STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676314	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Orem	3730 W. Orem Drive Houston, TX 77045

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to transmit accurate, encoded, complete MDS assessments to the CMS system within 13 days for 4 of 18 residents records reviewed for MDS transmission (Residents # 2, 6, 13). -The facility failed to ensure that Resident #2's, annual MDS assessment dated [DATE] was transmitted within 14 days -The facility failed to ensure that Resident #6's, annual MDS assessment dated [DATE] was transmitted within 14 days -The facility failed to ensure that Resident #13's, annual MDS assessment dated [DATE] was transmitted within 14 days These failures put residents at risk of not having their assessments completed timely which could result in denial of services or denial of payment for services. Findings included: Record review of Resident #2's face sheet dated 06/02/26 revealed Resident # 2 was admitted to the facility on [DATE]. His diagnoses included the End stage renal diseases (Organs lose ability to filter waste), type 2 diabetes body inability to process glucose), essential hypertension (high blood pressure), muscle weakness and unsteady feet . Record review of Resident #6's annual MDS with ARD date of 04/14/26 was signed as completed on 05/05/26 which was 25 days after the ARD date. -Review of Resident #6's face sheet, dated 06/03/26, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted [DATE]. Her diagnoses included Demetia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance, mood disturbance, depression, and essential hypertension (primary). Record review of Resident # 6's MDS assessment dated [DATE] revealed the MDS was completed on 05/17/26 which was 21 days after the ARD date. -Record review of Resident #13's Record review of Resident #13's face sheet, dated 06/03/26 revealed Resident #13 was admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included post-traumatic stress disorder (witness to a traumatic or threatening event), developmental disability, muscle wasting, abnormal gait and mobility, anxiety disorder and communicative deficit (lack of communication). Record review of Record review of Resident # 13's MDS assessment dated [DATE] revealed the MDS was completed on 10/15/25 which was 20 days after the ARD date. Record review of Resident #13's annual MDS with ARD date of 04/14/26 was signed as completed on 05/05/26 which was 25 days after the ARD date. Interview with the MDS Coordinator on 6/4/26 at 3:00PM, he said He was new to the position and had been trying to work on all the late MDS. He said he had just got a helper that would assist him in completing the MDS. HE said the facility followed the RAI manual. Record review of the facility policy on resident assessment, revised March 2022, referring to the RAI manual, revealed, in part: .a comprehensive assessment of every resident's needs is made at intervals designated by OBRA requirements.OBRA required assessments are federally mandated and must be performed on all residents of Medicare and/or Medicaid certified nursing homes.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare and distribute food in accordance with professional standards for food safety in that - The facility failed to ensure that the vVent hood above the stove was free of grease build up. The facility failed to ensure that frozen meat was properly thaw under running These failures placed residents at risk of foodborne illness and accident. Findings included: Kitchen observation, and interview with the Dietary Manager on 06/02/26 at 8:30am, revealed Dietary Aide K washing her hands in one side of 2 compartment sink and on the other side were 2-10lbs of frozen grand ground beef was in a pan of standing water. During an interview theThe Dietary Manager said the staff was supposed to wash her hands in one of the handing washing sink in the kitchen and not in the food preparation sink. She said all frozen food was are supposed to be thawed in a bowl under running water to prevent bacteria growth. Observation of the vent hood above the stove and interview with the Dietary Manager, revealed the vent hood was coated with grease build up. Review of the cleaning schedule that was posted on the side of the vent hood, revealed the last time the vent hood was clean was in December of 2025 and was scheduled to be clean in March of 2026. The Dietary Manager said the cleaning company did not show up as scheduled. She said the Administrator was aware of the grease built up. She said the grease build up was a fire hazard. During an interview with the Administrator on 06/02/26 at 4:00PM, he said the vent hood was supposed to be clean in March, but the company did not show up for the cleaning, and he had tried to contact them but no show. He said he was aware of the situation, and he hopes hoped they would come this weekend 06/05/26 to do the cleaning Record review of facility's policy dated 2001 and revised 11/2022- revealed :policy statement: Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices Food Preparation Area. 4. Appropriate measures are used to prevent cross contamination. These include:d. cleaning and sanitizing work surfaces (including cutting boards) and food-contact equipment between uses, following food code guidelines.5. Handwashing sinks are located near food preparation and clean dish areas and are separate from ware washing sinks. Thawing Frozen Food1. Foods are not thawed at room temperature. Appropriate thawing procedures include:a. thawing in the refrigerator in a drip-proof container.b. completely submerging the item in cold running water (70 F or below) that is running fast enough to agitate and remove loose ice particles.c. thawing in a microwave oven and then cooking and serving immediately; ord. thawing as part of a continuous cooking process

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed did not implement policies and procedures to ensure the resident's medical record includes documentation of receiving or refusal of influenza or pneumococcal immunization for 5 of 6 residents reviewed for immunizations (Resident#2, Resident #3, Resident #11, Resident #60, and Resident #84). The facility failed to implement their influenza and pneumococcal immunization policies to document evidence in the electronic medical record the offering or the refusal of the influenza and pneumococcal immunization status for Resident #2, Resident #3, and Resident #11. The facility failed to implement their pneumococcal immunization policy to document evidence in the electronic medical record the offering or the refusal of the pneumococcal immunization status for Resident #60 and Resident #84. The failures could place residents at risk of contracting viral illness, influenza or pneumococcal disease, or of not being informed of the benefits and risk which could cause respiratory complications and lead to potential adverse health outcomes.Record review of Resident #2's face sheet dated 6/4/2026 revealed a [AGE] year-old male admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included Unspecified cerebral infarction(a condition where a blood clot blocks a blood vessel in the brain), Type 2 diabetes mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), end stage renal disease (a condition in which the kidneys no longer function normally). Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. Section O of Resident #2's quarterly MDS dated [DATE] indicated that he was offered both influenza and pneumococcal vaccinations and had declined the offer of both the influenza and pneumococcal vaccines. Record review of Resident #2's electronic record revealed no documented evidence of the facility offering or the refusal of influenza or pneumococcal vaccines. Record review of Resident #3's face sheet dated 6/4/2026 revealed a [AGE] year-old female was originally admitted into the facility on 8/21/2023 and readmitted on [DATE] with diagnoses that included hypokalemia (low potassium level in the blood), muscle weakness and Essential Hypertension (a type of high blood pressure that does not have a known cause).Record review of Resident #3's quarterly MDS dated 4/1602026 revealed a BIMS score of 10 which indicated moderate cognitive impairment. Section O of Resident #3's quarterly MDS indicated that Resident #3 was offered both influenza and pneumococcal vaccinations and had declined the offer of both the influenza and pneumococcal vaccines. Record review of Resident #3's electronic record did not reveal documented evidence of Resident #3's refusal of the influenza and pneumococcal vaccine. Record review of Resident #11's face sheet dated 6/4/2026 revealed a [AGE] year-old male originally admitted into the facility on 8/31/2023 and readmitted on [DATE] with diagnoses that included cerebral atherosclerosis (a condition where fatty deposits build up inside the arteries that supply blood to the brain), Type 2 Diabetes Mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), and hemiplegia (a condition where one side of the body becomes completely or almost paralyzed). Record review of Resident #11's quarterly MDS dated [DATE] revealed a BIMS score of 13 which indicated moderately cognitive impairment. Section O of Resident #11's quarterly MDS dated [DATE] indicated Resident #11 was not up to date on his influenza and pneumococcal vaccination and had declined the offer of both the influenza and pneumococcal vaccines. Record review of Resident #11's electronic record did not reveal documented evidence of Resident #11's refusal of the influenza and pneumococcal vaccine. Record review of Resident #60's face sheet dated 6/4/2026 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Nontraumatic intracerebral hemorrhage in hemisphere subcortical (a sudden, unexplained bleed inside the brain that is not caused by an injury, and happening in a deep part of the brain within one of the brain's lobe), anxiety disorder (is a type of mental health where you feel intense, persistent, and often (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uncontrollable fear or worry that goes beyond normal nervousness), and Chronic Obstructive Pulmonary Disease (a group of diseases affecting the lungs). Record review of Resident #60's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. Section O of Resident #60's quarterly MDS dated [DATE] indicated that she was offered both influenza and pneumococcal vaccinations and had declined the offer of both the influenza and pneumococcal vaccines. Record review of Resident #60's electronic record revealed no documented evidence of pneumococcal vaccine offering, administration, or refusal. Record review of Resident #84's face sheet dated 6/4/2026 revealed a [AGE] year-old female originally admitted into the facility on 3/20/2025 and readmitted on [DATE] with diagnoses that included senile degeneration of brain (a slow, progressive decline in brain function that happens with age, often leading to memory loss, confusion, and trouble with everyday tasks), Type 2 diabetes mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), and Essential Hypertension (a type of high blood pressure that does not have a known cause). Record review of Resident #84's quarterly MDS dated [DATE] revealed a BIMS score of zero which indicated severe cognitive impairment. Section O of Resident #84's quarterly MDS dated [DATE] indicated that she was offered both influenza and pneumococcal vaccinations and she had declined the offer of both the influenza and pneumococcal vaccines.Record review of Resident #84's electronic record revealed no documented evidence of pneumococcal vaccine offering, administration, or refusal. Interview with the DON on 6/4/2026 at 12:22 pm revealed the DON stated that the ADON was responsible for coordinating and administering resident vaccinations, including influenza, COVID-19, and pneumococcal vaccines. The DON reported that she had personally observed the ADON administering vaccines. The DON stated that the ADON was currently on leave and was responsible for overseeing the facility's vaccination program for both residents and staff, including vaccine education, administration, tracking, and documentation. The DON was asked to provide documentation of offering, administration or refusal of the influenza and pneumococcal vaccines for Resident #2, Resident #3, Resident #11, Resident #60, and Resident #84, but she stated the refusal documentations were expected to be in the ADON's office, however, the binder could not be found. The DON stated the refusal documentation was an area that she was aware of that needed attention and would be working on getting the refusal documentation uploaded and updated in PCC (Point click care). The DON stated the risk of not having up to date immunization records for residents could possibly lead to preventable illness, or unnecessary vaccinations. Interview with the ADON on 6/4/2026 at 1:22 p.m., revealed she was the infection preventionist for the facility and was responsible for immunization compliance. The ADON stated that a resident's immunization status should be listed in the immunization tab of the electronic record but sometimes it was in the notes section. The ADON stated that all residents were offered influenza and pneumococcal immunizations. She stated that the facility conducted an annual influenza vaccination clinic for residents. The ADON stated that refusals were entered into PCC (Point Click Care) and that signed refusal forms and Vaccine Information Statements (VIS) were maintained in binders located in her office. The ADON was asked to provide documentation of offering, administration or refusal of the influenza and pneumococcal vaccines for Resident #2, Resident #3, Resident #11, Resident #60, and Resident #84. She stated she had been away from the facility for approximately one month and was unsure whether the records remained in the office, but she did not know why the binder could not be found. When asked how she monitored immunization compliance for the residents, the ADON did not have an answer. When asked what the risk was associated with not assessing immunization compliance, the ADON stated the residents could be vaccinated twice for the same illness, the residents could get sick with a preventable disease, or the resident could receive vaccinations that were contraindicated. Record review of facility policy statement, undated and titled Influenza vaccine revealed in part. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. Record review of facility policy titled Pneumococcal Vaccine revealed in part. Residents/representative have the right (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the of the refusal of the pneumococcal vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to develop and implement policy and procedures to ensure residents were offered, received, or refused the Covid-19 immunization, for 5 of 6 residents (Resident #2, Resident #3, Resident #11, Resident #60 and Resident #84) who were reviewed for immunization compliance. The facility failed to develop a Covid-19 immunization policy that addressed the documentation in Resident #2, Resident #3, Resident #11, Resident #60 and Resident #84's electronic medical records for having received or not receiving the Covid-19 immunization due to medical contraindication or refusal. This failure could place residents at risk of not being informed of complications and potential adverse health outcomes. Record review of Resident #2's face sheet dated 6/4/2026 revealed a [AGE] year-old male admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included Unspecified cerebral infarction(a condition where a blood clot blocks a blood vessel in the brain), Type 2 diabetes mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), end stage renal disease (a condition in which the kidneys no longer function normally). Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. Section O of Resident #2's quarterly MDS dated [DATE] indicated Resident #2's COVID - 19 vaccination was not up to date. Record review of Resident #2's electronic record revealed no documented evidence that revealed his immunization status for Covid-19. Record review of Resident #3's face sheet dated 6/4/2026 revealed a [AGE] year-old female was originally admitted into the facility on 8/21/2023 and readmitted on [DATE] with diagnoses that included hypokalemia (low potassium level in the blood), muscle weakness and Essential Hypertension (a type of high blood pressure that does not have a known cause). Record review of Resident #3's quarterly MDS dated 4/1602026 revealed a BIMS score of 10 which indicated moderate cognitive impairment. Section O of Resident #3's quarterly MDS indicated that Resident #3's COVID - 19 vaccination was not up to date. Record review of Resident #3's electronic record did not reveal documented evidence of Resident #3's refusal of the COVID - 19 vaccinations. Record review of Resident #11's face sheet dated 6/4/2026 revealed a [AGE] year-old male originally admitted into the facility on 8/31/2023 and readmitted on [DATE] with diagnoses that included cerebral atherosclerosis (a condition where fatty deposits build up inside the arteries that supply blood to the brain),Type 2 Diabetes Mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), and hemiplegia (a condition where one side of the body becomes completely or almost paralyzed).Record review of Resident #11's quarterly MDS dated [DATE] revealed a BIMS score of 13 which indicated moderately cognitive impairment. Section O of Resident #11's quarterly MDS dated [DATE] indicated Resident #11's COVID - 19 vaccination was not up to date. Record review of Resident #11's electronic record did not reveal documented evidence of Resident #11's refusal of the COVID - 19 vaccinations. Record review of Resident #60's face sheet dated 6/4/2026 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Nontraumatic intracerebral hemorrhage in hemisphere subcortical (a sudden, unexplained bleed inside the brain that is not caused by an injury, and happening in a deep part of the brain within one of the brain's lobe), anxiety disorder (is a type of mental health where you feel intense, persistent, and often uncontrollable fear or worry that goes beyond normal nervousness), and Chronic Obstructive Pulmonary Disease (a group of diseases affecting the lungs). Record review of Resident #60's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated intact cognition. Section O of Resident #60's quarterly MDS dated [DATE] indicated Resident #60's COVID - 19 vaccination was not up to date. Record review of Resident #60's electronic record revealed no documented evidence that revealed his immunization (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	status for Covid-19. Record review of Resident #84's face sheet dated 6/4/2026 revealed a [AGE] year-old female originally admitted into the facility on 3/20/2025 and readmitted on [DATE] with diagnoses that included senile degeneration of brain (a slow, progressive decline in brain function that happens with age, often leading to memory loss, confusion, and trouble with everyday tasks), Type 2 diabetes mellitus (a condition where the body's cells do not respond properly to insulin leading to high blood sugar levels), and Essential Hypertension (a type of high blood pressure that does not have a known cause). Record review of Resident #84's quarterly MDS dated [DATE] revealed a BIMS score of zero which indicated severe cognitive impairment. Section O of Resident #84's quarterly MDS dated [DATE] indicated Section O of Resident #84's quarterly MDS dated [DATE] indicated Resident #84's COVID - 19 vaccination was not up to date. Interview with the DON on 6/4/2026 at 12:22 p.m., revealed that the ADON is responsible for coordinating and overseeing the facility's immunization program, including COVID-19 vaccinations. The DON stated the ADON was on leave and maintained immunization tracking and documentation. When requested to provide documentation of COVID - 19 vaccines offering, administration or refusal of covid -19 vaccine for Resident #2, Resident #3, Resident #11, Resident #60, and Resident #84 the DON was unable to locate the refusal records and stated the documentation was expected to be in the ADON's office. The DON stated the refusal documentation was an area that she was aware of that needed attention and would be working on getting the refusal documentation uploaded and updated in PCC (Point Click Care - facility's system of electronic documentation). The DON stated the risk of not having up to date immunization records for residents could possibly lead to preventable illness, or unnecessary vaccinations. Interview with ADON on 6/4/2026 at 1:22 p.m., revealed she was the infection preventionist for the facility and was responsible for immunization compliance. The ADON stated that a resident's immunization status should be listed in the immunization tab of the electronic record but sometimes it was in the notes section. The ADON stated that all residents were offered COVID - 19 on admission. The ADON stated that refusals were entered into PCC (Point Click Care) and that signed refusal forms and Vaccine Information Statements (VIS) were maintained in binders located in her office. The ADON was asked to provide documentation of offering, administration or refusal of the COVID - 19 vaccines for Resident #2, Resident #3, Resident #11, Resident #60, and Resident #84, but she stated she had been away from the facility for approximately one month and was unsure whether the records remained in the office but could not be found. When asked how she monitored immunization compliance for the residents, the ADON did not have an answer. When asked what the risk was associated with not assessing immunization compliance for COVID - 19, the ADON stated the residents could be vaccinated twice for the same illness, or the resident could receive vaccinations that were contraindicated. Record review of facility policy statement titled Coronavirus Disease (COVID - 19) - Infection Prevention and Control Measures revealed in part. This facility follows infection prevention and control (IPC) practices recommended by the Center for Disease Control and Prevention to prevent the transmission of COVID - 19 within the facility. The facility's policy did not address did not address this failure.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan with measurable objectives and timetable to meet the resident's medical, nursing, and psychosocial needs that were identified in the comprehensive assessment for 1 of 18 residents reviewed for care plans (Resident # 105). --Resident # 105 did not have a care plan for ADLs. This failure placed residents at risk of not having their needs identified and addressed. Reord review of Resident # 105's admission record revealed admission date 10/4/24 with diagnoses including dementia (loss of cognitive functioning), major depressive disorder (persistent feeling of sadness and loss of interest), chronic kidney disease (inability of kidneys to filter waste from the body), heart disease (condition affecting heart structure, function, vessels), heart failure (inability of heart muscle to pump blood), Diabetes (imbalance of glucose in the blood), embolism and thrombosis of deep veins of lower extremities (restriction of blood flow to lower extremities), hypertension (high blood pressure). Record review of Resident #105's Quarterly MDS dated [DATE] revealed always understood and always understands, BIMS of 14, indicating independent cognitive skills; moderate staff assistance required for hygiene, and dressing of upper body, with maximum staff assistance required for toileting, bathing/showering, and lower body dressing; occasional bladder incontinence, continent of bowel, and therapeutic (diabetic) diet. Observation of Resident 105 on 6/2/26 at 9:30am revealed she was in bed and said she was waiting for the CNA to come back and help her get cleaned up and out of bed. She said she could do most things on her own and was ok once she was in her wheelchair but needed assistance with changing briefs and dressing. Observation of Resident #105 on 6/3/26 at 10:00am revealed she was in her wheelchair, dressed, and participating in the resident council meeting. She said she did have assistance with toileting and dressing this morning. Record review of Resident # 105's care plan dated 9/2/25 revealed no care plan for ADLs, which would include appropriate interventions. Interview with MDS coordinator on 6/4/26 at 10:30am revealed he did not see a care plan for ADLs for Resident #105. He searched through all of the care plans with the surveyor and could not find a care plan for ADLs. He said it was an omission and the care plan should have been updated to include ADLs for Resident # 105. He said he receives input from the different departments for the resident's condition and needs, and he completes the care plan for all residents. He said the risk to the residents of having an incomplete care plan would be the resident would not get what they need. Interview with the DON on 6/4/26 at 10:55am revealed the care plan should be complete and reflect the resident's condition. She said all the departments contribute to the care plans and the MDS coordinator completes it, and the risk to the residents if it was not accurate would be the residents would not receive the care they needed. Record review of the facility care plan policy, revised March 2022, revealed, in part: .comprehensive resident-centered care plans are developed within 7 days of the MDS assessment .includes measurable timeframes and objectives .describes services to be furnished .assessments of residents are ongoing and care plans are revised if information about a resident or resident's condition change.