

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2025
NAME OF PROVIDER OR SUPPLIER  Avir at Converse		STREET ADDRESS, CITY, STATE, ZIP CODE  7700 Mesquite Pass Converse, TX 78109	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 5 medication carts, (the 100-hall medication cart) reviewed for locked compartments. LVN A left the medication cart she was assigned, unlocked outside of a resident's room while she was in the room with the door shut. This deficient practice could place residents at risk for unauthorized persons having access to medications not approved for them. The Findings included: During an observation on 9/2/2025 at 8:47 AM revealed a medication cart on the 100-hallway with the drawers facing the hallway, unlocked, unattended, with staff, the public, and residents ambulated by the cart. During an observation and interview on 9/2/2025 at 9:10 AM revealed the medication cart continued on the 100-hallway with the drawers facing the hallway, unlocked, unattended, with staff, the public, and residents ambulated by the cart. The Administrator and the Director of Nursing (DON) witnessed the unlocked medication cart and identified LVN A as the nurse assigned to the medication cart. LVN A was summoned by the DON and LVN A stated she was in a resident's room providing care and could not see her cart. LVN A stated she had left her cart unattended and unlocked. The DON stated the expectation was for all medications to be secured when not being utilized and the potential negative outcome could be loss of control of residents' medications. A record review of the facility's policy titled Medication Labeling and Storage dated 2001 revealed, the facility stores all medications and biologicals and locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to the keys. Policy interpretation and implementation: medication storage: . compartments, including but not limited to; drawers, cabinets, rooms, refrigerators, carts, and boxes containing medications and biologicals are locked when not in use and trays or carts used to transport such items are not left unattended if opened or otherwise potentially available to others.</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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