

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675809	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/05/2025
NAME OF PROVIDER OR SUPPLIER  Avir at Lancaster		STREET ADDRESS, CITY, STATE, ZIP CODE  1241 Westridge Ave Lancaster, TX 75146	
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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and facility policy review, the facility failed to ensure the individual financial record must be available to the resident through quarterly statements and upon request for 1 (Resident #1) of 5 residents reviewed for personal funds. The facility failed to provide statements of personal funds upon request. This failure could place the residents at risk of not having knowledge of the balance of their funds. Findings included:Record Review of Resident #1 face sheet, dated 11/0525, revealed a [AGE] year-old man originally admitted on [DATE] with a diagnosis of end stage renal disease (kidneys have severely damaged and can no longer function properly), anxiety disorder due to known physiological condition (mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life). Record review of Resident #1's discharge MDS assessment, dated 09/26/2025, revealed Resident #1 BIMS score of 14 which indicated intact cognitive function. Record review of an undated list of residents provided by the ADM revealed that 26 residents received healthcare insurance funds. The list included Resident #1. An interview on 11/05/25 at 11:16 a.m., the BOM revealed she was hired on 10/27/25 and on 10/29/25 Resident #1 asked for her to provide a printout of his account statements. The BOM stated Resident #1 revealed to her that he had not received a statement since July 2025. The BOM could not provide evidence that Resident 1's received monthly statements from July to September that he had requested. The BOM stated residents who had a trust fund must be provided with a monthly statement and a quarterly trust fund statement. The BOM stated that the importance of the statement was to inform the residents where he or she money went and how much remained. An interview on 11/05/25 at 12:47 p.m., Resident #1 revealed that he had not been provided with an account statement since July until the current BOM gave him one on 10/29/25. Resident #1 stated that he would like to see how much remained on his account to ensure he didn't overdraw his account. Resident #1 stated that the BOM provided his balance, but he wanted preferred the statement. An interview on 11/05/25 at 4:17 p.m., with the ADM revealed he was hired on 10/27/25 and upon hire he ensured the new BOM provided all residents with their most recent October statement. The ADM stated that his expectation was for the facility to provide them with the monthly schedule and as requested by the residents, it is their right to know how their funds are being used.Requested resident rights policy from BOM on 11/05/25 did not receive prior to exit.</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
---	-------	-----------