

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 03/06/2026
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 observation, interview and record review, the facility failed to ensure all drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 1 of 2 medication carts (Medication Cart 300/400) reviewed for storage of drugs and biologicals. The facility failed to ensure the medication cart for hall 300/400 did not have a vial of unlabeled insulin in it. These deficient practices could place residents at risk of receiving the wrong medication, misuse of medication or drug diversion. The findings included: During an observation and interview on 3/5/26 at 11:14 a.m., observation of the 300/400-hall medication cart had a vial of insulin, without a box, without a name or pharmacy prescription label on it and with an open date. Interview with LPN A she stated they were responsible for the 300/400 medication cart. LPN A stated if medication does not have a label on it they usually will either discard the medication or contact the nurse who was in charge of the medication cart previous to them. LPN A stated that residents' names should be on their medications to know who's running out and so the medication is not shared amongst residents because everyone can have different reactions to medication. During an interview on 3/5/26 at 4:55 p.m., the DON stated insulin should be labeled with the medication name, residents name, directions and when it is opened if it is opened. The DON stated the nurse is in charge of the medication cart. The DON stated the pharmacy is responsible for labeling the medications and if the medication does not have a label, staff will need to contact the pharmacy for one. The DON stated an unlabeled insulin could have a risk of giving the wrong person the wrong insulin. Record review of the facility document titled Medication Labeling and Storage, with a revision date February 2023, reflected: Medication Labeling2. the medication label includes, at a minimum:a. medication name (generic and/or brand);b. prescribed does;c. strength;d. expiration date, when applicable;e. resident's name;f. route of administration; andg. appropriate instructions and precautions.</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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