

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Avir at Heritage Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 University Ave Lubbock, TX 79413	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 6 residents (Resident #1) reviewed for respect and dignity. CNA C failed to provide privacy to Resident #1 when CNA C left Resident #1 naked in bed with the door open on 3/15/2026. This failure could place residents at risk of emotional distress, embarrassment, and lower self-esteem. Findings include: Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old male, originally admitted to the facility on [DATE]. Resident #1 had a medical history of chronic kidney disease, malignant neoplasm of the spinal cord (a cancerous tumor arising within or spreading to the spine), and paraplegia (impairment of motor and sensory function in the lower half of the body). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 15, which indicated Resident #1 was cognitively intact. Section GG- Functional abilities revealed Resident #1 was dependent on toileting hygiene requiring 2 or more helpers, and substantial assistance required for showers. Record review of Resident #1's care plan dated 3/20/2026 revealed [Resident #1] have impaired functional abilities r/t DX of Paraplegia. [Resident #1] require assistance with ADLs. Required assistance may vary. Some days/times may require more assistance than other. Usual performance Toileting Hygiene: Dependent Usual performance Personal Hygiene: Partial/moderate assistance Staff assistance: [times]1-2. Resident #3 (Resident #1's roommate) Record review of Resident #3's face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #3 had a medical history of gastroenteritis and colitis (colon inflammation), hypertension (high blood pressure) and paraplegia (impairment of motor and sensory function in the lower half of the body). Record review of Resident #3's quarterly MDS dated [DATE] revealed a BIMS score of 15, which indicated Resident #1 was cognitively intact. During an interview on 4/01/2026 at 10:45AM, Resident #3 stated he did remember the incident between Resident #1 and CNA C. He stated he was not sure what CNA C said but she had told him she couldn't give him a shower because she was doing rounds. He stated he did not know what time it was, but she did get him undressed in bed and then left. He stated Resident #1 was in bed naked and the door was left open. He stated he did not recall her yelling at Resident #1, only that she would do his shower later. He stated Resident #1 was saying stuff to her and CNA C walked out. Resident #3 stated he believed it was about 30 minutes before another nurse came to finish Resident #1's care. During an interview on 4/01/2026 at 10:58AM, Resident #1 stated that night he had gotten back to the facility late at approximately 11:30PM or 12:00AM on 3/14-3/15. He stated he had requested his bath but fell asleep after CNA C put him in bed. He stated when he woke up a few hours later at approximately 4:00AM he used his call light and CNA C came into his room. He stated he requested his shower from CNA C and she told him she was unable to do so at that time since she was in the middle of rounds. Resident #1 stated he was a little mouthy with CNA C and she took off his clothes and told him someone else would come into the room to give him his shower. He stated he had requested a shower because he did not want to wait until Tuesday for his next shower. He stated he was laying in bed for approximately 20 minutes until he called LVN D, a nurse from a different unit, and she showered him and got him cleaned up. He stated he did not usually have issues getting his showers, (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>but he was not sure if something else was going on. He stated he did not feel embarrassed or humiliated but did not feel CNA C should have left him in bed naked. He stated he did not remember if the door was open or not. He stated this was the first time something like this had happened. He stated LVN D reported the incident to the DON, and it was immediately addressed. He stated he was happy with how quick the DON addressed it and was happy with the facility removing CNA C from his hall. He stated he was not sure if CNA C was still employed but he had not seen her. During an interview on 4/1/2026 at 1:45PM with CNA C, she stated she had been waiting for Resident #1 to get back from his pass to give him his shower. She stated when he requested his shower, at approximately 12:45AM she was in the middle of rounds and explained to Resident #1 she would lay him down and would come back to give him his shower. She stated Resident #1 stated I just want my fucking shower and she got him into bed. She stated he was cussing at her and saying, this is some bullshit. She stated she was attempting to complete Resident #1's incontinence care but Resident #1 had stopped cooperating with her and refused to turn for her and she was unable to complete his brief change at that time. She stated she told Resident #1 You know what, I am going to step out and someone else will come finish. CNA C stated she notified her charge nurse (LVN E) and did not return to the room the rest of the night because she did not want to make him more agitated. CNA C stated she had taken his bottoms off, and he was still wearing a shirt, and had half a brief on because he did not assist her in turning and she did not complete the care. She stated she was not sure if she did or did not leave the door open. She stated she did not cover him with a sheet before she left the room because he was cussing at her saying fuck this, fuck this bullshit. She stated she was not sure when someone else went in there or if his care was completed because she did not follow up. She stated a CNA from a different hall took over his room and they checked on him the rest of the night. She stated she felt she did the right thing by leaving because being in the room would make him more agitated. She stated she did not believe how she left Resident #1 in bed was a dignity concern. She stated she had been trained on de-escalation, and she did the right thing by stepping out and letting someone else step in. She stated she was suspended following the incident and had remained on suspension since then. She stated the incident occurred between 12:45AM- 1:15AM on 3/15/2026. During an interview on 4/1/2026 at 4:47PM with LVN D, she stated she received a call on the facility phone from Resident #1 on 3/15/2026 at approximately 3-4AM. She stated Resident #1 asked I know you're not my nurse, but can you come help me?. She stated she walked down to his room and the door was wide open, he was completely naked on the bed and the privacy curtain was not pulled between Resident #1 and Resident #3. She stated he had a bowel movement on his brief and dirty wipes on the bed. She stated she asked Resident #1 what happened and he explained CNA C had left him like that. She stated Resident #1 told her that CNA C had screamed at him and he had screamed back at her. She stated she got Resident #1 showered and cleaned up and went straight to the DON to report the incident. She stated she was not sure how long he had been left in bed like that, but it had not been long because Resident #1 mentioned CNA C had just laid him down. LVN D stated she was very irritated with the way Resident #1 was left and CNA C had not treated Resident #1 with respect or dignity. She stated CNA C should have at least provided privacy before leaving the room, if she felt she needed someone else to intervene, but she should not have left him exposed in that manner. She stated Resident #1 was calm with her and he did not appear to have any long-lasting changes to his behavior or emotional distress. She stated she felt Resident #1 was a little quieter for a few days following the incident, but he was back to himself. LVN D stated she attempted to speak to CNA C regarding the incident and CNA C told LVN D that Resident #1 was yelling at her and she (CNA C) was not going to take that, and walked away from LVN D. During an interview on 4/1/2026 at 5:32pm with LVN E, she stated she had not heard the interaction between CNA C and Resident #1 or if CNA C had yelled or not yelled at Resident #1. She stated CNA C had reported to her that Resident #1 had been cursing at her and she had stepped out to let him calm down. She stated CNA C never mentioned Resident #1 still required care or that he had been left in bed naked with no privacy curtain. LVN E (continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated she did not remember what time it was, but it was well past midnight when CNA C told her about Resident #1. She stated they had been trained to grab a second person or call for help if there is a resident who is yelling at them. She stated they had not been trained to leave the room if a resident is cussing at them, only to call for help. She stated after she learned of Resident #1's being left in bed naked with the door open, she agreed that it could be a violation of his dignity. During an interview on 4/2/2026 at 11:18 with the ADM, she stated she was the abuse coordinator. She stated she had not been the ADM at the time of the incident, but she had been made aware of the incident. She stated she expected staff to do all they can when they have to delay care to a resident by explaining what the plan would be and if the Resident was not cooperating, or if they refused care, she expected them to notify their charge nurse and the administrative team. She stated before staff leave any resident room, the resident should be in a dignified position, not exposed and they should be safe. She stated she would have expected CNA C to cover up Resident #1 and explained to Resident #1 that she would be going to get assistance. She stated CNA C should not have left him naked and exposed. She stated Resident #1 had not expressed any further concerns over the incident and he had been back to baseline. She stated the potential negative outcome of not treating residents with dignity and respect would be emotional distress, refusing care, or embarrassment. She stated they would be conducting rounds throughout the facility and ensuring all residents are being treated with respect and dignity, and if there are concerns, they would be addressing them at that time. During an interview on 4/2/2026 at 12:05pm with the DON, she stated training on resident rights was done with competencies, upon hire, and as needed. She stated her expectation of staff when any resident is being verbally aggressive is to excuse themselves but only if the resident is safe and needs are met. She stated staff are taught to treat residents how they would want to be treated. She stated she would have expected CNA C to use the call light and asked for assistance. She stated if CNA C had to step out, she should have provided privacy and dignity by covering Resident #1 with a blanket, close the privacy curtains and the doors before leaving the room. She stated CNA C should have been clear with LVN E and requested another aid to finish the care. The DON stated a potential negative outcome of not treating residents with respect and dignity could be emotional distress from being in an undignified manner. She stated the facility monitors compliance with respect and dignity by doing observation rounds, in-services, and re-enforcement of resident's rights. Record Review of facility policy titled Resident Rights last revised 2/2021, revealed; Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; be treated with respect, kindness, and dignity. privacy and confidentiality;. perform services for the facility if he or she chooses or refuse to perform services for the facility.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were free from abuse and/or neglect for 1 of 6 residents (Resident #1) reviewed for abuse and/or neglect.MM A told Resident #1 to get the fuck out of my face on 3/20/2026.This failure could cause residents emotional distress, a decrease in their health conditions, or exacerbation of their health conditions.Findings include:Resident #1Record review of Resident #1's face sheet revealed a [AGE] year-old male, originally admitted to the facility on [DATE]. Resident #1 had a medical history of chronic kidney disease, malignant neoplasm of the spinal cord (a cancerous tumor arising within or spreading to the spine), and paraplegia (impairment of motor and sensory function in the lower half of the body).Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 15, which indicated Resident #1 was cognitively intact.Resident #2Record review of Resident #2's face sheet revealed a [AGE] year-old male, originally admitted to the facility on [DATE]. Resident #2 had a medical history of cerebral infarct (stroke caused by a blockage in brain blood), hemiplegia (a severe or total paralysis affecting one side of the body caused by brain damage), and epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures).Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15, which indicated Resident #2 was cognitively intact.During an interview on 4/01/2026 at 10:58AM, Resident #1 stated he did not know what had happened between him and MM A on 3/20/2026. He stated they had always gotten along and there was not much to say about the situation because nothing had happened and he had not heard anything. He stated the DON had spoken to him about the incident, but he did not have any information because nothing had happened. He stated he only felt bad that MM A had been fired but that he had no other feeling towards the situation because he never heard MM A say anything to him. Resident #1 did not provide further details in regard to the incident.During an interview on 4/1/2026 at 1:37pm with MM A, he stated he had recently changed the codes to the exterior doors, and he had gone outside to smoke. He stated Resident #1 came over to him and had been antagonizing him about giving him the code to the door. He stated he explained to Resident #1 that he could not give him the code because he had to follow facility policy and not give the code out. He stated he attempted to defuse the situation a few times but Resident #1 kept egging on (means strongly encouraging, urging, or [NAME] someone to do something). He stated Resident #1 was stating he would tell others he got the door code from him (MM A) and it had upset him. He stated Resident #1 wasn't close to his face, but he stated, get the fuck out of my face. He stated he was frustrated and should have just walked away but he had become irritated at the situation. He stated he apologized to Resident #1. He stated Resident #1 was laughing with Resident #2 and did not appear upset. He stated he immediately reported himself to the DON. He stated Resident #1 and him do joke around at times, but he believed he had been having a bad day. He stated he was not sure if Resident #1 did or did not hear him because he did not say it loudly or in anger, but he was aware he said it and that is why he reported himself. He stated he had been trained on abuse and neglect, and his abuse coordinator was the ADM. He stated he did not feel that what he said was verbal abuse, but by definition it was and he followed his training. He stated he was immediately suspended and then fired.During an interview on 4/1/2026 at 3:00 pm with Resident #2, he stated he had heard MM A and Resident #1 bickering (argue about petty and trivial matters) back and forth. He stated he heard Resident #1 tell MM A that we would tell others that MM A gave him the code to the doors. He stated he then heard MM A tell Resident #1 get out of my face. He stated MM A did not cuss or yell just said, get out of my face. He stated Resident #1 was laughing and MM A walked away. He stated Resident #1 looked at him (Resident #2) and asked, what's his problem?. He stated himself (Resident #2) and Resident #1 were not upset and did not feel bad. He stated he did not believe MM A should have said it but that he did not hear him say fuck. During an interview on (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/1/2026 at 3:13pm with MM B, he stated he had been outside with MM A, Resident #1 and Resident #2 on 3/20/2026. He stated MM A and himself (MM B) had finished changing the door codes and Resident #1 approached MM A. He stated Resident #1 told MM A he already knew the code to the doors and would tell other people that MM A gave him the code. He stated MM A told Resident #1 no one will believe you but Resident #1 kept antagonizing MM A. He stated MM A got up and told Resident #1 Get the fuck out of my face and walked away. He stated Resident #1 did not appear upset and asked, what is wrong with him?. He stated he heard Resident #1 say he was just playing. MM B stated he had been trained on ANE, and his abuse coordinator was the ADM. He stated he felt that MM A's actions were verbal abuse. During an interview on 4/2/2026 at 11:18AM with the ADM, she stated she was the abuse coordinator. She stated she expects her staff to report ANE immediately. She stated if a resident is being intentionally verbally agitated toward staff, she expects the staff to walk away as long as the resident is safe and their needs are met. She stated when she spoke to MM A, she had expressed he should have just walked away and not replied to Resident #1's comments. She stated Resident #1 was not being mean, but he does like to push buttons (to deliberately annoy, irritate, or provoke a strong emotional reaction from someone). She stated MM A had been suspended and ultimately terminated following the incident. She stated a potential negative outcome of verbal abuse could be emotional distress and infringing on resident's rights. Record review of facility document titled Record of employee counseling dated 3/23/2026 revealed; Employee name [MM A]. Detail of situations: Directed inappropriate and unprofessional language toward a resident by telling the resident get the fuck out of my face .Expectations/Outcome: Your actions are inconsistent with the expectation and policies outlined in the employee handbook and code of conduct, immediate termination is the result. Record review of facility policy titled Identifying Types of Abuse last revised September 2022 revealed, As part of the abuse prevention strategy, volunteers, employees and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents. Abuse includes verbal abuse. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication or sounds to residents within hearing distance, regardless of age, ability to comprehend or disability.</p>		