

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Avir at Caldwell		STREET ADDRESS, CITY, STATE, ZIP CODE 1022 Presidential Corridor Hwy 21 E Caldwell, TX 77836	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were free from verbal abuse from staff for 1 of 5 residents (Residents #1) reviewed for verbal abuse. The facility failed to ensure Resident #1 was protected from verbal abuse on 04/25/2026 when CNA A confronted Resident #1 and proceeded to yell and threaten her after Resident #1 reported her for sleeping at the nurse's station. This failure could place residents at risk of fear, depression, intimidation, and diminished quality of life. Findings included: Review of Resident #1's face sheet dated 06/10/2026 reflected a [AGE] year old female admitted to the facility on [DATE] with the following diagnoses: major depressive disorder (A mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.) and anxiety (Fear characterized by behavioral disturbances.). Review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 13 indicating she was cognitively intact. Resident #1 was assessed to not have any behaviors. Review of Resident #1's comprehensive care plan reflected no entries related to the allegations of verbal abuse or her psychological diagnoses. Review of Resident #1's psychiatry progress notes dated 04/01/2026 reflected the resident was seeing psychiatry, the notes reflected the resident had no behaviors and was diagnosed with major depressive disorder and post-traumatic stress disorder. Review of the facility's self-report dated 04/25/2026 at 10:30 pm reflected the facility first learned of the allegation of verbal abuse at approximately 7:40 pm on 04/25/2026. The reported reflected Resident #1 went to the nurses' station to ask for medication. CNA A. Had her head wrapped up and head on the desk. Resident #1 stood there for a min. Then RN D came down the hallway and asked resident if she needed something. Resident then went back to bed. Resident #1 told RN D that CNA A was asleep at the nurses' station last night. RN D told CNA A that she cannot sleep at the nurses' station or while on duty. CNA A then went down to Resident #1's room and proceeded to yell at her and tell her she is a liar for saying she was asleep. CNA A told her, I don't like you and kept yelling. RN D came by and told CNA A to leave the area. RN D then called Director of Nurses. Further review of the facility's investigation report reflected the AP (CNA A) denied the allegations. The facility confirmed the allegations and terminated the AP. Interview attempts for RN D on 06/10/2026 at 10:30 am and 2:30 pm were unsuccessful. Review of RN D's written statement dated 04/26/2026 reflected During the overnight shift on April 24, 2026, I observed CNA A take a blanket and fell asleep at the Nurse's Station. As call lights were activated, she remained unresponsive, forcing me to interrupt my own duties to wake her and request that she attend to the residents. When I addressed this, CNA A questioned why I could not handle the calls myself. I informed her that I was occupied with my own responsibilities and that it was unreasonable to expect me to perform both of our roles while she slept. CNA A remained uncooperative for the remainder of the shift, continuing to ignore call lights and requiring repeated prompts to fulfill her basic job requirements. I am submitting this statement to formally document these lapses in resident care, professional conduct, and workplace accountability. Signed by RN D. Review of Resident #1's nursing (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note dated 04/25/2026 at 6:30 pm reflected I promptly presented to the facility to assess the situation. The alleged perpetrator was instructed to remain in the parking lot of the facility until receiving further instructions. She was notified of her suspension pending the investigation. Upon arrival, I assessed the resident and engaged in conversation to evaluate her condition and well-being. The resident was alert and able to provide her account of the events. She reported that the CNA had been pointing her finger in her face and yelling at her. The resident stated the CNA told her that she was a liar, that she was not asleep, and questioned why she would lie to get her in trouble. The resident further reported the CNA stated she did not like her anyway and said, "I don't need this job, I work at the school full time. During the assessment, the resident was noted to be tearful; however, she stated that she was okay overall. She was asked if she felt safe in the facility, to which she responded that she did feel safe. The resident expressed that she did not wish for disciplinary action against the staff member about requested that the CNA no longer be assigned to her hall. She also stated that she would like an apology from the CNA and indicated that this would be acceptable to her. A full physical assessment was completed, and no injuries or signs of physical harm were observed. Safe surveys were conducted on all residents on that unit. Residents that were awake had no complaints and stated feeling safe in the facility. Nursing progress note was signed by the DON. In an observation and interview on 06/11/2026 at 9:45 am Resident #1 was in her room alert and oriented. Resident #1 stated she has not seen CNA A since the incident she state that the facility fired her. Resident #1 stated she went to nurses' station to ask for medication and CNA A was sleeping at the nurses' station. Resident #1 later told the night nurse about it (RN D) stated he is a PRN staff. Resident #1 stated CNA A confronted her yelling and threatening her, she stated she got right in her face. She stated the incident did trigger her PTSD, she stated she was in a bad relationship with her family member and the yelling and aggression triggered her. She stated CNA A had not acted like that before she was grouchy but not like that. Resident #1 stated she felt safe at the facility and was happy with how staff handled the situation. She stated her neighbor Resident #2 was a witness to the incident, she stated he was in the hospital. Interview attempt with the witness Resident #2 on 06/10/2026 at 9:30am was unsuccessful due to Resident #2 was in the hospital. Review of Resident #2's statement provided to the facility on [DATE] reflected I was down the hall from my room and heard shouting. It went on for quite a while, probably 7-10 minutes and at one point I felt the need to get closer in case it became physical. I cannot do anything, but I can get in the way. I heard the staff member yelling at my neighbor, and it was terrible. I felt bad for my neighbor because she didn't deserve it. The staff member was saying that she wasn't asleep and calling her a liar. She basically told her she didn't need this job. I talked to my neighbor afterwards and she was upset and crying. In an interview on 06/10/2026 at 10:35 am CNA A stated she went to Resident #1 and ask her why she told the nurse that she was sleeping. CNA A stated she told the resident she saw her when she went to get ice so how can you say I was sleeping. She stated the resident said because she had a blanket over her head and CNA A told her she was not sleeping. She stated she told Resident #1 that she was just mad at her because she would not talk to her after she told people she was stealing snacks. CNA A stated that was when she knew she was not someone who did not tell the truth. CNA A denied calling the resident a liar or any other names. She stated the resident called her a Bi**h. CNA A stated she was not yelling at the resident that she talked loudly and had a loud tone. CNA A denied getting in the resident's face. CNA A stated no confronting a resident was not an appropriate response, and she should have just talked to the supervisor. CNA A stated she was trained regarding resident behavior and de-escalation of situations and stated that confronting the resident was not a de-escalation but an escalation of the situation. She stated she did not know the incident would go this way stated at the time did not know confronting the resident was bad. CNA A stated she was trained on abuse and neglect. Review of the statement provided to the facility from CNA A on 04/27/2026 sent via email reflected On April 25, 2026, at approximately 7:30 p.m., during my shift, I had an interaction with a resident in the hallway. I approached the resident to ask about a statement (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she made to another staff member. My intent was to clarify what she said. During this conversation, the resident became upset, called me a bi**h, and stated that I was asleep. She then changed her statement and said she thought I was asleep because I had a blanket around me. She also stated that when people come into her room, they sometimes think she is asleep. I responded by asking her to clarify what she meant and stated that I had just seen her sit down after getting ice, which had only been a few minutes prior. My tone remained calm, and I did not use any profanity or abusive language at any time. I did not verbally abuse the resident. This statement is provided to document the interaction as it occurred. Review of the facility's termination record of CNA A reflected that she was terminated on 05/13/2026 that her last day worked was 04/25/2026. The documented reflected that she was not eligible for rehire and was terminated due to misconduct. In an interview on 06/10/2026 at 1:30 PM the Administrator stated the findings of the abuse investigation for Resident #1 was confirmed and CNA A was terminated. She stated the facility had a zero tolerance policy regarding abuse of residents. Review of the facility's policy on abuse, neglect, exploitation and misappropriation prevention program dated April 2021 reflected Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. 6. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. 7. Implement measures to address factors that may lead to abusive situations, for example: a. adequately prepare staff for caregiving responsibilities. b. provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation. c. instruct staff regarding appropriate ways to address interpersonal conflicts; and d. help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. Further review of the facility's policy reflected an abuse, neglect, and exploitation statement which reflected In keeping with the facility belief that the residents are the most important persons and are the reasons for our Company's existence, the facility observes the following with respect to treatment of residents, Residents of the facility shall not be subject to abuse, neglect or exploitations by company employees, and if a resident accuses an employee of abuse certain procedures will be followed (see Abuse Policy in the facility Policies and Procedures). Abuse shall be defined as follows: a) The negligent willful infliction of injury unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.		

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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, interviews and record reviews, the facility failed to develop and implement a comprehensive care plan that describes the services that are to be furnished to maintain the resident's highest practicable physical, mental, and psychological well-being for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1 comprehensive care plan reflected a plan of care for her diagnoses of PTSD and major depressive disorder that included medication management and psychiatric services. This failure could place residents at risk of increased symptoms, lack of treatment or diminished quality of life. Findings included: Review of Resident #1's face sheet dated 06/10/2026 reflected a [AGE] year old female admitted to the facility on [DATE] with the following diagnoses: major depressive disorder (A mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.) and anxiety (Fear characterized by behavioral disturbances.). Review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 was assessed to have a BIMS score of 13 indicating she was cognitively intact. Resident #1 was assessed to not have any behaviors. Resident #1 was assessed to have diagnosis of anxiety disorder and depression. Review of Resident #1's consolidated physician orders dated 06/10/2026 reflected an order dated 05/13/2026 for Lexapro (an antidepressant) and trazodone HCL dated 05/13/2026 for major depressive disorder. Review of Resident #1's psychiatry progress notes dated 04/01/2026 reflected the resident was seeing psychiatry, the notes reflected the resident had no behaviors and was diagnosed with major depressive disorder and post-traumatic stress disorder. Review of Resident #1's comprehensive care plan reflected no entries related to her psychological diagnosis of PTSD or major depression, her antidepressant medication use or her treatment with psych services. In an observation and interview on 06/11/2026 at 9:45 am Resident #1 was in her room alert and oriented. Resident #1 stated she had PTSD from a bad relationship with her family, and the yelling and aggressive behaviors were a trigger for her. She stated she was seeing psych services. In an interview on 06/10/2026 at 11:52 am the MDS RN stated she was responsible for care plans. She stated after reviewing Resident #1's care plan she stated Resident #1 was not care planned for her diagnoses or treatment of her psychological conditions of major depression or PTSD and should be. She stated she was new at the facility but had missed her being diagnosed with PTSD. She stated she would update Resident #1 care plan to include these areas. In an interview on 06/10/2026 at 2:12 pm the RNC stated that residents' care plans should be updated to include all their problems and should be updated when their needs change to accurately reflected the residents' needs to ensure their needs are met. Review of the facility's policy care plans, comprehensive person-centered dated March 2022 reflected 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. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: any specialized services to be provided as a result of recommendations; and which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.		