

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 06/20/2026
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accidents hazards as was possible for one of two housekeeping carts (Housekeeping Cart #1) reviewed for hazards. The facility failed to ensure Housekeeping Cart #1, with chemicals inside the compartments, was locked when unsupervised. This failure could place residents at risk for injuries, illness, and hospitalization. Findings included: During an observation on 06/20/2026 at 8:15 a.m., Housekeeping Cart #1 was located on 100 hall in front of room [ROOM NUMBER]. Observation reflected the compartment where chemicals were stored was not locked and contained micro-kill bleach, disinfectant cleaner, and two bottles filled with chemicals without a label on the bottles. Observation reflected Housekeeper A was not standing near the housekeeping cart. She exited room [ROOM NUMBER] at 8:20 a.m. and walked to the housekeeping cart and was standing beside the cart. There were no residents or staff in the hallway when observation was made of Housekeeping Cart #1 unlocked. During an interview on 06/20/2026 at 8:19 a.m., Housekeeper A stated Housekeeping Cart #1 was expected to be locked anytime the housekeeper walked away from the cart. Housekeeper A stated she could not see Housekeeping Cart #1 from inside room [ROOM NUMBER] with the door partially closed. She stated there was a possibility that if a resident drank some of the chemicals the resident may become sick with stomach issues or have an allergic reaction. She stated it was possible a resident may need to be evaluated at the hospital. Housekeeper A stated all chemicals were required to have labels on the bottles. She stated she did have a key to the housekeeping cart. During an interview on 06/20/2026 at 3:30 p.m., the Housekeeping Supervisor stated all bottles with chemicals were expected to be labeled. He stated if a resident swallowed the chemical the nurse would not know what type of care to give the resident without knowing the name of the chemical. He stated all housekeeping carts were expected to be locked anytime the housekeeper was not standing in front of the cart. The Housekeeping Supervisor stated if a resident ingested some chemicals there was a potential for an allergic reaction, such as burning their throat, stomach and may need to be assessed at the hospital. He stated all housekeeping staff were in-serviced on locking housekeeping carts. He stated there was a possibility that if a resident spilled a chemical on their skin it may cause irritation to the skin. During an interview on 6/20/2026 at 4:00 p.m., the Administrator stated he expected the housekeeping cart to be locked at all times when the housekeeper was not obtaining an item from the housekeeping cart. She stated all chemical bottles were expected to be labeled with the correct chemical name and directions how to use the chemical. The Administrator stated all housekeeping staff had been in-serviced on locking the housekeeping carts. She stated she checked with the nursing staff and there were not any residents who wandered on the 100 hall. The Administrator stated if a resident drank a chemical there was a possibility a resident may become ill with nausea and vomiting. She stated there was a possibility a resident may need to be transported to the emergency room for further evaluation. Record review of the facility policy titled, Facilities Hazardous Areas, Devices and Equipment, dated 2001, reflected, All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675885	If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mitigate accident hazards to the extent possible. A hazard is defined as anything in the environment that has the potential to cause injury or illness such as access to toxic chemicals. Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to 1 of 3 medication carts (Medication Cart #1) reviewed for drug storage and labeling. The facility failed to ensure Medication Cart #1, was locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included: During an observation of the 300 hall Nurses Station on 06/21/2026 at 7:34 a.m., revealed Medication Cart #1 was facing toward the hall area near the nurses' station. Observation reflected there was not any staff in the hall or near the nurse's station. Med Aide B exited a room approximately 7:45 a.m. on 300 hall and walked toward the nurse's station. During an interview with LVN B on 06/20/2026 at 7:50 a.m., he stated he was trained on medication storage. He stated the policy was staff must lock the medication carts any time the nurse walked away from the medication cart. He stated the nurse or medication aide who was working on the cart was responsible for locking the medication cart. He stated if the staff left the medication cart unlocked and unattended a resident could get into the medication cart and take medication that did not belong to them. LVN B stated everyone monitored to ensure the medication carts were locked. He stated he had been in-serviced on locking medication cart; however, he did not recall the date or time. During an interview with the Director of Nurses on 06/20/2026 at 3:00 p.m., she stated all medication carts were expected to be locked when the med-aide or nurse was not standing in front of the medication cart. She stated the nurse or the medication aide who was on the medication cart was responsible for ensuring the medication cart was locked. She stated if the medication cart was left unlocked and unattended a resident could get into the medication cart and take medications. The Director of Nurses stated leadership monitored to ensure staff locked the medication cart. She stated nurse leadership were to monitor by doing observations and in-service training. She stated she did not know why LVN B left the medication carts unlocked. During an interview with the Administrator on 06/20/2026 at 4:00 p.m., She stated the medication cart was to always be locked. She stated no matter what time of day the medication cart should be locked. She stated the nurse or medication aide who was assigned the medication cart were responsible for ensuring the medication cart was locked. The Administrator stated if the medication cart was left unlocked and unattended a resident could take medication that was harmful to them or an employee could steal medications. She stated the DON or any management should be monitoring, by observations, to ensure the staff were locking the medication cart. She said she did not know why LVN B left the medication cart unlocked. Record review of the Facility's Policy titled, Medication Labeling and Storage, revised 2023 reflected, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. 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 open or otherwise potentially available to others		