wall next to a window. He wore a t-shirt and an adult brief that appeared full by the way the brief drooped and swayed when he moved. Upon entry, the room had a very pungent smell of BM. When the surveyor entered the room, Resident #85 turned from the wall and walked toward the right side of the bed to sit. On the wall where he was standing was a mud brown smudge of a thick consistency that looked about 8 inches long. The smudge did not have any drip lines and looked raised on the left side and thinned out towards the right. During the interview, Resident #85 stated that he was doing alright and had no concerns regarding staff coming when he pressed his call light. He stated that he used the restroom on his own, but staff would assist him as needed. On his bed, there were brown stains of what appeared to be BM that appeared to be coming from the side of his brief. When asked about the stains on his linen, he stated that the aides changed his linen and housekeeping cleaned his room daily. Two flies buzzed around his room and he stated that he did not know where they came from but maintenance would come in and spray the room periodically and had set traps in the past to catch any pests. In a follow up interview on 4/15/26 at 9:47 a.m., Resident #85 stated that he had hemorrhoids and he told the nurses, but there was nothing they could do about it. When asked a follow up question regarding his linen, he stated that the stains on his sheets were given to him when he got them and the machine could not get everything out. During the interview, Resident #85 began to stare past the surveyor for a period of time. In the room, a strong smell of BM materialized. In an interview on 4/15/26 at 9:56 a.m. with CNA G, she stated that Resident #85 required assistance with getting dressed and undressed and he was able to feed himself. She stated that sometimes he would go to the restroom because he was able to walk around by himself but he would need follow-up assistance after to ensure cleanliness. When asked about the flies, CNA G stated that Resident #85 had a condition and she was unsure what it was but it caused him to go #2 frequently. She stated they could provide care for him, but he would go again. She stated that the aide that tended to Resident #85 on that hall was in his room almost every 30 minutes to an hour providing care and housekeeping would go all over to make sure the room was cleaned. In an interview on 4/15/26 at 10:03 a.m. with CNA R, she stated that she had first noticed the flies in Resident #85's room on 4/14/26 and she believed it was due to his incontinence and that (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>housekeeping probably had not cleaned the room yet. She stated that Resident #85 would not let the aides know when he used the bathroom and he did not use his call light. She stated that she would know that he needed incontinent care because there would be a noticeable smell and by the way his brief looked because he did not like to wear bottoms unless he left his room. She stated when she provided care, she would normally clean, wipe, and put him in a new brief. She stated he sometimes would have a loose stool and because he did not wear bottoms, the stool would leak out on his sheets so she regularly would have to change his linen but had not gotten to his room to repeat care at that time. When asked about the mud brown smudge on the wall, she stated she did not know what it was and could not speak to it. In an observation on 4/17/26 at 10:45 a.m., revealed the mud brown smudge on Resident #85's wall was still there. Flies were no longer present at the time. In an interview on 4/17/26 at 10:58 a.m. with HK A, she stated that she had worked at the facility for over 10 years and she normally worked on hall B where Resident #85 was housed. She stated that she had not gotten to his room yet because she was clearing the room across the hall from his for new admits but she would be there shortly. HK A was directed to the mud brown smudge on the wall of Resident #85's wall and she stated that perhaps the smudge was from his coffee. The surveyor pointed out how thick the smudge was and that there was no drip marks indicating that it was thin liquid. HK A said that she had been off for 2 days but she was not sure what it was but she would make sure the entire room was cleaned up. She followed up with the surveyor and stated that the room and the wall had been cleaned. In an interview on 4/17/26 at 11:02 a.m. with the EVS Director, he stated that he oversaw all maintenance responsibilities and housekeeping. He explained that housekeeping was supposed to dust, clean door knobs, wipe down beds, clean restrooms, floors, wipe down walls, and any and everything inside of a resident's room. He stated that harm in keeping the mud brown smudge on the wall could be sickness and he expected the rooms to be cleaned throughout every day. In an interview on 4/18/26 at 4:15 p.m., the DON stated that the harm in leaving substances like the mud brown smudge on the wall would be the potential for infections. She stated that sometimes Resident #85 would smear BM everywhere and if he had an incident, the facility staff was supposed to go behind him frequently. Record review of the facility's policy titled Homelike Environment revised February 2021, policy statement revealed that residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. In that:</p> <ol style="list-style-type: none"> 1. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; b. clean bed and bath linens that are in good condition; c. pleasant, neutral scents

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on interview and record review the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 (Resident #44) of 24 residents reviewed for PASRR. The facility failed to perform a new PASRR level 1 assessment on Resident #44 due to diagnoses, of major depressive disorder (persistent, intense, low mood, or a loss of interest), generalized anxiety disorder (persistent, excessive, and uncontrollable worry), mood disorder due to known physiological condition with mixed features (mania/hypomania and depression occur together), and adjustment disorder with mixed disturbance (emotional issues and behavioral problems after a stressor). This failure could place residents at risk of not receiving the services and support needed. Findings Included: Record review of Resident #44's undated face sheet revealed he was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses of mood affective disorder (long-term emotional disturbances), recurrent major depressive disorder, adjustment disorder with disturbance of conduct, generalized anxiety disorder, and mood disorder due to known physiological condition with manic features. Record review of Resident #44's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 4, which indicated severely impaired cognition. The resident had impairment on one side of his upper extremities and impairment of both sides of his lower extremities. He used a wheelchair for mobility. The resident was dependent for all ADLs and was always incontinent of bowel and bladder. The assessment revealed resident #44 was diagnosed with anxiety disorder, depression, and bipolar disorder and was taking anti-anxiety and antidepressant medications. Record review of Resident #44's Care Plan dated 12/16/23 revealed a Focus: Resident #44 was receiving psychology/psychiatry services in the facility. Interventions included communicating with Resident #44 his progress of the psychology/psychiatry services and notifying provider and family of any changes in resident's condition. Focus: Resident #44 was using anti-anxiety medication r/t anxiety disorder. Interventions included administering anti-anxiety medications as ordered, monitoring for side effects and effectiveness, and educating resident/family about risks and benefits. Focus: Resident #44 was using antidepressant medication r/t depression. Interventions included administering antidepressant medications as ordered, monitoring for side effects and effectiveness, and educating resident/family about risks and benefits. Record review of Resident #44's PASRR Level 1 Screening performed 12/6/23 by MDS N, revealed the resident the resident did not have evidence of dementia as the primary diagnosis, he did not have evidence of mental illness, he did not have evidence of an intellectual disability, and he did not have evidence of a developmental disability. Record review of Resident #44's Progress Notes revealed an H&P dated 12/11/23 from NP A that said, .past medical history of TBI, anxiety, depression. Record review of Resident #44's medical record revealed a Psychiatric Initial assessment dated [DATE] from MHNP F revealed that he was diagnosed with recurrent major depressive disorder and was being treated with Bupropion, generalized anxiety disorder and being treated with lorazepam, mood disorder due to known physiological condition with mixed features and being treated with Depakote, and adjustment disorder with mixed disturbance of conduct. Record review of Resident #44's Progress Notes revealed a note dated 4/9/26 from LCSW Z that revealed the resident was being treated for generalized anxiety disorder, recurrent major depressive disorder, and mood disorder due to known physiological condition with manic features. Record review on 4/16/26 of Resident #44's April 2026 Physician (continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Orders revealed the following orders from MD R:- VPA (Depakote) Level Q6 months. Ordered 5/23/24.- Antidepressant monitoring for sertraline and bupropion every shift for side effects, every shift. Ordered 5/23/24.- Behavior Monitoring - Antidepressant Behavior (Escitalopram), every shift. Ordered 4/14/26.- Behavior Monitoring - Antidepressant Behavior (Trazodone), every shift. Ordered 4/13/26.- Behavior Monitoring - Anxiolytic Behavior (Lorazepam), every shift. Ordered 4/6/26.- Behavior Monitoring for antidepressant medication: sertraline and bupropion, every shift document resident outcome following intervention. Ordered 5/23/24.- Behavior Monitoring for antipsychotic medication: depakote, every shift document resident outcome following intervention. Ordered 5/23/24.- Deer Oaks may provide psychiatry/psychology services and medication management as needed. Ordered 12/13/23.- Side effects - antidepressant: chart all appropriate codes, every shift. Ordered 4/14/26.- Side effects - anxiolytics: monitor every shift, document code and notify provider, every shift. Ordered 4/6/26.- Bupropion HCl ER (XL) Oral Tablet Extended Release 24 hour 150mg, 1 PO QD for depression. Ordered 12/6/23.- Depakote Oral Tablet Delayed Release 250mg, 1 PO BID for mood disorder. Ordered 5/28/24.- Lorazepam Oral Tablet 0.5mg, 1 PO TID for anxiety. Ordered 12/6/23.- Sertraline HCl Oral Tablet 50mg, 1 PO QD for recurrent major depressive disorder. Ordered 2/21/24.In an interview on 4/17/26 at 9:01am, the MDS Coordinator said she remembered Resident #44 being negative for the PE when he was first admitted , then he was diagnosed with other medical conditions and she did not submit a new PE because she knew he was not going to qualify since he had not been in any psychiatric facilities. She said since she did not do a PE the resident could be losing out on possible services.Record review of the facility's policy and procedure on PASRR (dated 1/20/26) read in part: The aim of the PAS RR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID) or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed , whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD.The PASRR Level 1 Screen (PL 1) The facility Admissions Coordinator or designee will ensure the referring entity provides a copy of the PL 1 upon admission.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 (MI) or new PL 1 (ID/DD). A subsequent positive PL 1 will be entered according to 1012 findings (MI). 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 (MI) or new PL 1 (ID/DD). A subsequent positive PL 1 will be entered according to 1012 findings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Veterans Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Fallbrook Drive Houston, TX 77038	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for 1 out of 24 residents (Resident #12) reviewed for ADLs.- The facility failed to shower/bathe Resident #12 for a week (from 4/9/26-4/16/26) when she was scheduled to have one three times a week on Tue/Thu/Sat.This failure could place residents at risk of skin breakdown, infection, and reduced feelings of self-worth.Findings included:Record review of Resident #12's undated face sheet revealed she was an [AGE] year old female who admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, hypertension, cirrhosis, heart failure, chronic kidney disease, acute cystitis with hematuria, and asthma.Record review of Resident #12's admission MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15, which indicated moderately impaired cognition. The MDS revealed the resident was substantial/max assistance (helper does more than half the effort) with showers/baths. Resident #12 was always incontinent of bowel and bladder and had shortness of breath when lying flat. The resident took diuretics (medication that increased urination) and was on oxygen.Record review of Resident #12's Care Plan dated 1/13/26 revealed a Focus: Resident #12 had an ADL self-care performance deficit r/t weakness. The interventions included PT/OT evaluation and treatment and encouraging the resident to participate to the fullest extent possible. Focus: Resident #12 was at risk for skin breakdown due to incontinence. Interventions included keeping skin clean and dry.Record review of Resident #12's April 2026 Physician Orders as of 4/14/26 revealed the following orders from MD R:- Contact Isolation Dx VRE/UTI, every shift for 14 days. Recollect UA C&S 48hr after antibiotics complete. Ordered 4/1/26.- Healing Partners to consult for skin and wound conditions/prevention. Ordered 2/15/26.- Calamine External Lotion, Apply to affected area topically Q6hr PRN for itching. Ordered 4/2/26.- Lubriderm External Lotion, Apply to trunk and BLE topically QAM and QHS for dry skin. Ordered 4/2/26.- Nystatin External Powder 100000 unit/gm, Apply to abdominal folds topically QAM and QHS for erythema intertrigo (rash caused by skin-on-skin friction, heat, and moisture). Ordered 2/20/26.In an interview and observation on 4/14/26 at 9:48am, Resident #12 was in a room with contact isolation. She was sitting up in bed and had brown, dirty looking nails. Resident #12 said she was in contact isolation for bacteria in her urine. She said she was moved to the 400 hall from the 100 hall and she had not had a bath/shower since she moved there. She said she had no problems with showers/baths on the 100 hall. Resident #12 said it had been almost 2wks since she had a bath/shower.Record review on 4/16/26 of Resident #12's April 2026 Shower/Bathing Task, revealed she was scheduled for Tuesdays, Thursdays, Saturdays on the 2pm-10pm shift. The task revealed her last shower/bath was on 4/9/26 at 3:14pm.In an interview on 4/16/26 at 11:58am, CNA M said she gave showers to all of the residents in A beds, except for the residents on the 300 hall. She said the 2pm-10pm shift gave showers to the B beds. CNA M said she documented the showers and refusals in the POC under the shower/bath task. She said she thought she had given Resident #12 a shower the previous week but was not sure. The CNA said if she was unable to give a shower/bath it was because she was pulled to the floor to work as a CNA, and in that case the CNAs for that hall were responsible for giving their own showers/baths. CNA M said if residents did not get showers/baths they could stink and could have skin breakdown.In an interview on 4/16/26 at 1:35pm, Resident #12 said she had not received a shower/bath yet.In an interview on 4/17/26 at 10:01am, the DON said she expected residents to get their scheduled showers/baths and whenever they needed them. She said they had enough help that (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avir at Veterans Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Fallbrook Drive Houston, TX 77038	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>every resident should get theirs. The DON said if a resident did not get their shower/bath they could have dignity issues or could have skin breakdown. She said the IDT Team talked about the POCs in the morning meetings. Record review of the facility's policy and procedure on Activities of Daily Living (ADL), Supporting (revised February 2025) read in part: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care).</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure radiology services were obtained and reported in a timely manner for 1 of 8 residents (Resident #14) reviewed for radiology services.-The facility failed to ensure Resident #14 received a STAT (immediately or without delay) chest x-ray as ordered on 04/13/2026 which delayed further medical assessment and treatment until 04/14/2026.This failure placed residents at risk of experiencing delays in clinical decision-making and treatment.Finding included:Record review of the face sheet for Resident #14 dated 04/14/2026 revealed an [AGE] year-old female admitted to the facility on [DATE] with principal diagnoses of other specified chronic obstructive pulmonary disease (COPD progressive and lifelong respiratory disorder that leads to an abnormal inflammatory response in the lungs).Record review of Resident #14's undated care plan revealed the following:Focus: Resident #14 is at risk for having altered respiratory status/difficulty breathing due to her COPD, she does require the use of oxygen.Goal: Resident #14's will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date. Resident #14 will have no complications related to her COPD though the review date.Intervention: Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Assist resident/family/ caregiver in learning signs of respiratory compromise. Encourage sustained deep breaths by: Using demonstration (emphasizing slow inhalation, holding end inspiration for a few seconds, and passive exhalation); Using incentive spirometer (place close for convenient resident use); Asking resident to yawn. Maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as ordered/required to clear secretions. Monitor /document changes in orientation, increased restlessness, anxiety, and air hunger. Monitor for s/sx (sign and symptoms) of respiratory distress and report to MD(Doctor of Medicine) PRN: Increased Respirations; Decreased Pulse oximetry; Increased heart rate (Tachycardia);Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough; Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey. Monitor/document/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring. O2 as indicated by the MD. Pace and schedule activities providing adequate rest periods.Record Review of Resident #14's Quarterly MDS dated [DATE] revealed a BIMS score 12 of 15; indicating Resident #14's had cognition that was moderately impaired. In section I Resident#14 was triggered for Asthma, Chronic Obstructive Pulmonary Disease), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis) in section I. In Section O Resident #14 was triggered for oxygen therapy in respiratory treatments. Record Review of Resident#14's progress note dated 04/13/2026 at 09:13am by LVN G read in part, Resident c/o(complaints of) increasing aching chest pain upon exhalation. Resident did not appear to be in any respiratory distress. v/s (vital signs) obtained BP(blood pressure 135/64 HR(heart rate) 80, RR(respiration rate) 18 T (temperature)97.7 O2(oxygen) 97% on 2L(liters) NC(nasal cannula) 6 out of 10 on a 0-10 pain scale. Nitroglycerin(used to treat chest pain) administered, resident requested PRN(as needed) Pain medication, nurse administered, On call notified, new order for STAT CXR (chest x-ray) ordered. @ 2040 (8:40pm) resident stated chest pain had subsided. Will continue to monitor throughout shift for coc[sic].Record Review of Resident #14's physician order dated 04/13/2026 at 08:47pm for a STAT chest x-ray. Record Review of Resident #14's chest x-ray dated 04/14/2026 with no abnormal results.In an interview and observation on 04/14/2026 at 9:39am LVN H was observed to enter/exit the room of Resident#14 responding to the call light. She said that Resident#14 requested an update on when she would receive a chest x-ray that was order on the night shift on 04/13/2026 (continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>after she experienced chest pain. She said that she completed an assessment of Resident#14 with vitals within normal limits and no complaints of pain. She said that the resident expressed she was upset that she had not got the x-ray because the night nurse (LVN G) told her that it would be completed the same night. She said that she asked the resident if she wanted to go to the hospital to complete the x-ray but the resident declined. She said that she told Resident #14 to give her some time to research because she was not aware of the order. In an interview on 04/14/2026 at 9:42am Resident#14, said that sometime after lunch on 04/13/2026 she started to have chest pains, but she did not alert the day nurse. She said that the pain worsened, and she told the night nurse(LVN G). She said that the night nurse (LVN G) called the nurse practitioner who ordered medication and a chest x-ray. She said that the night nurse (LVN G) told her that she would get the x-ray the night of 04/13/2026, but she had not received the x-ray. She said that she was not currently in pain, the nurse(LVN H) had assessed her and asked if she wanted to go to the hospital. She said that she declined going to the hospital. In a follow up interview on 04/14/2026 at 10:32am LVN H said that LVN G received orders from the on-call nurse practitioner for Resident#14 to receive a STAT chest x-ray. She said that she confirmed with laboratory company that the x-ray had not been completed and they could send a technician between 5:00pm-6:00pm on 04/14/2026. She said that she provided the information to Resident#14's primary physician who was present in the building and agreed to reassess Resident #14 for a need for a STAT chest x-ray. She said that she did not see that LVN G followed up with the on-call nurse practitioner after the x-ray was not completed the night of 04/13/2026. She said that LVN G did not give her information to follow up on a chest x-ray for Resident#14 during shift change. She said that when a STAT order was given the expectation was that it was completed within 2-4 hours. She said that if the order can not be completed in the four-hour window contact should be made with the physician or nurse practitioner immediately. She said that if the physician or nurse practitioner are not notified, they are not able to make changes to the treatment plan, it could cause a delay in treatment, and the residents condition could worsen. In a follow up interview on 04/14/2026 at 11:33pm with Resident #14, she said that LVN H told her that the x-ray technician should arrived around 5:00pm, and her primary physician will come see her that same day. She said that LVN H asked if she wanted to go the hospital again and she declined. In an interview on 04/14/2026 at 11:45am with MD R, who said that LVN H came to her and asked if Resident#14 could be assessed after a STAT Chest X-ray was not completed the night of 04/13/2026 after complaint of chest pain. She said that LVN H told her that the residents vitals were within normal limits, the resident was not currently in pain, and Resident #14 was offered transfer to the hospital and declined. She said that she had been made aware that a technician was expected at the facility by 5pm to complete the order. In a follow up interview on 04/14/2026 at 1:38pm with MD R, who said she assessed Resident #14, to have no pain, normal vital signs, and clear lungs. She said that the lab technician will arrive by 6:00pm to complete the chest x-ray. She said that STAT labs should be completed within 2-4 hours. She said that staff should notify the physician if the lab can not be completed, to assess the need to send to the hospital or remain at the facility and wait. She said that if the task is not completed it could cause a delay in treatment. She said that when she reviewed the order for Resident#14 she did not see that the order was STAT. In an interview on 04/15/2026 at 12:44pm with NP A, who said that STAT labs should be completed within 2-4 hours. She said that staff should notify the physician if the lab can not be completed, to assess the need to send to the hospital, remain at the facility and wait, or additional orders could be given. She said that if the task were not completed it could cause a delay in treatment. She reviewed the electronic medical records of Resident# 14. She said that that the on call nurse practitioner ordered a STAT chest x-ray for Resident #14 on 04/13/2026 at 8:00pm. She said that that the chest x-ray was not completed until 04/14/2026 at 5:00pm with no abnormal results. She said that there was a delay in treatment for Residene#14. In a phone interview on 04/16/2026 at 12:16pm LVN G said that stat labs should be completed within 3-5 hours. She said that if a technician does not arrive to the facility within the (continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>window notification should be made to the physician or nurse practitioner for additional orders or interventions. She said that if the physician or nurse practitioner are not notified it could cause as delay in treatment. She said that she worked the 6:00pm to 6:00am shift on 04/13/2026. She said that during her shift Resident #14 complained of chest pains, and she notified the on-call nurse practitioner who order Nitroglycerin and a STAT chest x-ray. She said that at the end of the shift the lab company had not arrived, and she gave the information to LVN H on the next shift to follow up as the lab company were still in the 3-5 hour window. She said that if LVN H did not follow up on the 6:00am-6:00pm shift on 04/14/2026 it would have been a delay in treatment. In a follow up interview on 04/16/2026 at 12:35 pm with MD R, who said after reviewing the electronic medical records for Resident #14 she confirm that the order for the chest x-ray was given as STAT. She said that the x-ray was completed outside of the 2-4 hour window, and notification should have been made to physician or nurse practitioner. She said that Resident#14 had a delay in treatment with no negative impact because the x-ray was completed on 04/14/2026 with no abnormal results. In an interview on 04/16/2026 at 1:08pm with the DON who said that a stat lab order should be completed within 3-5 hours, with notification made to the physician or nurse practitioner if a technician does not arrive during the time frame. She said that if notification was not made it could cause a delay in treatment. She said that she would provide a copy of the contract with the lab company to confirm the response time for STAT lab services. In an interview on 04/17/2026 at 9:35am with the DON. She said that STAT lab orders should be completed within 4-6 hours. She said that she reviewed the electronic medical records for Resident #14. She said that LVN G should have notified the on call nurse practitioner during her shift when a technician did not come to complete the chest x-ray for Resident#14. She said that the LVN G should could have notified the ADON, DON, or given LVN H the information during report that the order had not been completed. She said that there was a delay in treatment. She said that she would provide a copy of the contract with the lab company to confirm the response time for STAT lab services due to inconsistencies provided multiple interviews. An email was sent 04/16/2026 at 11:44am to the Administrator and DON for the following policies, laboratory services and stat labs policy and procedures. An email was sent 04/17/2026 at 3:42pm to the Administrator and DON for the following policies, STAT labs, incomplete labs, notifying physician of incomplete labs, and a copy of the lab contract with stat lab response times. An email was sent 04/18/2026 at 1:27pm to the Administrator and DON for the following policies, Labs (a policy that addresses the time frame for stat labs) -incomplete labs, notifying the physician of incomplete labs, and Quality and/or timeliness of providing laboratory services. A policy was requested for STAT Laboratory Services policy from both the Administrator and DON was not received prior to exit.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food safety. -The facility failed to ensure food was discarded from the refrigerator prior to the use by date.-The facility failed to ensure food was labeled with a discard or use by date.-Dietary Staff A used an object to prop open the kitchen door allowing two flies to enter the kitchen. These failures could place residents at risk of foodborne illness and disease.Findings include:1.Observation on 04/14/2026 at 8:40am with the Food Service Director of the refrigerator located in the kitchen revealed the following:*an open bag of shredded lettuce secured with a clip to be brown with a brown liquid at the bottom of the bag. Observation of the bag of shredded lettuce to have no manufacture package date, with a handwritten date of 03/29/2026, and no use by/discard date written on the package. *an unopened bag of mozzarella cheese to have a manufacture package date of 02/25/2026, with a handwritten date of 03/26/2026, and no use by/discard date written on the package.In an interview observation on 04/14/2026 at 8:45am with the Food Service Director, who said that food items in the refrigerator should be labeled with a delivery date if a manufacture date does not exit, open date, and use by date. She said that food items that are not labeled appropriately in the refrigerator are at risk of being consumed after it was no longer safe. She said that if a resident consumed expired food, it could cause food borne illness. She said that the dates written on the package were use by date, but it was not indicated on the package. She said that the mozzarella cheese and shredded lettuce should have been thrown out. She said that staff should check at the start of each shift that all expired foods had been thrown out and it was an oversight. The Food Service Director disposed both food items in the garbage. In an interview on 04/14/2026 at 9:15am with the Administrator, DON, and RNC B, all said that expired food should not be stored in the kitchen. All said that food should be discarded before the use by date or manufacture expiration date. All said that dietary staff should ensure food products are labeled to ensure that expired food was not stored in the kitchen. All said that the risk of consuming expired food was food borne illness.2.Observation on 04/15/2026 at 10:50am Dietary Staff A used a cardboard box to prop the door to the kitchen open while taking the trash out. Two flies entered the kitchen. [NAME] A used a towel to swat the flies, removing them from the kitchen and closing the door A sign was posted on the door, to keep it closed. In an interview on 04/15/2026 at 10:55am [NAME] A said the kitchen door should be closed immediately when exiting and entering in effort to keep pest out. She said that pests can cause cross contamination and food borne illness. In an interview on 04/15/2026 at 11:00am Dietary Staff A said the kitchen door should be closed immediately when exiting and entering in effort to keep pest out. She said that pests can cause cross contamination and food borne illness. She said that she used the cardboard box to prop the door when she should not have done so because she was going to make multiple trips to the dumpster. In an interview on 04/15/2026 at 11:05 am with the Food Service Director, who said the kitchen door should be closed immediately when exiting and entering in effort to keep pest out. She said that pests can cause cross contamination and food borne illness.In an interview on 04/15/2026 at 11:10am with the Administrator, who said that dietary staff should follow guidelines in place to prevent concerns with pest control. She said that if there was a sign posted to keep the door closed in the kitchen, staff should not have prop open the door for any reason. She said that pests can cause cross contamination and food borne illness. Record review of the policy titled, Food Receiving and Storage, revised date November 2022 read in part, . Policy Statement.Foods shall (continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation.Refrigerated/Frozen Storage 1. All foods stored in a refrigerator or freezer are covered, labeled and dated (use by date).7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observation, interview, and record review, the facility failed to ensure rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 2 of 8 residents (Resident #69 and Resident #109) reviewed for call systems. The facility failed to provide a functioning call light system in the rooms of Resident #69 and Resident #109. This failure could place residents at risk for a delay in care and services, increased falls, excessive wait times, pain, and a decreased quality of life. Finding included: 1.Record review of the face sheet for Resident #69 dated 04/16/2026 revealed an [AGE] year-old female admitted to the facility on [DATE], with principal diagnoses of Alzheimer's Disease, Unspecified (brain condition that slowly damages memory, thinking, learning, and organizing skills). Record Review of Resident #69's Quarterly MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score 0 out of 15; indicating Resident #69's cognition was severely impaired. In Section GG Resident# 69 required substantial/maximal (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) assistance for rolling to left to right, moving from sitting on the side of the bed to lying, when standing, being transferred form the chair, bed, and shower. Record review of Resident #69's undated care plan revealed the following:Focus: Resident #69 has impaired cognition and poor safety awareness , she does require assistance with all her transfer, she is at risk for falls.Goal: Resident #69's risk for falls will be reduced through the next review date.Intervention: Assist with all transfers. Keep call light within reach. Monitor for changes in condition that may warrant increased assistance and notify the physician. Refer to physical therapy for evaluation. Remind resident to ask staff for assistance with all transfers. 2.Record review of the face sheet for Resident #109 dated 04/16/2026 revealed an [AGE] year-old female admitted to the facility on [DATE], with principal diagnoses of Hypertensive Chronic Kidney Disease (condition where high blood pressure both causes and worsens kidney damage,). Record Review of Resident #109's Quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score 7 of 15; indicating Resident #109's cognition was severely impaired. In Section GG Resident# 109 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. or, the assistance of 2 or more helpers is required for the resident to complete the activity.) with assistance for rolling to left to right, moving from sitting on the side of the bed to lying, when standing, being transferred from the chair, bed, and shower. Record review of Resident #109's undated care plan revealed the following:Focus: Resident #109 has poor balance and weakness putting her at risk for falls, she does require assistance with all transfers.Goal: Resident #109's risk for falls will be reduced through the next review date.Intervention: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Follow facility fall protocol. Pt evaluate and treat as ordered or PRN. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. In an interview and observation on 04/14/2026 at 9:57 am with Resident #109 in room [ROOM NUMBER]B, she said that she wanted to be repositioned in the bed, she pressed the call light but no one had come. She said that she could not (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2026
NAME OF PROVIDER OR SUPPLIER Avir at Veterans Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Fallbrook Drive Houston, TX 77038	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>recall how long ago she had pressed the call light. Observation at this time of Resident #109 to have pressed the call light, the indicator light did not flash on the wall at the bedside, and the indicator light did not come on in the hallway outside of the room. She said that she was not aware that the call light was not functioning and she thought it had worked on 04/13/2026. In an interview and observation on 04/14/2026 at 10:10am with LVN H, who pressed Resident #109's call light and stated the indicator light did not flash on the wall at the bedside, and the indicator light did not come on in the hallway outside of the room. She was not sure of how long the call light had not functioned. LVN H said that residents had a right to a functioning call light at all times. She said that residents without a functioning call light were not able to alert staff of care needs, incidents, accidents, or changes in conditions. She said that she would report the issues to the EVS Director immediately. Observation on 04/14/2026 at 10:12am LVN H reported the issue of the call light not functioning to the EVS Director who was on the 400 hall In an interview and observation on 04/14/2026 at 10:14am with EVS Director, who said that he was responsible for ensuring that call lights functioned in the facility. He said that he did weekly documented testing to catch any call lights that may not be functioning, and staff should alert him immediately if they identify a call that was not functioning. He said that residents needs to have a functioning call light to alert staff when they need something, and without a functioning call light staff will not know what the residents may need. He was observed to pressed Resident #109's (room [ROOM NUMBER]B) call light and stated the indicator light did not flash on the wall at the bedside, the indicator light did not come on in the hallway outside of the room, and he said that he would repair it immediately. Observation on 04/14/2026 at 10:16am Resident #69's call light was pressed on the wall at the bedside in room [ROOM NUMBER]A, and the indicator light did not come on in the hallway outside of the room. Resident#69 was not present in the room during the observation. In an interview and observation on 04/14/2026 at 10:21am with CNA P, who pressed Resident #69's call light and confirmed the indicator light did not flash on the wall at the bedside, and the indicator light did not come on in the hallway outside of the room. She was not sure of how long the call light had not functioned. CNA P said that residents had a right to a functioning call light at all times. She said that residents without a functioning call light were not able to alert staff of care needs, incidents, or changes in conditions. She said that she would report the issue to the EVS Director immediately. In an interview on 04/14/2026 at 10:38am with the DON and Administrator, both said that residents should have functioning call lights. Both said that Residents need call lights to alert staff for care needs, change in condition, and incidents/accidents. Both said that without a functioning call light care needs, change in condition, and incidents/accidents could be missed by staff. Both said that staff should alert the EVS Director when a call light was observed not functioning. The Administrator said that the EVS Director should test call lights functioning routinely in effort to ensure all resident have call that function. Efforts to interview Resident #69 on 04/14/2026 at 10:50am were not successful as the resident was not interviewable. Record review of electronic work orders from January 2026-April 2026 with no outstanding repair request for call light malfunction for Resident #69 or #109. Record review of electronic work orders report for conducting a test of the nurse call system dated 01/30/2026. The report revealed that only rooms 102, 104, 105, 112, 205, 209, 210, 212, 216, 402,404,410, and 418 were tested for functioning call lights. Record review of electronic work orders report for conducting a test of the nurse call system dated 02/27/2026. The report revealed that only rooms 201, 202, 204, 205, 206, 207, 208, 209, 210, 211,212,213, 214, 215, and 216 were tested for functioning call lights. Record review of electronic work orders report for conducting a test of the nurse call system dated 03/13/2026. The report revealed that only rooms 301, 302, 304, 305, 306, 307, 308, 309, 310, 311, 312,313, 314, 315, and 316 were tested for functioning call lights. Record review of electronic work orders report for conducting a test of the nurse call system dated 04/15/2026. The report revealed that only rooms 109, 114, 115, 203, 207, 214, 215,306, 310, 312, 402,404, 407, 416, and 418 were tested for functioning call lights. Record review of the policy titled, Call System, Resident, and updated January 2025 read in part, . (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avir at Veterans Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Fallbrook Drive Houston, TX 77038	
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy Statement. Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation. 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. 5. The resident call system is routinely maintained and tested by the maintenance department.</p>		