STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed on 01/28/26 to seal food stored in the dry storage and food stored in the refrigerator. This failure could place residents at risk for food contamination and foodborne illness.Findings included: The following observation was made on 05/14/2026 at 11:25 a.m. during the tour of the kitchen: Dry Storage:Spaghetti noodles stored in zip lock bag not sealed.Garlic powder with lid open.Salt with spout open. Refrigerated Storage:Prepared drink on a metal sheet pan with no cover.Plate of salad with no date.Package of turkey breast lunch meat with no date and not sealed. During an interview on 05/14/2026 at 12:29 p.m., the DM stated all food in the refrigerator should be sealed and dated. She stated all dry storage food should be sealed and closed. During an interview on 05/15/2026 at 01:50 p.m., the DM stated the purpose of sealing all food stored was to keep it fresh and no contaminants get in the food. She stated all staff were responsible for dating and sealing stored food. She stated all staff have been trained in food storage. She stated the potential negative outcome could be something getting into the food, food contamination and could make the residents sick. During an interview on 05/15/2026 at 02:25 p.m., the ADM stated he was not aware food was not properly stored. He stated the purpose of dating and sealing stored food was to maintain a sanitary condition. He stated everyone was responsible for dating and sealing stored food. He stated all staff have been trained in food storage. He stated the potential negative outcome could be preliminary expiration, freshness and possible expose to cross contamination. Record review of the facility's policy, titled Food Receiving and Storage, dated revised November 2022, reflected the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation: .Dry Food Storage.4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date) .Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date) .7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen or discarded.

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: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their own established smoking policy for 3 of 11 residents reviewed for smoking. (Residents #25, #43, #49)The facility failed to follow smoking policy for Residents #25, #43, #49.This failure could place residents at risk of smoking while unsupervised.Findings include:1. Record review of Resident #25's face sheet dated 05/15/2026 indicated she was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE]. Resident #25 had diagnoses which included hepatic encephalopathy (damaged liver allows toxins to build up in blood), anxiety (feeling of fear or worry), depression (mental illness) and hypertension (high blood pressure).Record review of Resident #25's annual MDS assessment dated [DATE], indicated she had a BIMS score of 09, which indicated she had mild cognitive impairment. The MDS indicated Resident #25 used tobacco. Record review of Resident #25's Care Plan Report dated 04/23/2026 revealed no care plan for smoking.Record review of Resident #25's Safe Smoking assessment dated [DATE] indicated Resident #25 needed facility to store lighter and cigarettes. Safe Smoking Assessment further revealed Resident #25 was safe to smoke without supervision.2. Record review of Resident #43's face sheet dated 05/15/2026 indicated he was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE]. Resident #43 had diagnoses which included heart failure, diabetes (high blood sugar), anxiety (feeling of fear and worry) and hypertension (high blood pressure).Record review of Resident #43's quarterly MDS assessment dated [DATE], indicated he had a BIMS score of 14, which indicated no cognitive impairment. The MDS indicated Resident #25 used tobacco. Record review of Resident #43's Care Plan Report dated 03/20/2026 indicated he was a smoker.Record review of Resident #43's Safe Smoking assessment dated [DATE] indicated Resident #43 needed facility to store lighter and cigarettes. Safe Smoking Assessment further revealed Resident #43 was safe to smoke without supervision.3. Record review of Resident #49's face sheet dated 05/15/2026 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #49 had diagnoses which included cerebral infarction (stroke), depression (mental illness) and hypertension (high blood pressure).Record review of Resident #49's annual MDS assessment dated [DATE], indicated he had a BIMS score of 13, which indicated no cognitive impairment. The MDS indicated Resident #25 used tobacco. Record review of Resident #49's Care Plan Report dated 03/06/2026 indicated he was a smoker.Record review of Resident #49's Safe Smoking assessment dated [DATE] indicated Resident #49 needed facility to store lighter and cigarettes. Safe Smoking Assessment further revealed Resident #49 was safe to smoke without supervision.During an interview on 05/15/2026 at 12:48 p.m. LVN D stated all resident smoking were to be supervised. She stated smoking supplies were kept in a box at the nurse's station. She stated the previous ADM allowed residents to smoke unsupervised. She stated she had been trained in the facility smoking policy. She stated staff supervise residents according to the smoking schedule. She stated housekeeping supervisor supervises them at 01:00 p.m.During an observation on 05/15/2026 at 01:05 p.m. revealed the HSK supervisor was outside observing smoking while the residents smoked.During an interview on 05/15/2026 at 01:08 p.m., the HSK Supervisor stated she was scheduled to supervise smoking. She stated all residents had their own cigarettes and lighters. She stated she did not hand out any smoking supplies. She stated it was her understanding the residents stopped by the nurse's station for supplies before going outside. She stated she had been trained on the facility smoking policy.During an interview on 05/15/2026 at 01:15 p.m., Resident #38 stated he keeps cigarettes in his nightstand. He stated he currently was out of cigarettes and has no cigarettes in his room at this time. He stated he did have a lighter in his pants pocket. He stated he had not been told he could not keep his smoking supplies in his room.During an interview and observation on 05/15/2026 at 01:25 p.m., Resident #49 stated he keeps cigarettes and lighter in his nightstand. Surveyor observed cigarettes and lighter in the top drawer of the nightstand. He stated he had not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been told he could not keep his smoking supplies in his room. During an interview on 05/15/2026 at 01:30 p.m., Resident #25 stated she keeps her cigarettes and lighter in her room. She stated if you give the nurses your cigarettes and lighter they will take them. She stated she doesn't remember being told she could not have supplies in her room.During an interview on 05/15/2026 at 02:00 p.m., the DON stated the smoking policy was for all residents to be supervised while smoking. He stated staff were to keep smoking supplies at the nurse's station. He stated he was not aware residents had smoking supplies in their rooms. He stated residents were notified of the smoking policy. He stated all staff have been trained on the facility smoking policy. He stated the smoking schedule has an assigned department at each time to make sure smoking was supervised. He stated the potential negative outcome could be burns from unsupervised smoking.During an interview on 05/15/2026 at 02:25 p.m., the ADM stated residents were not to have smoking supplies in their rooms. He stated the smoking residents have been told the facility smoking policy several times. He stated all staff had been trained on the facility smoking policy. He stated he was not aware residents had smoking supplies in their rooms. He stated the potential negative outcome could be unauthorized smoking.Record review of the facility policy titled Smoking Policy - Resident dated October 2022 reflected the following: Policy Statement - This facility shall establish and maintain safe resident smoking practices.Policy Interpretation and Implementation.14. Residents may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the reasonable accommodation of resident needs and preferences for 1 of 22 residents (Resident #6) reviewed for call light placement. The facility failed to ensure the resident call light system was within reach for Resident #6 on 05/14/2026 and 05/15/2026. This failure could place residents at risk of not receiving the necessary assistance they need to maintain their highest level of independence. Findings included: Record review of Resident #6's face sheet dated 05/15/2026 revealed an [AGE] year-old-female admitted on [DATE] with the following diagnoses: dementia (memory loss), chronic obstructive pulmonary disease (lung disease that makes it hard to breathe), depression (illness that involves the body, mood and thoughts), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). Record review of Resident #6's comprehensive MDS dated [DATE] revealed Resident #6 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS further revealed Resident #6 had limited range of motion - bilateral lower extremity. Resident #6 required partial/moderate assistance with activities of daily living. Record review of Resident #6's care plan dated 03/10/2026 revealed a focus area Resident #6 had activity of daily living self-care performance deficit related to dementia. Interventions with activities of daily living with substantial assistance of one. During an observation on 05/14/2026 at 02:12 p.m. Resident #6 was lying in bed and her call light was hanging on the bed frame under the head of bed. During an interview on 05/14/2026 at 03:20 p.m. LVN C stated Resident #6 call light should always be in reach. She stated she was not sure why the call light was not within reach. She stated Resident #6 was able to use call light if available. During an observation on 05/15/2026 at 10:13 a.m. Resident #6 was lying in bed and her call light was tucked in-between the mattress and bedframe at the head of bed. During an interview on 05/15/2026 at 12:35 p.m. CNA E stated the purpose of a call light was for the residents to call when they needed help or assistance with something. She stated there was no reason a resident should not have a call light in reach. She stated she was not aware Resident #6 did not have her call light. She stated she had been trained on call light placement. She stated everyone was responsible for making sure the residents had call light in reach. She stated the potential negative outcome could be falls, possible chocking and the residents not being able to call for help. During an interview on 05/15/2026 at 12:48 p.m. LVN D stated a residents call light should always be within reach. She stated there was no reason a resident would not have a call light. She stated she was not aware Resident #6 did not have her call light. She stated she had been trained on call light placement. She stated she monitors residents every two hours by making walking rounds. She stated the potential negative outcome could be a resident getting hurt. During an interview on 05/15/2026 at 02:00 p.m. the DON stated the purpose of a call light was for the residents to notify staff of needing assistance. He stated the call light should be placed near the resident. He stated there was no reason for a resident to not have a call light. He stated all staff had been trained on call light placement. He stated all staff were responsible for ensuring residents have call lights. He stated he was not aware Resident #6 did not have her call light. He stated the potential negative outcome could be resident dignity. During an interview on 05/15/2026 at 02:25 p.m. the ADM stated the purpose of the call light was to allow the resident to call for assistance. He stated there was no reason at resident would not have a call light. He stated the call light system must be available for all residents. He stated he was not aware Resident #6 did not have her call light. He stated all staff had been trained on call light placement. He stated all staff were responsible for making sure residents have access to call light. He stated the potential negative outcome could be residents not being able to call for assistance when needed. Record review of the facility's policy, titled Call System, Residents revised date 1/2025, reflected the following: Policy - Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station.Policy Interpretation and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implementation1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 24 residents hand sinks (room [ROOM NUMBER] and room [ROOM NUMBER]) in that: The facility failed to ensure the hot water in the hand sink in room [ROOM NUMBER] was at a comfortable temperature.The facility failed to ensure the hot and cold water in the hand sink in room [ROOM NUMBER] was functioning properly. These failures could lead to residents experiencing a diminished quality of life and a lack of home-like environment and/or comfort. The findings include: During a confidential interview on 05/13/2026 at 09:30 AM the confidential resident stated there was no warm water in the hand sinks in the residents' bedrooms. The resident stated they often had to wash their hands with cold water, causing their hands to feel cold. The resident stated they felt the facility did not take the cold water issues seriously. The resident stated they would like the water to be warm to wash their hands and face. During an observation on 5/13/2026 at 10:00 AM the hot water in Resident room [ROOM NUMBER] remained cold after allowing the water to run for several minutes. During an observation on 05/13/2026 at 10:30 AM the hot water in Resident room [ROOM NUMBER] remained cold after allowing the water to run for several minutes. During an observation on 05/14/2026 at 2:55 PM, the hot water at the shared hand sink in room [ROOM NUMBER] was checked with a water thermometer and noted to be 73.6 degrees Fahrenheit.During an observation on 05/14/2026 at 3:05 PM, the hot water at the shared hand sink in room [ROOM NUMBER] was checked with a water thermometer and noted to be 70.5 degrees Fahrenheit.During an interview on 05/15/2026 at 12:00 PM the MD stated he completed water temperature checks weekly on the shared hand sinks in residents' rooms. The MD stated he did not complete temperature checks on every hand sink but completed spot checks. The MD stated he kept temperature logs to verify his weekly checks, and he would locate the logs for verification. The MD stated he was not aware of any recent issues with water temperatures in any of the hand sinks in resident rooms. The MD stated all maintenance requests were reported in the facility's online system. The MD stated he did not have any recent reports concerning water temperatures. The MD stated residents could also verbally report any concerns to him directly. The MD stated all staff were responsible for reporting maintenance repair needs to the online system or by communicating with him directly. The MD stated hot water temperatures in the shared hand sinks in residents' rooms should have been between 100 and 110 degrees Fahrenheit. The MD stated he was not aware the hot water temperature in resident room # 1 was 73.6 degrees Fahrenheit and resident room [ROOM NUMBER] was 70.5 degrees Fahrenheit. The MD stated he received training upon hire regarding safe and comfortable water temperatures. The MD stated he was responsible for ensuring all water temperatures were adequate. The MD stated it was important for water temperatures to be adequate to provide comfort to the residents. During an interview and observation on 05/15/2026 at 12:20 PM the MD completed a check of the hot water in the shared hand sink in resident room [ROOM NUMBER]. The MD obtained a temperature, with a digital thermometer, of 70 degrees Fahrenheit. The MD then ran the cold water which began to turn warm. The MD stated the water valves must have been switched after a recent repair, transposing the hot and cold water valves. The MD obtained a hot water temperature of 100 degrees Fahrenheit on the cold water side of the hand sink. The MD stated he would work to correct the issues as soon as possible. The MD stated he would also follow up on resident room [ROOM NUMBER] to verify the hot water temperature and make any necessary repairs. During an interview on 05/15/2026 at 12:30 PM the ADM stated the MD was responsible for ensuring water temperatures were adequate throughout the facility. The ADM stated hot water temperatures should have been between 100 and 110 degrees Fahrenheit in residents' rooms. The ADM stated he was not aware of any recent reports of low hot water (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	temperatures. The ADM stated all maintenance repair requests were submitted in the facility's online reporting system, and the MD was responsible for completing these repair requests. The ADM stated the MD also completed regular checks on water temperature and should have had a log to verify these temperature checks. The ADM stated he was not aware the cold and hot water valves were transposed in resident room # 6. The ADM stated a toilet was repaired in the shared bathroom of resident room [ROOM NUMBER], and it was possible it was not put back together correctly after the plumbing repair, transposing the hot and cold valves. The ADM stated it was his expectation that hot water temperatures were kept within the adequate temperature range. The ADM stated if water temperatures were not within an adequate temperature range, it may not be comfortable for the resident. The ADM stated if the hot water and cold water valves were transposed, this could be unfamiliar to the resident and could cause discomfort. During an interview on 05/15/2026 at 1:0 PM the DON stated the MD was responsible for completing regular water temperature checks and completing any necessary repairs. The DON stated all staff were responsible for reporting any needed repairs to the MD either directly or through the facility's online reporting system, The DON stated he was not aware of any concerns regarding hot water temperatures. The DON stated he was not certain what the hot water temperature range was. The DON stated it was important to maintain adequate water temperatures to ensure comfort levels for residents. The DON stated if water temperatures were below an adequate range, this could be uncomfortable to the resident. Record review of facility policy pertaining to Maintenance Requests was requested from the ADM on 05/15/2026 at 12:30 PM and 05/19/2026 2:44 PM, and the policy was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with an accurate PASRR Level I for 1 of 24 residents (Resident #10) reviewed for PASRR screening, in that:Resident #10 did not have an accurate and updated PASRR Level 1 assessment, reflecting a diagnosis of mental illness. This failure could place residents, with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation, at risk for not receiving care and services to meet their needs. The findings included: Record review of Resident #10's electronic face sheet dated 05/14/2026 revealed a [AGE] year-old female initially admitted to the facility on [DATE]. The face sheet included the following diagnoses: Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (primary) (weakness or paralysis on one side of the body resulting from a stroke), Major Depressive Disorder, recurrent, severe without psychotic features (a mood disorder that causes a persistent feeling of sadness and loss of interest), Major Depressive Disorder, recurrent, mild, and Cognitive Communication Deficit. Record review of Resident #10's Annual MDS dated [DATE], under section I (Active Diagnoses), indicated Resident #10 had a Psychotic/Mood Disorder of Anxiety and Depression (other than Bipolar). It was also indicated under Section I, other, an active diagnosis of Major Depressive Disorder, recurrent, mild. Additionally, under Section C Cognitive Patterns, Resident #10's MDS revealed a BIMS of 15, indicating the resident was cognitively intact. Record review of Resident #10's care plan dated 05/13/2026, under Diagnoses indicated Resident #10 had a diagnosis of Major Depressive Disorder, recurrent, severe without psychotic features and Major Depressive Disorder, recurrent, mild. The care plan included a focus area that stated, (Resident) has depression r/t Disease Process Major Depressive D/O on psychotropic medication. Date Initiated: 01/06/2026. Record review of Resident #10's physician's Order Summary as of 05/14/2026 revealed under Diagnoses Major Depressive Disorder, recurrent, severe with psychotic features and Major Depressive Disorder, recurrent, mild. Resident #10 was prescribed Cymbalta Oral Capsule Delayed Release Particles 60 MG (Duloxetine HCl) related to Major Depressive Disorder, recurrent, mild. Record review of Resident #10's PASRR Level 1 Screening dated 07/28/2024 revealed the following: under section C (PASRR Screening), C0090 Primary Diagnosis of Dementia: NO, under section C (PASRR Screening), C0100 Mental Illness: NO. Record review of Resident #10's Diagnosis Report, dated 05/14/2026, revealed the following under Diagnosis: Major Depressive Disorder recurrent, Severe without Psychotic Features with an onset date of 07/23/2023 and Major Depressive Disorder recurrent, mild with an onset date of 02/15/2024. During an interview on 05/15/2026 at 12:30 PM the ADM stated the MDS nurse was responsible for ensuring PASRR Level 1 screenings were accurate upon admission and for requesting an updated PASRR Level 1 screening when a resident received a new mental illness diagnosis. The ADM stated the MDS nurse was not available for interview as she was currently on leave. The ADM stated he was not aware Resident #10 did not have an accurate PASRR Level 1 screening, reflecting a mental illness diagnosis. The ADM stated the facility's MDS nurse was new and was not working at the facility at the time of the PASRR screening for Resident #10. The ADM stated Resident #10 did have an active diagnosis of Major Depressive Disorder, and this should have been indicated as a mental illness diagnosis on Resident #10's PASRR. The ADM stated he did not know why it was not accurate, and he stated he would follow up as soon as possible. The ADM stated PASRR screenings were reviewed during the admission process and should have been updated if any changes arose. The ADM stated it was his expectation for all residents' PASRR Level 1 screenings to be accurate and updated. The ADM stated he and facility staff have received training on PASRR. The ADM stated if a resident's PASRR Level 1 screening was not accurate, the resident may have had a delay in receiving services for which they may have qualified for. During an interview on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/15/2026 at 1:00 PM the DON stated the MDS nurse was usually responsible for PASRR screenings and ensuring they were completed and accurate. The DON stated the MDS nurse was on leave and was unavailable for interview. The DON stated Resident 10 did have a diagnosis of Major Depressive Disorder. The DON stated he was not aware if a diagnosis of Major Depressive Disorder would classify as a mental illness and stated he would follow up. The DON stated when a resident was admitted to the facility with a diagnosis of a mental illness, or if the resident received a new diagnosis of a mental illness, it was his expectation that a new PASRR Level 1 screening was requested for the resident. The DON stated he did not know why this was not completed for Resident #10, and he stated he would follow up as soon as possible. The DON stated staff received training on PASRR upon hire. The DON stated if a resident did not have an accurate PASRR Level 1, it could affect the resident receiving services from which they may benefit. During an interview on 05/15/2026 at 1:30 PM the Regional MDS coordinator stated she verified that Resident #10's current PASRR Level 1 screening was not accurate as it did not reflect the resident's diagnosis of a mental illness. The Regional MDS Coordinator stated the resident had an active diagnosis of Major Depressive Disorder, and she stated this should have been reflected as a mental illness on Resident #10's PASRR Level 1 screening. The Regional MDS Coordinator stated she did not know why the PASRR Level 1 screening was not accurate. The Regional MDS Coordinator stated Resident #10's PASRR was since updated on 05/15/2026 to reflect the [NAME] illness diagnosis, and she stated the facility would follow up to ensure the resident was assessed for the PASRR Level 2 Evaluation. Record review of the facility's policy titled, PASRR, dated 1/20/2026 revealed the following: Purpose:The aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID), or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD.Procedure:2. When it is determined that a PL1 was filled out incorrectly, the MOS Coordinator, Social Worker or designee will reach out to the hospital/responsible case worker and ask them to correct the form.a. If the referring case worker is unwilling/unable to correct the PL1 that contains a potential error, the social worker or designee will complete and submit a form 1012 (MI) or new PL1 (ID/DD). A subsequent positive PL1 will be entered according to 1012 findings (MI).3. When it is determined that an individual's diagnosis was changed and/or a state surveyor determines the PL1 was incorrect, the social worker or designee will complete and submit a form 1012 (MI) or new PL1 (ID/DD). A subsequent positive PL1 will be entered according to 1012 findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 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 observations, interviews 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 2 of 24 residents (Resident #12 and Resident #39) reviewed for care plans. The facility failed to develop an accurate, consistent, and completed care plan for Resident #12, specific to Resident #12's dietary needs ordered by the physician.The facility failed to develop an accurate, consistent, and completed care plan for Resident #39, specific to Resident #39's PASRR needs and services. This failure could place residents at risk of not receiving the care required to meet their individualized needs. Findings include: Resident #12Record review of Resident #12's face sheet, dated 05/15/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included unspecified Dementia, unspecified severity, with other behavioral disturbances (a decline in cognitive abilities that affects a person's daily functioning), Type 2 Diabetes (when the body doesn't use insulin well and can't keep blood sugar at normal levels),unspecified protein-calorie malnutrition (when the body does not get enough protein and calories to stay healthy and function properly), and vitamin deficiency. Record review of Resident #12's admission MDS assessment, dated 01/29/2026, revealed in Section C - Cognitive Patterns, Resident #12 had a BIMS score of 07, which indicated moderate cognition impairment. The MDS assessment indicated under Section GG - Functional Abilities, Resident #12 was independent in eating. Additionally, under Section I - Active Diagnoses, Resident #12 showed to have active diagnoses of Diabetes, Dementia, Malnutrition, and vitamin deficiency. The MDS assessment, under Section K - Swallowing/Nutritional Status did not indicate any diet restrictions or specifications. Section K also indicated Resident #12 had no weight loss. Record review of the current care plan for Resident #12, undated, revealed the following Focus areas: I have a Dx. of Diabetes Mellitus. Date Initiated: 01/26/2026, with a Goal that stated, I will have no complications related to diabetes through the review date. The Interventions/Tasks included the following: Dietary consult for nutritional regimen and ongoing monitoring. Date Initiated: 01/26/2026 . Discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. Date Initiated: 01/26/2026 . I am receiving a Regular Diet with Thin liquids. Date Initiated: 02/03/2026, with a Goal that stated, I will maintain my weight Date Initiated: 02/03/2026. The Interventions/Tasks included: Monitor % of meals eaten. Date Initiated: 02/03/2026.Regular Diet as ordered. Date Initiated: 02/03/2026.Thin liquids as ordered. Date Initiated: 02/03/2026. The resident has a potential nutritional problem r/t disease process, medications. He is on a regular diet. Date Initiated: 04/29/2026, with a Goal that stated, The resident will not develop complications related to malnutrition, including skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date. Date Initiated: 04/29/2026. The interventions/Tasks included the following: Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. Date Initiated: 04/29/2026. Monitor/record/report to MD (medical director) PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date Initiated: 04/29/2026.Provide and serve diet as ordered. Date Initiated: 04/29/2026. RD to evaluate and make diet change recommendations PRN. Date Initiated: 04/29/2026. Record review of Resident #12's active physician's order, dated 05/15/2026, revealed an order that stated the following: Large Portions diet Regular texture, Regular consistency, Double Portions. Order start date: 02/04/2026. Record review of Resident #12's Vitals/Weights Report, dated 05/15/2026, revealed the following (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weights for the resident:5/13/2026 - 158.0 lbs. 4/29/2026 - 150.0 lbs.4/13/2026 - 150.0 lbs. 4/06/2026 - 150.0 lbs.02/02/2026 - 132 lbs. Record review of Resident #12's lunch meal ticket, dated 05/14/2026, indicated Resident #12 received a Regular diet with Double Portions. Resident #39Record review of Resident #39's face sheet, dated 05/15/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included hypertensive emergency (severe increase in blood pressure that leads to acute damage to target organs), schizophrenia (serious mental health condition that affects how people think, feel, and behave, resulting in symptoms such as hallucinations, delusions, and disorganized thinking), and schizoaffective disorder, bipolar type (mental health condition that combines symptoms of schizophrenia with episodes of mania or depression). Record review of Resident #39's annual MDS assessment, dated 07/10/2025, revealed in Section C - Cognitive Patterns, Resident #39 had a BIMS score of 10, which indicated moderate cognition impairment. Additionally, under Section I - Active Diagnoses, Resident #39 showed to have active diagnoses of anxiety disorder, schizophrenia, and schizoaffective disorder, bipolar type. Record review of Resident #39's active physician's order, dated 05/15/2026, revealed active diagnoses of the following: schizophrenia and schizoaffective disorder, bipolar type. Record review of Resident #39's PASRR Level 1 Screening dated 03/16/2023 revealed the following: under section C (PASRR Screening), C0090 Primary Diagnosis of Dementia: NO, under section C (PASRR Screening), C0100 Mental Illness: YES. Record review of Resident #39's PASRR Level 2 Evaluation Screening dated 0 3/16/2023 indicated Resident #39 was not interested in being enrolled in a community based program. Record review of the current care plan for Resident #39, undated, revealed the following active diagnoses: schizophrenia, and schizoaffective disorder, bipolar type. There were no Focus areas found addressing Resident #39's PASRR level 1 screening or PASRR level 2 evaluation. During an interview on 05/13/2026 at 11:00 AM Resident #12 stated he received a regular diet, and he asked for more food sometimes at meals due to being hungry. Resident #12 stated he did not feel he had enough on his plate some meals. Resident #12 stated he was able to get a second portion of food when he asked, so he never felt hungry after he finished his meals. Resident #12 stated he had weight loss prior to coming to the facility, but he did not think he had lost any weight recently. Resident #12 did not know what his diet order was. During an observation and interview on 05/13/2026 at 1:00 PM Resident #12 was observed to receive double portions during his lunch meal. Resident #12 was observed to receive double portion of chicken, rice, squash and red peppers and a dinner roll. Resident #12 stated he was full and had plenty to eat. During an observation and interview on 05/14/2026 at 12:20 PM Resident #12 was observed to receive double portions during his lunch meal. Resident #12 was observed to receive double portions of pork chops, brussels sprouts, red beans, and cornbread. Resident #12 stated he also requested a salad because he was still hungry. Dietary staff were observed requesting a salad for Resident #12. During an interview on 05/15/2026 at 12:30 PM, the ADM stated the MDS nurse was responsible for ensuring care plans were updated when a resident's physician's orders were changed or updated reflecting a new diet order. The ADM stated Resident #12's active physician order reflected double portions at meals. The ADM stated this should have been reflected on Resident #12's care plan as well. The ADM stated when Resident #12's physician ordered a dietary change, the care plan should have been updated as soon as possible. The ADM stated care plan reviews were completed as changes occurred, and during quarterly reviews. The ADM stated he was not aware Resident #12's care plan did not reflect double portions. The ADM stated he did not know why the care plan was not updated to reflect double portions. The ADM stated he was not aware Resident #39's care plan did not reflect the PASRR level1 screening or PASRR level 2 evaluation. The ADM stated if Resident #39 had a positive PASRR Level 1 screening indicating a mental illness, this should have been reflected on the care plan. The ADM stated he did not know why the care plan did not reflect this. The ADM stated the MDS nurse was new and on leave, and she was not available for interview. The ADM stated nursing staff received training on care plans upon hire and received regular in-service trainings. The ADM stated it was his (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation that care plans were updated as soon as any changes or updates were received. The ADM stated Resident #12 did not have any recent weight loss, and the he believed the diet order was due to the resident's preference. The ADM stated if care plans were not accurate, it could affect a resident receiving their preference in care. During an interview on 05/15/2026 at 1:00 PM, the DON stated the MDS nurse was responsible for ensuring care plans were updated with any changes to dietary orders. The DON stated he was not aware Resident #12's care plan did not reflect his physician order for double portions. The DON stated the care plan should have reflected the resident's physician order. The DON stated all staff received training on care plans, upon hire. The DON stated care plans were reviewed regularly when changes occurred and during quarterly reviews. The DON stated Resident #12 did not have any recent weight loss. The DON stated he believed the resident's diet order for double portions was due to the resident stating he was still hungry and requesting additional food at meals. The DON stated he did not know why the care plan was not updated. The DON stated Resident #39's care plan should have reflected the positive PASRR level 1 screening and the PASRR level 2 evaluation. The DON did not know why Resident #39's care plan did not reflect the PASRR. The DON stated the MDS nurse was new and was not working at the time Resident #12's new diet order was received. The DON stated the MDS nurse was not currently available for interview as she was on leave. The DON stated it was his expectation that care plans were updated and accurate. The DON stated if a care plan was not updated or accurate, a resident's preference may not be honored and the resident may not be happy. Record review of the facility's, updated 12/2024, policy titled, Care Planning- Interdisciplinary. Team reflected the following: Policy Statement:The interdisciplinary team is responsible for the development of resident care plans.Policy Interpretation and Implementation:l. Resident care plans are developed according to the timeframes and criteria established by S483.21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 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 ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on the comprehensive assessment of residents for 1 (Resident #11) of 22 residents reviewed for weight assessment. The facility failed to follow physician orders for weekly weights for Resident #11. This failure placed residents at risk of weight loss and overall decline in health.Record review of the admission record for Resident #11, dated 05/14/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: severe dementia with agitation (cognitive decline with emotional distress), depression (mood disorder that causes feelings of sadness and loss of interest in activities), schizoaffective disorder- bipolar type (a mental health condition with severe mood swings), and protein-calorie malnutrition (undernutrition caused by inadequate intake or absorption). Record review of Resident #11's Quarterly MDS Assessment, dated, 02/22/26, reflected Resident #11 had a BIMS score of 0, indicating she had severe cognitive impairment. Section K - Swallowing/Nutritional Status revealed Resident #11's weight was 120 pounds. Record review of #11's current Physician Orders dated 05/14/26 reflected the following: Weekly weights every Wednesday, with a start date of 01/21/26. Record review of Progress Note for Resident #11, dated 03/20/26, reflected Resident #11's BMI (a measure of body fat based on height and weight) was within normal limits, the resident was on a regular diet with regular texture, and the resident had been eating approximately 76-100% of meals. Weights were notated as follows: 3/18/2026 - 119.0 lbs2/23/2026 - 120.0 lbs1/21/2026 - 120.2 lbs1/19/2026 - 118.0 lbs Record review of Resident #11's Treatment Administration Records dated 1/1/2026 - 5/13/2026 reflected missing weekly weight assessments for the following dates: 1/28/20262/11/20263/11/20263/25/20264/08/20264/22/2026 Observation and interview during the initial tour on 05/13/2026 at 11:02 AM, Resident #11 was seated in the dining area of the secured unit. Resident #11 was dressed and well-groomed and did not appear underweight or emaciated. During an observation of the noon meal, Resident #11 was observed to be assisted by a facility staff member to eat her lunch and had consumed approximately 75% of the meal. Resident #11 did not respond coherently when spoken to. During an interview on 05/15/2026 at 12:35 PM, the DON stated he was not aware that weekly weights had not been obtained for Resident #11 on 1/28/2026, 2/11/2026, 3/11/2026, 3/25/2026, 4/08/2026 and 4/22/2026, according to the physician's order. The DON stated Resident #11's weight had been stable, and weekly weights had been implemented, along with other interventions to avoid weight changes for the resident. He stated nursing administration was responsible to assure that physician's orders were being followed. He stated the facility had recently implemented a new procedure for resident weight assessments and the ADON was assigned to monitor weight assessments for accuracy and completion. He stated prior to the new procedure, various CNA's were requested to obtain resident weight assessments throughout the month. The DON stated a designated CNA was now assigned to obtain all weights on residents, with the assistance of the ADON. He stated his expectation of staff was to follow all physician's orders as written. The DON stated a potential negative outcome for failure to follow physician's orders was a potential delay in resident care. During an interview on 05/15/2026 at 1:50 PM, the ADON stated she had been assigned the task of monitoring resident weights, assuring weights were obtained accurately, and inputting resident weights into the electronic health record, beginning 05/01/2026. She stated she was unaware that Resident #11's weekly weights had been occasionally missed during the timeframe prior to being assigned to monitor resident weights. She stated Resident #11 had significant cognitive impairment and would refuse to be weighed two out of three times when staff would attempt to weigh her. The ADON stated she was responsible for assuring the designated CNA obtained weights accurately and timely. She stated she was responsible (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for recording the resident's weights in the electronic health record and informing the DON of any significant weight changes. The ADON stated a potential negative outcome for failure to follow physician's orders was a resident could have a decline in health. During an interview on 05/15/2026 at 2:06 PM, the ADM stated he was not aware the physician's order for weekly weights had not been followed for Resident #11. He stated the DON was responsible to assure all physician's orders were being followed at all times. He stated his expectation of staff was to follow physician's orders with accuracy and timely completion. The ADM stated a potential negative outcome for failure to follow physician's orders was missed frequency on an order for a resident's care. Record review of the facility-provided policy titled, Physician Orders, revised February 2025, revealed: PurposeThe purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services.Supervision by a Physician.5. Physician orders are essential for the comprehensive care of the residents . Record review of the facility-provided policy titled, Weight Assessment and Intervention, revised 05/12/25, revealed: PolicyResident weights are monitored for undesirable or unintended weight loss or gain.Policy Interpretation and Implementation.2. Weights are recorded in the resident's electronic health record .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 22 residents (Resident #6) reviewed for infection control. 1. The facility failed to store oxygen nasal cannula off the floor.2. CNA E failed to replace nasal cannula after finding it on the floor. These failures could place residents at risk for cross contamination and infection.Findings included: Record review of Resident #6's face sheet dated 05/15/2026 revealed an [AGE] year-old-female admitted on [DATE] with the following diagnoses: dementia (memory loss), chronic obstructive pulmonary disease (lung disease that makes it hard to breathe), depression (illness that involves the body, mood and thoughts) atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). Record review of Resident #6's comprehensive MDS dated [DATE] revealed Resident #6 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS further revealed Resident #6 received oxygen therapy. Record review of Resident #6 care plan dated 03/10/2026 revealed a focus area Resident #6 was at risk for respiratory infections/distress related to diagnosis of chronic obstructive pulmonary disease with interventions to administer oxygen as ordered. Record review of Resident #6 physician orders dated 05/15/2026 revealed an order for oxygen at 2-3 liters via nasal cannula to keep oxygen saturations over 90 percent as needed for shortness of breath dated 03/18/2026. During an observation on 05/14/2026 at 03:15 p.m. observed Resident #6's nasal cannula laying on the floor beside the bed. During an interview on 05/14/2026 at 03:20 p.m., LVN C stated resident oxygen tubing should be stored in bag on oxygen concentrator while not in use. During an observation on 05/15/2026 at 10:57 a.m. observed Resident #6's nasal cannula laying on the floor beside the bed. During an interview on 05/15/2026 at 12:35 p.m., CNA E stated oxygen nasal cannula should be stored in the bag on her oxygen concentrator. She stated she was not aware the tube was on the floor until she went into Resident #6 room to assist her with noon meal. She stated she picked the oxygen nasal cannula up and placed it back on the resident. She stated she did clean the tubing with an incontinent wipe before placing it on resident nose. She stated the incontinent wipes did not have any type of disinfectant. She stated the incontinent wipes were skin use. She stated she had been trained in oxygen tubing storage. She stated she should have replaced the nasal cannula. She stated the potential negative outcome could be infection and cross contamination. During an interview on 05/15/2026 at 12:48 p.m., LVN D stated oxygen nasal cannula was to be stored in the bag on the oxygen concentrator. She stated if the oxygen nasal cannula was found on the floor it should be replaced. She stated that incontinent wipes do not have disinfectants, they were used to clean skin. Stated she had been trained on oxygen storage and use. She stated the potential negative outcome could be infection control.During an interview on 05/15/2026 at 02:00 pm, the DON stated the oxygen nasal cannula should be stored in the bag on the oxygen concentrator when not in use. He stated if found on the floor, staff should replace it. He stated all staff had been trained on oxygen cannula storage and use. He stated if the CNA finds the oxygen nasal cannula on the floor, they should notify the charge nurse to change it out. He stated the purpose of the oxygen nasal cannula was to deliver supplemental oxygen. He stated the LVN was responsible for oxygen monitoring and use. He stated the potential negative outcome could be a lapse in oxygen administration and infection control. He stated incontinent wipes were not a disinfectant wipe.During an interview on 05/15/2026 at 02:25 p.m., the ADM stated the purpose of an oxygen nasal cannula was to provide oxygen to residents from an oxygen concentrator. He stated the oxygen nasal cannula should be stored in a bag on the oxygen concentrator. He stated if found on floor the oxygen nasal cannula should be replaced. He stated cleaning oxygen nasal cannula with an incontinent wipe does not disinfect it. He stated all staff had been trained in oxygen use and storage. He stated the DON was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for monitoring residents on oxygen. He stated the potential negative outcome could be cross contamination and infection control.Record review of the facility policy titled, Infection Prevention and Control Program, with dated March 2022 reflected the following: Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Policy Interpretation and Implementation.11. Prevention of Infectiona. Important facets of infection prevention include:(1) identifying possible infections or potential complications of existing infections;(2) instituting measures to avoid complications or dissemination; .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER Avir at Lubbock		STREET ADDRESS, CITY, STATE, ZIP CODE 4710 Slide Rd Lubbock, TX 79414	

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 all drugs and biologicals were stored properly for 2 of 2 medication carts (Station 1 medication cart and Station 2 medication cart), reviewed for medication storage. 1. The medication cart assigned to Station 1 contained two loose pills.2. The medication cart assigned to Station 2 contained four loose pills. This failure could place residents at risk of not receiving prescribed medications as ordered and place the facility at risk of drug diversions.1. On 05/14/26 at 11:03 AM an observation of the medication cart for Station 1 was conducted with MA A. Two loose pills were found in drawer of the medication cart. MA A placed the pills in a dispensing cup and took them to the DON for identification. The DON identified the medication as Carbidopa-Levodopa 25-100 (1 tablet) and Zofran 4mg (1 tablet). MA A destroyed the loose pills by crushing them and placing them in the sharps container. During an interview on 05/14/26 at 11:10 AM, MA A stated the medication cart should not contain loose pills. She stated she was responsible for the cart when she came on duty and stated, Once I get the keys, it's mine. She stated she usually checked the cart at the beginning of the shift for loose or expired medications and cleaned the cart prior to medication pass. MA A stated she had been trained through in-services on proper medication storage, and her cart was randomly spot checked for loose or expired medication by the DON and audited monthly by the pharmacy consultant. She stated a potential negative outcome for loose pills on the cart was not having enough medication and running out too soon for the pharmacy to refill the medication. 2. On 05/14/26 at 11:16 AM an observation of the medication cart for Station 2 was conducted with MA B. Four loose pills were found in the drawers of the medication cart. MA B placed the pills in a dispensing cup and took them to the DON for identification. The DON identified the medication as Allopurinol 100 mg (1 tablet), Metoprolol 25mg (1 tablet), Lasix 20 mg (1 tablet), and Amlodipine 5 mg (1 tablet). MA B destroyed the loose pills by crushing them and placing them in the sharps container. During an interview on 05/14/26 at 11:22 AM, MA B stated the medication cart should not contain loose pills. She stated she was responsible for the medication cart during her shift, and she usually checked the cart for cleanliness and loose medications at the beginning of each shift. MA B stated she had been trained on proper storage of medications on the cart and random spot checks of the cart were conducted by nursing administration. She stated the carts were also audited by the pharmacy consultant, but she did not recall how often the audits occurred. MA B stated a potential negative outcome for loose pills on the cart was that a resident could miss a dose of medication. During an interview on 05/15/26 at 12:35 PM, the DON stated he was not aware there were loose medications on the carts. He stated medications should be stored securely at all times. The DON stated medication aides and nurses were responsible for the proper storage of medication on the carts. He stated staff were in-serviced on proper medication storage by nursing administration and random cart checks were conducted by himself and the ADON. The DON stated the pharmacy consultant also conducted cart audits monthly. He stated a potential negative outcome for loose medications on the cart would be running out of a resident's medication, which could cause a resident to miss a medication. During an interview on 05/15/26 at 2:06 PM, the ADM stated he was not aware there were loose medications on the carts. He stated it was the responsibility of the charge nurse and medication aide to assure medications were properly stored on the medication carts. The ADM stated proper storage of medications on the carts was monitored through periodic cart audits conducted by nursing administration and the pharmacy consultant. He stated his expectation of staff for proper medication storage was to follow policy for securing medications and keep the carts in compliance by not having loose medications. The ADM stated a potential negative outcome for loose medications on the cart was inventory control issues. Record review of the facility-provided policy titled, Medication Labeling and Storage; revised February 2023 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455940	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Lubbock	4710 Slide Rd Lubbock, TX 79414

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	revealed:Policy Interpretation and ImplementationMedication Storage1. Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received.2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.