

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 11/24/2025
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)		
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. (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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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to hold, safeguard, manage personal funds for 1 of 4 residents (Resident #5) reviewed for management of resident funds. The facility failed to ensure the BOM had a witness when distributing cash from the trust fund for Resident #5. The Facilities policy requires the signatures of 2 staff members when cash is dispersed to residents. The failure could place residents at risk for not having funds available when needed. Findings included:Record review of Resident #5's face sheet dated 09/30/2025 reflected the resident was a [AGE] year-old female admitted on [DATE] with active diagnoses that included Schizoaffective disorder, bipolar, Posterior subcapsular polar age-related cataract, right eye, Posterior subcapsular polar age-related cataract, bilateral, Age-related choroidal atrophy, bilateral, Transient visual loss, right eye, Major depressive disorder.An interview with Resident #5 on 09/30/2025 at 10:20 am. The resident stated that she had been at the facility for a long time. She stated the office gave her money when she asked for it. An interview Resident #5 on 10/01/2025 at 10:30 am revealed the resident asked for money on a regular basis, almost daily. She stated she got different amounts \$50, \$75 up to \$90. She reported having \$65 in her possession at the time of the interview. She was able to present this money as it was kept in her shoe. She reported she liked having her money in her hand. She stated that she buys food and cigarettes. She stated she gets all of her money. She stated she could see her money and counted her money. Record review of Resident #5's MDS assessment dated [DATE] list the resident's vision as impaired, reflecting she is able to read large print. The resident had a BIMS of 9 (moderate impairment). Record review of undated policy titled 'Resident Trust Fund & Representative Payee Regulation' reflected the following: (Page 3) .Witness Signature Requirement When a resident cannot sign to approve a withdrawal, the facility must obtain the signature of a witness.The witness cannot be: The person responsible for accounting for the resident's trust funds. That person's supervisor. The individual who accepts the withdrawn funds or sells the item being purchased. The facility must be able to identify the witness's name, address, and relationship to the resident or facility.Record review of the Resident Trust fund Petty Cash Logs revealed the following: The 09/03/2025 log revealed Resident#5 withdrew \$75 and signed for the cash. There were no witness signature. The 09/05/2025 log Revealed Resident #5 withdrew \$200 and signed for the cash. There were no witness signature.The 09/15/2025 log revealed Resident #5 withdrew \$125 signed for the cash. There were no witness signature.and The 09/17/2025 log revealed Resident #5 withdrew \$85 signed for the cash. There were no witness signature.Review of Resident #5's clothing store receipt, dated 09/09/25 reflected clothing purchased for \$167.29. The receipt corresponded with the \$200 withdrawal on 09/09/2025. The receipt was signed by Resident #5.The interview with the facility administrator on 09/30/2025 at 2:15 pm, revealed the BOM was still on leave. She stated that policy required two staff to issue cash. She stated that when she issued cash, she had another person with her and she counted the money out to them and signed the log and the other person counted the money out and signed the log. It was then passed to the person receiving the cash and the log was signed by that person. She stated the BOM did not have a witness or that second person observe the transaction. She stated during a corporate audit the issue with the BOM not having a witness when she dispensed cash was found. She stated corporate called and asked for the Resident Trust Fund Petty Cash Log report that she was not aware she needed to submit, at that point they conducted an audit. She stated that corporate was conducting the investigation, so she was not fully aware of all details at this time. She stated she did not believe there were any funds missing, it was a process that was not being followed. A telephone interview was attempted with the facility BOM on 09/30/2025 at 3:01 pm and 3:45pm. without success. A message was left on the telephone and requested a call back. (No call was received prior to exit.)An interview with corporate BOM on 09/30/2025 at 3:07 pm, revealed during an audit it was found that the business office manager was not following proper procedures. She stated her manager(regional BOM) would be able to give greater detail about the situation and provided a number for her.An interview with Regional Business Office Manager on 09/30/2025 03:26 pm she stated they found an issue where the BOM was not having a witness and witness signature when the BOM passed out funds. Corporate audited several resident's records and Resident #5 was the only one they had questions about. She stated some transactions had witnesses and other's only had the business office manager's signature. When corporate staff talked to Resident #5 she reported she never got more than \$50 At that point the corporate office was not sure if Resident #5 was being sincere or</p>		