STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675809	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lancaster	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1(Resident #1) of 6 residents reviewed for baseline care plan. The facility failed to include on baseline care plan that Resident #1 was placed in the secure unit.The facility failed to include on baseline care plan that Resident # 1was an elopement risk.The facility failed to include Resident #1 Behaviors on baseline care plan. These failures place residents at risk of not receiving the care needed. Findings included: Record review of Resident #1's face sheet dated 06/30/26 reflected, Resident #1 was a [AGE] year-old male, initially admitted on [DATE] and readmitted on [DATE]. Resident#1 was diagnosed with Schizophrenia unspecified, (severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, and disorganized thinking), depression unspecified (common and serious mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of emotional and physical problems), and cognitive communication deficit (A condition where communication is impaired due to underlying cognitive difficulties rather than a primary language or speech problem). Record review of Resident#1's MDS entry assessment, dated 05/23/26 reflected a BIMS of 03 which indicated, severe cognitive impairment. Resident#1 entered from nursing home (long-term care facility). MDS reflected, Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). Documented at a 1 for behavior occurred 1 to 3 days. Record review of Resident#1's previous long term care facility orders dated 04/15/26 to 05/15/26 reflected, Resident#1 requires secured unit d/t wandering (moves with no rational purpose, seemingly oblivious to needs or safety). Record review of Resident#1's elopement evaluation dated 05/15/26 reflected elopement score of 0.0 (low risk for elopement) written by RN D. Record review of Resident#1's progress note dated 05/16/26 reflected, Upon arrival, [RN E] observed the [Resident #1] actively breaking a dining room window using a chair. Record review of progress note dated 05/22/26 reflected, Resident #1 grabbed his plastic tray and slammed it on the floor several times until it broke. Resident then began waving a broken piece of the tray at staff. Resident became upset in room and tore blinds off the wall. Resident threw a cup, causing the window to break again, and kicked a hole in the wall. Written by DON. Record review of Resident#1's MDS entry, dated 06/13/26 reflected, a BIMS of 99 which indicated, resident was rarely/never understood. Resident#1 entered from psychiatric Hospital. Record review of Resident#1's elopement evaluation dated 06/12/26 reflected elopement score of 7.0 (high risk), written by RN B. Record review of Resident#1's baseline care plan undated reflected, no notation of Resident#1's need for secure unit, elopement risk and behaviors. During an over the phone interview on 06/30/26 at 1:15 P.M., NP and MD stated they did not write an order for Resident#1 to be in the secure unit. The resident was transferred in from another facility secure unit. NP stated at this time Resident#1 needed to be on the secure unit. During an interview on 06/30/26 at (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:50 P.M., the MDS Nurse stated Resident#1 was transferred from another facility secure unit. MDS Nurse stated the 48-hour care plan was in the EHR. The MDS Nurse stated she had 21 days to update the care plan. During an interview on 06/30/26 at 2:00 P.M., the Admin stated the facility had clinical meetings weekly and went over concerns for residents. The Admin stated Resident#1 came in on 05/11/26 and was discharged to the Psychiatric hospital on [DATE] and returned back to the facility on [DATE]. The Admin stated he did not have a specific policy about baseline care plan but did have the policy on the comprehensive care plan. During an over-the-phone interview on 06/30/26 at 4:15 P.M., the Marketer stated she received a referral from a local nursing facility secure unit. The marketer stated Resident #1 was on the secure unit for behavior and elopement risk. During an interview on 06/30/26 at 4:50 P.M., DON stated Resident#1's care plan had to be completed in 21 the days. The DON stated Resident#1's baseline care plan should include falls, code status, diet, ADL, immediate concerns/goals. The DON stated the MDS Nurse was responsible for care plans.

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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 - Some	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 and interview the facility failed to store all drugs and biologicals in locked compartment and permit only authorized personnel to have access to the keys for 1 (medication cart #1) and 1 (crash cart #2) of 3 medication carts observed for medication and biological storage. On 06/30/26, LVN A failed to ensure medications were secured or attended to by authorized staff when LVN A did not lock medication cart #1. On 06/30/26, the facility failed to ensure crash cart #2 (a wheeled container carrying medicine and equipment for use in emergency resuscitations) was secured. These failures place residents at risk of unauthorized access to medications and biologicals. Findings Included: During an observation on 06/30/26 at 6:42 A.M., one medication cart #1 and one crash cart #2 were unlocked with drawers facing outward towards the hallway at the North nursing station. The red dot was visible on the lock mechanism of both carts.During an observation on 6/30/26 at 6:43 A.M., nursing staff left the North nursing station with the medication cart #1 and crash cart#2 unlocked with no staff in view of the carts.During an interview on 06/30/26 at 6:50 A.M., LVN A stated the medication cart #1 was her cart and she did not realize it was unlocked. LVN A stated the medication cart should be kept locked for safety of the medications and the residents. LVN A stated residents could take medications that did not belong to them. During an observation on 6/30/26 at 6:57 A.M., crash cart #2 revealed:Alcohol prep padsSaline solutions tubeslancetsScissors(AA) batteriessuction catheterLarge adult reservoir mask not in bagSilicone fix tapeGauze sponge (2x2) boxAdult electrode padSuction tubingLubrication jelly Normal saline I.V flush syringes - 12ml Adult nasal oxygen canula tubingDuring an interview on 06/30/26 at 7:42 A.M., RN A stated the medication cart must stay locked when not in use. RN B stated the crash cart should be left unlocked for easy access. During an interview on 06/30/26 at 12:05 P.M., LVN C stated the medication cart and crashed cart must be locked when not at use to prevent unauthorized use of medications and to keep residents safe.During an observation on 06/30/26 at 3:00 P.M., crash cart #2 was unlocked at the North Nursing station.During an interview on 06/30/26 at 3:30 P.M., the DON stated medication cart and crash cart must be locked when not in use to protect the residents and staff from taking medications. The DON stated the nurse on the cart was responsible for the cart security and she was responsible for in-services with staff. Record review of facility policy, titled, Administering medications reflected, 19. During administration, 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 room, with open drawers facing inward and all other sides closed.