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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lancaster	1241 Westridge Ave Lancaster, TX 75146

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 1 of 3 residents (Resident #44) reviewed for contracture management.The facility failed to provide equipment/services for Resident #44's left hand contracture (a permanent tightening of the muscles). This failure could place residents at risk for a decline in range of motion, decreased mobility, worsening of contractures, and a decline in physical capabilities.Findings included:Record review of Resident #44's quarterly MDS dated [DATE] reflected the resident was [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included diabetes, non-Alzheimer's dementia, and seizure disorder. Resident #44 had a BIMS of 3 which indicated his cognition was severely impaired. The MDS further reflected the resident used a manual wheelchair and had impairment on one side to the upper extremity and impaired on both sides to the lower extremities.Record review of Resident #44's care plan edited on 09/01/25 reflected the resident had self-care deficits and required assistance with ADLs. The resident required assistance from two staff for bathing/hygiene. The Care plan further reflected to consult PT, OT, and ST as needed. Record review of Resident #44's OT Evaluation and Plan of Treatment dated 06/18/25 completed by the previous therapist reflected the following: .New GoalPt will maintain L hand ROM via us of hand roll splint for contracture management. Review of Resident #44's monthly physician orders for January 2026 reflected there was no order for a left hand contracture or management in place. Observation and interview on 01/13/26 at 11:02 AM revealed Resident #44 was in his wheelchair in the day room playing with a puzzle. The resident was noted to have a left-hand contracture and there was no device in place. Resident #44 was asked if he could open his left hand and he said some and he was able to slowly open his fingers enough to show there were no skin issues or odors in his contracted hand. The resident was asked if he had ever had a device in place for his contracture and he said no and he went on to play with his puzzle. Interview on 01/14/26 at 3:36 PM with CNA A revealed he had worked at the facility for 3 weeks and he had never seen Resident #44 wear a device in his contracture. CNA A said the resident was able to open his hand a little and the resident would allow the staff to clean inside his hand. Interview on 01/14/26 at 3:38 PM with the Director of Rehab revealed Resident #44 had a splint to his left-hand contracture and he was supposed to wear for 2 to 3 hours a day or however long he could tolerate it if there was no pain or skin issues. The Director of Rehab said she was not sure if it was the DON or nursing staff that would apply the splint to the resident. The Director of Rehab further stated Resident #44's contracture could worsen if he did not wear the splint. Interview on 01/14/26 at 3:49 PM with LVN B revealed she had never seen any kind of device on Resident #44's left hand contracture nor had anyone told her the resident needed one. LVN B said Resident #44 was able to open his contracted hand a little bit, enough to clean the palm and see the skin integrity. Interview on 01/15/26 at 10:31 AM with LVN C revealed she had never seen a splint on Resident #44's left hand contracture. LVN C said if residents required some kind of device for a contracture, they would get an order from therapy (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and get instructions on how to apply the device and told how long the resident needed to wear it. LVN C further stated she had never seen an order for Resident #44 to wear a splint for the contracture. Interview on 01/15/26 at 12:24 PM with the Director of Rehab revealed Resident #44 had a splint evaluation in June 2025, prior to her working at the facility by a therapist that no longer worked at the facility. The Director of Rehab said normally if a resident required a device for contracture management, they would give the order to the nurse and educate them about the use of the device. She further stated she could not recall the last time she saw Resident #44 wearing the hand splint and could not locate it when she looked for it in the room. The Director of Rehab also said Resident #44 was currently on therapy caseload for his hand contracture and they were working on range of motion and said the resident's contracture had not worsened. Interview on 01/15/26 at 2:08 PM with the ADON revealed she had been at the facility for over a year, and she had never seen a splint in Resident #44's left hand contracture. The ADON said that if Resident #44 required a splint it would help keep his hand open and keep his fingernails from embedding in his palm. Interview on 01/15/26 at 3:13 PM with the DON revealed she had been at the facility since September 2025, and she had never seen a splint on Resident #44's left hand contracture and nothing had been discussed with her that he needed one. The DON said usually therapy would order the contracture device and write the order and then inform the nurse to educate them on it. The DON said it was important for Resident #44 to have a splint in his hand contracture to prevent the contracture from worsening and to prevent skin breakdown and infection. Record review of the facility's undated policy titled Therapy Policy and Procedures Contracture Management reflected the following: Purpose and ScopePurpose:To ensure effective, evidence-based, and interdisciplinary management of contractures in residents, promoting optimal functional outcomes, comfort, and quality of life.Policy StatementContracture management in this facility will be approached through proactive assessment, early intervention, and interdisciplinary collaboration. The use of splints, braces, therapeutic modalities, and nursing/therapy coordination is critical in both prevention and treatment.

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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, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure kitchen food processor equipment was clean and free from build-up. [NAME] F placed food containers of the lunch meal in the steamtable that contained contaminated tinted water and burnt food particles floating in it on 01/14/26.These failures could place residents at risk for food contamination and foodborne illness.Findings included:Continuous observations on 01/14/26 from 10:56 AM to 12:15 PM revealed the following:- [NAME] F preparing the pureed lunch meal. [NAME] F pureed sweet potatoes, greens, and ham. The food processor/blender that [NAME] F used to puree the food had a see-through handle, which had a white build-up inside the handle. [NAME] F washed the food processor after every use, but the handle continued to have the white build-up inside the handle. - The kitchen steam table had five compartments, and the last two compartments from the right side had a few inches of brown tinged water. There was also build-up of food particles at the bottom of the compartment and floating in the water [NAME] F placed the pureed trays in the dirty steam table compartments. Interview on 01/14/26 at 12:20 PM, [NAME] F revealed she noticed the steamtable compartments in the kitchen had dirty water in them while she was placing the cooked food for the lunch service. [NAME] F stated it was the Cooks responsibility for cleaning the steamtables after every meal. [NAME] F stated she could not recall the exact date of when the last time the steamtables water was emptied out but could have been a month ago. She stated she does not know why it had not been done. [NAME] F stated the food processor had built-up inside the handle. She stated when cleaning the food processor/blender the handle could be removed so they could clean inside. She stated she had been busy and had not had the time to clean it. Interview on 01/14/26 at 12:26 PM, the Dietary Manager revealed it was the kitchen staff responsibility to clean kitchen equipment. She stated the steamtables were wiped down after every meal and deep cleaned monthly. She stated the steamtables water was emptied out daily. She stated the steamtables were emptied out the other day but could not recall the exact date. The Dietary Manager stated she was aware of how the food processor handled looked like and stated she had ordered a new food processor about 2 weeks ago. She stated the steamtable was not up to her expectations on how it should be. The Dietary Manager stated she had a cleaning schedule that helped monitor what items needed to be cleaned in the kitchen. She stated the potential risk would cross contamination with the steamtable and food processor handle. The Dietary Manager stated that it could make a resident sick. Record review of facility Daily Cleaning Schedule dated January 2026, week 11-19 revealed the steamtable was last cleaned Tues. Record review of facility Monthly Cleaning Schedule dated Year 2026, revealed Steamtable (Degrease & Polish) was completed December 2025. Record review of facility Sanitization policy, dated November 2022, reflected the following: The food service area is maintained in a clean and sanitary manager.2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning seals, hinges and fasteners are kept in good repair. 8. When cleaning fixed equipment (e.g., mixers, slicers, and other equipment that cannot readily be immersed in water), the removable parts are: a. washed and sanitized, and non-removable parts cleaned with detergent and hot water, rinsed, air-dried and sprayed with a sanitizing solution (at the effective concertation); and b. the equipment is reassembled and any food contact surfaces that may have been contaminated during the process are re-sanitized (according to the manufacturer's instruction).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 15 residents (Resident #44) reviewed for care plans. The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #44's left hand contracture.This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included:Record review of Resident #44's quarterly MDS assessment, dated 11/03/25, reflected the resident was [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included diabetes, non-Alzheimer's dementia, and seizure disorder. The MDS reflected Resident #44 had severe cognitive impairment with a BIMS score of 3. The MDS also reflected that the resident used a manual wheelchair for mobility, and he had impairment to both of his lower extremities (leges) and one of his upper extremities (arm). Record review of Resident #44's care plan edited on 09/01/25 reflected the resident had self-care deficits and required assistance with ADLs. The resident required assistance from two staff for bathing/hygiene. The care plan further reflected to consult PT, OT, and ST as needed. The care plan did not address Resident #44 had a left hand contracture or interventions to care for it. Record review of Resident #44's OT Evaluation and Plan of Treatment dated 06/18/25 completed by the previous therapist reflected the following: .New GoalPt will maintain [left] hand ROM via us of hand roll splint for contracture management. Review of Resident #44's monthly physician orders for January 2026 did not address a left hand contracture or contracture management devices. Observation and interview on 01/13/26 at 11:02 AM revealed Resident #44 was in his wheelchair in the day room working on a puzzle. The resident's left-hand was contracted, but he did not have a contracture management device in his left hand. Resident #44 was asked if he could open his left hand, and he said some. He was able to slowly open his fingers enough to show there were no skin issues or odors in his contracted hand. The resident was asked if he had ever had a device in place for his contracture, and he said no. He did not provide any further information. Interview on 01/14/26 at 3:36 PM with CNA A revealed he had worked at the facility for three weeks, and he had never seen Resident #44 wear a device in his contracture. CNA A said the resident was able to open his hand a little and the resident would allow the staff to clean inside his hand. Interview on 01/14/26 at 3:38 PM with the Director of Rehab revealed Resident #44 had a splint to his left-hand contracture and he was supposed to wear for 2 to 3 hours a day or however long he could tolerate it if there was no pain or skin issues. The Director of Rehab said she was not sure if it was the DON or nursing staff that would apply the splint to the resident. The Director of Rehab further stated Resident #44's contracture could worsen if he did not wear the splint. Interview on 01/14/26 at 3:49 PM with LVN B revealed she had never seen any kind of device on Resident #44's left hand contracture nor had anyone told her the resident needed one. LVN B said Resident #44 was able to open his contracted hand a little bit, enough to clean the palm and see the skin integrity. Interview on 01/15/26 at 10:31 AM with LVN C revealed she had never seen Resident #44 with a splint in his left contracted hand. LVN C said if residents required some kind of device for a contracture, they would get an order from therapy. The order would provide instructions on how to apply the device along with how long the resident needed to wear the device. LVN C stated she had never seen an order for Resident #44 to wear a splint for his contracted hand. Interview on 01/15/26 at 12:24 PM with the Director of Rehabilitation revealed Resident #44 had a splint evaluation in June 2025 completed by a therapist, who no longer worked at the facility. She stated this was done prior to her employment at the facility. She stated normally if a resident required a device for contracture management, they would give the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order to the nurse and educate them about the use of the device. She further stated she could not recall the last time she saw Resident #44 wearing the hand splint and could not locate it when she looked for it in the room. She stated Resident #44 was currently on their therapy caseload for his contracted hand. She stated they were working on his range of motion, and his contracture had not worsened. Interview on 01/15/26 at 2:08 PM with the ADON revealed the MDS Nurse usually created resident care plans, but there were some care plans the nursing staff could do. The ADON said she did not know if Resident #44's left hand contracture should have a care plan, but the staff knew about the resident's contracture because it was something the nursing staff talked about. The ADON did not have any further information related to Resident #44's care plan. Interview on 01/15/26 at 3:13 PM with the DON revealed care plans could be completed by the MDS nurse and/or the nursing staff. The DON said she was not aware the resident did not have a care plan for his left-hand contracture. The DON further stated care plans were important to ensure the residents got the care they needed so they could function to the best of their ability. Interview on 01/15/26 at 4:25 PM with the MDS Nurse revealed if Resident #44 had a contracture, then there should have been a care plan. She stated she was not aware of the issue and had she been aware she would have developed a care plan herself. The MDS Nurse further stated accurate resident care plans were important, so staff knew the care the residents required. Record review of the facility's Care Plans, Comprehensive Person-Centered policy, revised on March 2022, reflected the following: Policy StatementA comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 of 2 residents (Resident #8) reviewed for tube feedings. LVN E attempted to feed Resident #8 who was on a g-tube (a tube inserted through the abdomen directly into the stomach for feeding, fluids, or medicine when someone can't eat enough by mouth) a regular texture meal and had an order of NPO (nothing by mouth). This failure could place residents at risk for choking and aspiration.Findings included:Record review of Resident #8's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The residents' diagnoses included heart failure, diabetes, non-Alzheimer's dementia, and schizophrenia. The resident had long and short-term memory impairment and therefore a BIMS was not completed. The MDS further reflected Resident #8 was on a feeding tube. Record review of Resident #8's care plan edited on 09/01/25 reflected the resident was NPO due to oropharyngeal dysphagia (difficulty with the initial stage of swallowing). Approaches included administer bolus/continuous feeding per schedule and diet order of NPO (with trial feeding by speech therapy ONLY. Record review of Resident #8's January monthly order summary report reflected Resident #8 had an NPO diet, NPO texture, and NPO consistency. The order summary report further reflected continuous feeding started at bedtime and stopped in the morning (7PM to 7AM). Observation and interview on 01/14/26 at 12:05 PM revealed CNA E had a meal tray with regular texture food sitting on Resident #8's nightstand and she was trying to feed Resident #8, but the resident was observed pushing the CNA's hand away. There was a feeding pump next to the resident's bed and it was turned off at the time of the observation. CNA E then exited the room and stated she tried to feed Resident #8 food yesterday as well, 01/13/26, and the resident had pushed her hand away then too. CNA E further stated she had been told by other staff, but did not say who, that if the resident refused, they would leave the tray in the room and try again later. Surveyor attempted to speak with Resident #8 but the resident told the surveyor to get out of her room. Further interview on 01/14/26 with CNA E at 1:45 PM revealed she had just started working two days prior, 01/12/26 and it appeared she had gotten Resident #8 mixed up with her roommate. CNA E further stated she took responsibility and should have checked with another staff member to make sure the resident could or could not eat because she had noticed a feeding pump at the resident's bedside. CNA E also said there was another resident on that same hall that was on a g-tube and he also ate pureed foods. Interview on 01/14/26 at 3:48 PM with LVN B revealed Resident #8 was NPO and was not supposed to have anything by mouth. LVN B said because she worked the second shift, she was not aware CNA E, who worked first shift, had tried to feed Resident #8. Interview on 01/15/26 at 10:26 AM with LVN C revealed Resident #8 was NPO and CNA E was a new aide to the facility and yesterday, 01/14/26, had only been her second day working on the floor. LVN C said CNA E was safe to be on her own while she was training because she had been a aide for many years and she just had to learn the names of the residents. LVN C said if an aide was unsure of a resident's care needs, the new staff needed to ask another aide or her for further guidance. LVN C also said she was not aware CNA E had tried to feed Resident #8 and there could have been a risk of the resident aspirating if she tried to eat food. Interview on 01/15/26 at 2:02 PM with the ADON revealed Resident #8 had a feeding tube and was NPO. The ADON said she was not aware CNA E tried to feed Resident #8 regular food and there was a possibility of aspiration if the resident would have eaten it. Interview on 01/15/26 at 3:10 PM with the DON revealed Resident #8 was NPO and had been for a long time. The DON said she was not aware CNA E had tried to feed the resident regular food. The DON said new aides trained with another CNA and if they had questions, they should refer to the tenured aide for assistance or guidance. The DON further stated there was a risk of aspiration if the resident ate solid food.Record review of the facility's policy titled Enteral Nutrition updated on 12/17/24 reflected the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy StatementAdequate nutrition support through enteral feeding will be provided to residents as ordered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored securely and had acceptable labeling for 1 of 3 medication carts (North Hall nurse medication cart) reviewed for drug storage and labeling.The facility failed to ensure expired medications, Ondansetron and Naproxen, were removed from North Hall nurse medication cart.This failure could place residents at risk of not receiving the therapeutic benefit of medication or an adverse drug reaction. Findings included:Observation on 01/14/2026 at 8:26 AM of the North Hall nurse medication cart with LVN C revealed 30 tablets of ondansetron 4 mg (used to prevent nausea and vomiting) with an expiry date of December 2025 and 29 tablets of Naproxen 250 mg (used to reduce pain, fever, and inflammation from conditions like arthritis, gout, menstrual cramps) with an expiry date of December 2025.Interview on 01/14/2026 at 8:40 AM, LVN C revealed she was responsible for checking the cart for expired medications. She stated she checked the cart daily for expired medications. She stated she forgot to check her cart that morning. She stated failing to remove the expired medication could result in the medications being administered which could cause reactions, and the residents would not get the required therapy. She stated she had done training on checking the carts for expired medications, but she could not recall when she had completed the training. Interview on 01/15/2026 at 3:37 PM, the DON revealed she expected the nursing staff to check their carts for expired medications often. She stated it was all nurses' responsibility to check the carts and remove expired medications. She stated it was her responsibility and nursing management to monitor and ensure the nurses were discarding the expired medications, monthly. She stated the last time the carts were checked was on 01/12/26, and she thought they missed those medications. She stated if the staff were not checking carts for expired medications, it would place residents at risk of having reactions like the medication being ineffective since they could not tell of the potency. She stated she had done training on medications storage. The training titled auditing cart dated 10/27/25 revealed and LVN C was in attendance. Record review of the facility's training record, dated 10/27/25, reflected that: Expired medications should be removed from nurses' carts to ensure patient safety, maintain medication effectiveness, prevent errors and comply with healthcare. The training titled auditing cart dated 10/27/25 revealed LVN C was in attendance.Record review of facility's Medication Storage policy, dated February 2023, reflected:3.If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items