

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

Printed: 10/09/2026
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 07/31/2026
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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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, interviews, and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent fire affecting 44 of 44 Residents. The facility failed to implement effective interventions to prevent a second fire on [DATE] after a fire on [DATE] in the dining room. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:37 pm. While the IJ was removed on [DATE] at 3:45 pm, the facility remained out of compliance at a scope of widespread and severity level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk for injury and even death. Findings included: Record review of Resident #1's face sheet dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including mild persistent asthma (a person experiences symptoms such as wheezing, coughing, shortness of breath or chest tightness more than twice a week, but less often than every day), chronic obstructive pulmonary disease, unspecified (a long-term lung disease that blocks airflow and makes it hard to breathe - the exact disease has not been specified), allergic rhinitis, unspecified and anxiety disorder, unspecified (excessive fear or worry, feeling restless, and trouble focusing there is not enough detail for a precise label by a medical professional). Record review of Resident #1's Quarterly MDS dated [DATE] reflected Resident #1 had a BIMS score of 10 indicating her cognition was moderately impaired. Resident #1 was assessed to have diagnoses of anxiety, chronic obstructive pulmonary disease, and asthma. Record review of Resident #1's Comprehensive Care Plan, revised on [DATE] and on [DATE] reflected Resident #1 had an increased risk of impaired respiratory status related to her medical diagnosis of asthma. Interventions: Give medications as ordered, monitor/document any side effects and effectiveness. Give oxygen therapy as ordered by the physician. Monitor/ document/ report to MD as needed any signs or symptoms of respiratory infection: fever or chills, increase in sputum (document the amount , color and consistency), chest pain, increased difficulty breathing, increased coughing and wheezing. Record review of Resident #1's Physician Orders with a start date of [DATE] and revised on [DATE] reflected Resident #1 was ordered Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg/3ml. Change nebulizer tubing and mask every night shift every Sunday. Interview on [DATE] at 8:45 a.m. the Administrator stated there was a fire in the dining room on [DATE] and no residents were in the dining room and there were not any residents injured. She stated Dietary Aide A was in the dining room and saw smoke and some flames coming from the light in the ceiling. The Administrator stated Dietary Aide A exited the dining room and walked to the Business Office Manager office and explained to the Business office Manager there was a fire in the dining room. The Business office Manager exited her office and told the (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	when code statis is not known announce 3 times. Actual fire only, call: Administrator Director of Maintenance Director of Nursing See Emergency Contact List Will page All Clear when informed by person in charge. Department Heads: Any and All Department Heads on site during a fire drill or fire will report to the location of the fire to assist as needed. The Administrator was notified on [DATE] at 5:37 pm that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. An IJ template was provided and a POR was requested. Interview on [DATE] at 5:40 p.m. LVN B stated if she saw a fire she would tell the other staff on her halls there was a fire and to assist residents to somewhere else away from the fire. She stated she would call the Administrator on the phone and tell her there was a fire. LVN B stated she would yell fire to alert all the staff there was a fire. She stated she would get a fire extinguisher and attempt to put out the fire. LVN B stated she had never used a fire extinguisher and knew you had to pull something (she was unable to describe what to pull on the fire extinguisher). She would point the fire extinguisher toward the fire. LVN B stated there were two other things to do with the fire extinguisher, however, she was unable to recall them. She stated she had been in-serviced on fire extinguishers. LVN B stated the fire extinguisher was not demonstrated on how to use it. She stated the Maintenance Supervisor explained it verbally. LVN B stated she did not recall the last time she received in-service on how to use a fire extinguisher or the facility's policy on what to do when there is a fire. Interview on [DATE] at 5:50 p.m. CNA C stated if she saw a fire she would yell fire and would assist the residents to their rooms and close the residents' doors. She stated if the fire was near these residents' rooms she would assist the residents somewhere else in the facility. She did not respond when asked where she would assist the residents to if the fire was near the residents' rooms. CNA C stated she would wait and for further directions from Administer on what to do after she moved the residents. She stated she had been in-serviced on what to do if there was a fire and participated in fire drills, however, she did not recall the date of these in-services. She stated the Maintenance Supervisor gave the in-services and explained how to use fire extinguisher. CNA C stated the Maintenance Supervisor did not demonstrate how to use a fire extinguisher. She stated there was something about RACE you followed when there was a fire. CNA C stated she needed to check on a resident and did not finish the interview. Interview on [DATE] at 6:05 p.m. LVN D stated if there was a fire in the facility she would run and check all the doors in residents' rooms and she would close the doors. She stated she would yell fire and would find a fire extinguisher. LVN D stated she could not describe how to use a fire extinguisher. She stated she had never used a fire extinguisher, and she heard the Maintenance Supervisor explain how to use it and never seen a demonstration on how to use a fire extinguisher. LVN D stated the administration would call the fire department and if administration was not in the facility she would ask someone to call the fire department while she was closing the doors to residents' rooms. She stated if the fire was around residents' rooms she would assist the residents to another area in the facility. She did not specify the location she would assist the residents to in the facility. LVN D stated she was in-serviced on what to do if there was a fire within the past few weeks. She did not remember the date of the in-service. She stated the Maintenance Supervisor discussed about PASS when using fire extinguisher. LVN D stated she was to pull something on the extinguisher. She stated she could not recall what she was expected to pull on the fire extinguisher. She stated she was to aim the extinguisher at the fire. LVN D stated this was all she could recall on what to do when there is a fire. Interview on [DATE] at 6:16 p.m. CNA E stated she had been trained by the Maintenance Supervisor on fires in the facility. She stated the last time she received training on fires was approximately 1 or 2 weeks prior to today ([DATE]). CNA E stated if she saw a fire she would call the Fire Department and Director of Nurses. She stated she would pull the fire alarm and (continued on next page)		

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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.			
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	would check the residents' rooms and close the residents' doors to their rooms. CNA E stated she would obtain a fire extinguisher and use the extinguisher to contain the fire. She stated she had not used a fire extinguisher , however, the Maintenance Supervisor verbally explained how to use a fire extinguisher. CNA E stated she would evacuate the residents to the facility's parking lot. CNA E did not respond to any further questions about fires in the facility. Interview on [DATE] at 6:26 p.m. RN Charge Nurse F stated if he witnessed a fire in the facility he would follow the RACE guide such as R: rescue residents such as assisting the residents away from the fire (he did not elaborate where he would assist the residents in the facility). A - Activate the fire alarm and call 911. He would obtain the fire extinguisher and evacuate all the residents (he did not specify where he would assist the residents when he was evacuating). He stated he has not participated in a fire drill within the past 3 months. He stated he had been in-serviced on what to do if there was a fire in the facility within approximately 1 or 2 weeks ago. RN Charge Nurse F stated he had never used a fire extinguisher or observed anyone demonstrating how to use fire extinguisher. He stated the Maintenance Supervisor has explained it verbally. Interview on [DATE] at 6:40 p.m. LVN G stated she would investigate where the fire was located and would rescue the residents away from the fire (she did not state where she would assist the residents to in the facility). LVN G stated she would yell fire and then she would call 911. LVN G stated she would assist the ambulatory residents first, then the residents in the wheelchairs, and last she would assist residents in their beds. When asked where these residents would be evacuated to in the facility, LVN G did not respond to the question. LVN G stated once the residents were evacuated she would get		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review; the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (Including the State Agency) for incidents involving the environment for 44 of 44 residents. The facility failed to report smoke coming from the light fixture on 07/28/2026 in the dining room and assess Resident #1 after the smoke in the dining room on 07/28/2026. This failure could place residents at risk for injury or even death. Findings included: In an interview on 07/29/2026 at 10:45 a.m. the Administrator stated the facility did have an incident with smoke coming from the light in the corridor near the kitchen on 07/28/2026. She stated it was in the same area as the fire incident on 07/22/2026. The Administrator stated the facility did not complete an investigation of the smoke coming from light on 07/28/2026. The Administrator stated she or the Maintenance Supervisor did not contact the following: Fire Department, HHSC, Electricians, or the Sprinkler/ Fire alarm company. She stated the facility was not expected to contact anyone due to there were no flames, only smoke coming from the light in the ceiling. The Administrator stated the Dietary Manager was coming out of the kitchen and smelled smoke and saw smoke coming from the ceiling. The Dietary Manager yelled code red, and the Director of Nurses obtained fire extinguisher and pulled the pin from the extinguisher, however, was not required to use the extinguisher. She stated there was not as much smoke in the dining room as there was on 07/22/2026. She stated there was very little smoke on 07/28/2026. She stated the dining room was closed for dinner on 07/22/2026 until all the smoke was cleared and the dining room was cleaned. She stated the dining room has not been closed since 07/22/2026. She stated the dining room was reopened on 07/23/2026 for meals and activities. The Administrator stated she did not know why the Maintenance Supervisor stated the dining room had been closed since 07/22/2026. She stated the dining room was closed after the incident on 07/28/2026. The Administrator stated it was not required to report any type of smoke coming from anywhere in the facility. She stated they were only required to report if there were flames. The Administrator stated the incident on 07/28/2026 occurred approximately around 2:30 pm. She stated there were not any residents in the dining room during the incident on 07/22/2026 and on 07/28/2026. She stated the facility had 24 hours to report any incident to HHSC per their protocol. She did not respond when asked why did she not reveal this information when asked if any other incidents occurred with smoke/ fire from the lights after 07/22/2026 when she was asked this morning (07/29/2026). She stated the Maintenance Supervisor on 07/28/2026 turned off the breaker in the dining room and the dining room was currently closed for the residents to do activities and for their meals. She denied there was additional follow-up with residents or the maintenance director to prevent a new fire. The Administrator stated she was grateful there were no residents in the dining room on 07/22/2026 and on 07/28/2026 In an interview on 07/29/2026 at 3:38 p.m. Resident #1 stated she was in the dining room yesterday (07/28/2026) afternoon playing dominoes with two other residents (Resident #2 and Resident #3). She stated she saw smoke, and someone asked them to leave the dining room. Resident #1 stated it did bother her because she used a nebulizer for her asthma and she did have some difficulty with breathing yesterday (07/28/2026) after she left the dining room. She stated she went to her room and used her nebulizer. Resident #1 stated no one assessed her after she was around the smoke in the dining room. Resident #1 stated I hope someone came today and fixed the problem. This is the second time in a week we had a fire in (continued on next page)		

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the dining room. She stated she was not going back in the dining room until she knew it was safe. Resident #1 stated she felt safe in her room and other areas in the facility. Requested policy and protocol of reporting events to HHSC via email to the Administrator on 07/31/2026 at 2:54 p.m. The Administrator responded via email on 07/31/2026 at 3:36 p.m. We do not have a reporting policy or protocol. We follow the guidance provided in HHSC provider letter. Long-term care regulations provider letter for NF's (Nursing Facilities) on abuse, neglect, exploitation, misappropriation of resident property, and other incidents that a nursing facility must report to the health and human services commission. The Administrator did not provide the provider letter.		