STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676475	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Madisonville	600 Bacon Street Madisonville, TX 77864

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 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 medications and biologicals were stored in locked compartments for one of two medication carts reviewed for medication storage. The facility failed to ensure Medication Cart A was locked and medications were secure and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the-counter medications.Findings included:Observation on 01/27/2026 at 8:35 am revealed an unlocked medication cart (Medication Cart A) in front of one of the nurse's desks. The back of the medication cart was against the nurse's station. RN B was inside the nurse's station leaning against the desk with her back facing the medication cart. The medication cart's locking mechanism was protruding outward. The drawers of the medication cart were easily opened and the state surveyor captured photos.In an interview on 01/27/2026 at 8:40 am RN B stated she thought she had locked the medication cart before she walked inside the nurse's station. She said she could not believe the cart was unlocked, as she had the only set of keys for that cart. She said if residents had accessed the medication cart they could have overdosed, taken the wrong medication, had an allergic reaction, or could require hospital admission. She said she had previously been in-serviced on locking the medication carts and could not recall the specific date. She said she was aware the medication cart should have been locked. In an interview on 01/27/2026 at 12:30 pm the Administrator stated her expectation was for the medication carts to be locked when the nurses were not administering medications from the carts. She stated there was a possibility a resident may get medications out of the medication cart. The Administrator stated if a resident did take the medications by mouth there was a possibility a resident may have an allergic reaction. She stated it depended on the medication the resident ingested. She stated the nurse assigned to the medication cart was responsible for locking the medication cart after administering medications to a resident. The Administrator stated the Director of Nurses was responsible to monitor the nurse supervisor.In an interview on 01/27/2026 at 1:30 pm the Director of Nurses stated his expectation was for all medication carts to be locked when the nurse was not administering medications. He stated the staff had been in-serviced on securing the medication carts when not in use. The Director of Nurses stated he did not know the exact date of the in-service. He stated residents, other staff, and visitors would have access to the medications in the unlocked medication cart. He stated if a resident ingested medications not prescribed to them, there was a potential the resident may have an allergic reaction or may need to be admitted to the hospital. He stated it was the nurse's responsibility to ensure the medication cart was locked when not dispensing a resident's medication. The Director of Nurses stated he was responsible for monitoring the nurses.Record review of Administering Medications Policy, dated April 2019, reflected Medications are administered in a safe and timely manner, and as prescribed. During administration of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676475	A. Building B. Wing	01/27/2026

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Avir at Madisonville	600 Bacon Street Madisonville, TX 77864

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for one of one kitchen reviewed for kitchen sanitation. The facility failed to ensure Dietary Aide A wore a beard guard when standing over clean dishes in the kitchen. This failure could place residents who ate food from the kitchen at risk for foodborne illness.Findings included: Observation on 1/27/2026 at 8:45 am revealed Dietary Aide A was not wearing a beard guard. He was standing in the dishwashing room section of the kitchen over the clean plates. He had facial hair approximately 3-4 inches long around his chin. In an interview on 01/27/2026 at 8:50 am, Dietary Aide A stated he was expected to wear a beard guard anytime he was in the kitchen area. He stated if hair fell onto plates and the hair transferred to residents' food there was a possibility a resident may become ill with some type of stomach issues (when asked what type of stomach issues he did not respond to the question). He stated germs were located on hair. Dietary Aide A stated he had been in-serviced on wearing beard guards. He stated he did not recall the exact date. In an interview on 01/27/26 at 9:00 am Dietary Manager stated hair nets or cap and beard guard on facial hair are required for all staff while in the kitchen. Dietary Manager stated it could negatively affect a resident if hair restraints are not worn by a resident receiving food with hair in it. She stated there was a possibility a hair may fall on a clean plate to be used for meals. She stated it was a potential the staff may not see the hair on the plate and may serve food over the hair to a resident. She stated if a resident ingested hair there was a possibility the resident may become physically ill according to what type of bacteria was on the hair such as: nausea, vomiting or diarrhea. Dietary Manager stated it was her responsibility to ensure beard restraints were worn by the male staff in the kitchen. Dietary Manager stated all dietary staff had been in-serviced to wear hair nets and beard guards when in the kitchen. She did not recall the date or time of the in-service. In an interview on 01/27/26 at 12:30 pm the Administrator stated her expectation was that hair restraints were to be worn by all staff in the kitchen. The Administrator stated if hair restraints are not worn there was a possibility a hair may fall onto a clean plate and food can be served over the hair on the plate. She stated there was a possibility that if a resident ingested a hair the resident may become ill with some type of stomach issues or foodborne illness. The Administrator stated all kitchen staff are responsible for wearing hair restraints and that ultimately the Dietary Manager was responsible for ensuring hair restraints are worn by all staff in the kitchen. She stated she was the Dietary Manager's supervisor. Record review of the Facility's Policy on Employee Hygiene for Food Safety, dated 2023, reflected All food and nutrition services employees will practice good personal hygiene and safe food handling procedures. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.