

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Avir at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE  7441 Paseo Del Norte El Paso, TX 79911	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Avir at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE  7441 Paseo Del Norte El Paso, TX 79911	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility failed to maintain a system to prevent Resident #1's personal money from being taken by a staff member. Findings included:Record Review of the admission record dated 6/30/25, revealed an [AGE] year-old male with an original admission date of 11/27/24 and a readmission date of 12/18/24. Record Review of Resident # 1's admission MDS record dated 11/27/24 revealed a BIMS score of 2 reflecting severe cognitive impairment. MDS revealed Resident #1 had short-term memory problems and was moderately impaired to make decisions regarding tasks of daily life. It described the resident as lethargic (a state of extreme tiredness, sluggishness, and lack of energy or enthusiasm. It implies a noticeable decrease in physical and mental activity). MDS indicated Resident #2 had anxiety disorder and depression.Record Review of Resident # 1's Care Plan initiated on 11/29/24 revealed Resident #1 had a diagnosis of depression and at risk of fluctuating moods with little interest or pleasure in doing things with decreased socialization. The care plan called for interventions to encourage frequent socialization, to be an active participant in decision making and to voice feelings and thoughts. The care plan revealed Resident #1 had episodes of adverse behaviors such as being verbally aggressive evidenced by cursing, racial yelling and screaming and becoming physically aggressive by hitting staff, kicking, and throwing objects.Record Review of CNA C's bank account Deposits and other Additions from 11/20/24 to 12/19/24 revealed the following Mobile on-line banking deposits made by from Resident # 1's smart phone:*12/04/24 Mobile online bank payment of 3,500.00*12/05/24 Mobile online payment of 1,800.00*12/09/24 Mobile online payment of 1,480.00*12/13/24 Mobile online payment of 500.00*12/16/24 Mobile online payment of 500.00*12/18/24 Mobile online payment of 3,000.00The total amount deposited into CNA C's bank account from the Mobile-Online banking deposits was \$10,780.00 made by resident # 1.Record Review of CNA C's bank account Withdrawals and other subtractions dated 1/23/25 revealed the following transactions were done by Resident # 1's bank account:*01/23/25 CLAIMS PROCESSING -3,500.00*01/23/25 CLAIMS PROCESSING -3,000.00*01/23/25 CLAIMS PROCESSING -1,800.00*01/23/25 CLAIMS PROCESSING -1,480.00*01/23/25 CLAIMS PROCESSING -1,200.00*01/23/25 CLAIMS PROCESSING -800.00*01/23/25 CLAIMS PROCESSING -500.00*01/23/25 CLAIMS PROCESSING -500.00Total amount withdrawn from CNA C's bank account. Total Amount: -12,780.00 Record Review on 7/1/25 at 9:33 AM of the SW progress notes dated 12/23/24 revealed she had a meeting with the DON informing her Resident # 1 had a change of condition and was very confused. Progress notes indicated the facility discussed the possibility of having the resident on palliative care (specialized medical care for people living with a serious illness). Progress notes revealed the SW called the family to discuss this possibility, and the family had agreed with the plan. SW informed DON and LVN D that family had agreed to place Resident # 1 under palliative care.Record Review on 7/1/25 at 11:33 AM of the medical progress notes dated 11/25/24 revealed Resident # 1 was an [AGE] year-old male who seemed slightly confused on that date but was alert to time, place and person.In an Interview on 6/26/25 at 3:38 PM with the Administrator, revealed, he was informed by his superiors that a Google review was posted in the facility's website by the resident's family, that stated that a nurse, name unknown, had stolen thirteen thousand dollars from the resident. The Administrator said the facility made several attempts to contact the family but were not successful, and the family did not return their calls. The Administrator said the investigation was concluded and was deemed unfunded since there was no way to gather information. He said that he had not conducted any investigation to determine if a staff member had taken money from the resident, because had had not been able to contact the resident's family member.Telephone interview on 6/30/25 at 11:36 AM with Resident #1's family member, stated Resident #1 had been admitted to the facility for about a month and they visited him frequently. The family member said Resident #1 was very confused and unable to carry meaningful conversations, remember passwords or easily operate his smartphone, so she had removed the passwords to allow him to use the phone without issues. The family member also stated that during one visit, she accessed Resident #1's Bank account app on his smartphone to monitor for activity and observed several transactions made from Resident #1's phone through the Mobile banking on-line application (a popular money transfer service that allows individuals to send and receive money directly between eligible U. S. bank accounts) to a recipient identified as CNA C. These transactions totaled almost thirteen thousand dollars. The family member reported that after noticing these transactions, she reported it to the police and was informed the financial crimes department would investigate the incident. The family member stated she</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Avir at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE  7441 Paseo Del Norte El Paso, TX 79911	

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 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Respond appropriately to all alleged violations.  (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Avir at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE  7441 Paseo Del Norte El Paso, TX 79911	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that incidents and investigations were complete and accurately documented for 2 of 6 (Resident #1 and #2) residents reviewed for accuracy and completeness of records. 1. The facility failed to have complete and accurate documentation and investigation for an allegation of misappropriation and exploitation for Resident # 1. 2. The facility failed to complete an incident report or accurately document progress notes, when Resident # 2 exited the facility. These deficient practices could put residents at risk of not receiving needed services such as monitoring or supervision, and incident investigations. Findings included: Resident # 1 Record Review of the admission record dated 6/30/25, revealed an [AGE] year-old male with an original admission date of 11/27/24 and a readmission date of 12/18/24. Record Review of the Initial Evaluation dated 11/27/24 revealed an [AGE] year-old male with a diagnosis of type two diabetes, coronary artery disease (a common and serious condition that affects the heart. It occurs when the coronary arteries, which are the blood vessels responsible for supplying oxygen-rich blood to the heart muscle, become narrowed or blocked), hypertension (a medical condition where the force of blood pushing against the walls of your arteries is consistently too high), and hypothyroidism (or underactive thyroid, is a medical condition where the thyroid gland does not produce enough thyroid hormones to meet the body's needs). Record Review of Resident # 1's initial MDS record dated 11/27/24 revealed a BIMS score of 2 reflecting severe cognitive impairment. MDS revealed Resident #1 had short-term memory problems and was moderately impaired to make decisions regarding tasks of daily life. It described the resident as lethargic (a state of extreme tiredness, sluggishness, and lack of energy or enthusiasm. It implies a noticeable decrease in physical and mental activity). MDS indicated Resident #1 had anxiety disorder and depression. Record Review of Resident # 1's Care Plan initiated on 11/29/24 revealed Resident #1 had a diagnosis of depression and at risk of fluctuating moods with little interest or pleasure in doing things with decreased socialization. The care plan called for interventions to encourage frequent socialization, to be an active participant in decision making, and to voice feelings and thoughts. The care plan revealed Resident #1 had episodes of adverse behaviors such as being verbally aggressive evidenced by cursing, racial yelling and screaming and becoming physically aggressive by hitting staff, kicking, and throwing objects. Record Review of the facility's grievances binder on 6/27/25 at 3:30 PM revealed there were no records of the facility investigation on the allegations of exploitation for Resident # 1. Record Review of Resident #1s EMR from 12/27/24 to 7/1/25, revealed there were no progress notes created to document the Exploitation allegation regarding Resident # 1. In an Interview on 6/26/25 at 3:24 PM with ADON A, she stated she did not know anything about this incident. ADON A said she had not discussed the possible misappropriation of the resident's funds with the Administrator or anyone in the facility. ADON A stated any suspicion of exploitation was expected to be thoroughly investigated by gathering information with staff, residents, and family members. ADON A said if she had been overseen the investigating of the incident, she would have documented attempts to contact the family members and would have conducted in-services to employees to make sure everyone knew how to report ANE if they suspected something. In an Interview on 6/26/25 at 3:38 PM with the Administrator, he explained the facility made several attempts to contact the family but were not successful, and the family did not return their calls. The Administrator admitted there were no records of the facility's attempts to contact the family. He stated the investigation was concluded and was deemed unfunded since there was no way to gather information from the family members. In an interview on 6/27/25 at 9:30 AM with the Ombudsman revealed he had no knowledge of the incident in which it was alleged that a staff member from the facility had stolen money from Resident # 1. He stated the facility had not provided information on this incident to him. In an interview on 6/30/25 at 10:06 AM with SW, revealed she remembered Resident # 1 being discharged from the facility in December 2024. SW said she had no knowledge of the incident in which it was reported that someone from the facility had stolen money from Resident # 1. SW stated that whenever there's an allegation of abuse, neglect or exploitation, it was expected for the facility to investigate and make the effort to contact family members and other residents and determine if they felt safe in the facility. SW explained that after an investigation of this nature, the facility gives training to staff to ensure they know how and when to report any suspicions of ANE. In an interview on 6/30/25 at 1:03 PM with LVN D, she stated she was the charge nurse of the hallway on which Resident # 1 resided while admitted in the facility. LVN D said she had no knowledge</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Avir at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE  7441 Paseo Del Norte El Paso, TX 79911	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Avir at El Paso		STREET ADDRESS, CITY, STATE, ZIP CODE  7441 Paseo Del Norte El Paso, TX 79911	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 (Resident #2) of 6 residents reviewed for accident prevention. The facility failed to provide supervision when Resident #2 exited the facility on 6/23/25 and propelled herself in her wheelchair down towards the sidewalk exiting the parking lot of the facility. This failure could place residents at risk of a fall, weather exposure, or being run over by a moving vehicle, which could result in injuries. Scope and Severity D Findings include: Record Review of Resident #2's admission record dated 6/26/25, revealed a [AGE] year-old female with an admission date of 4/22/25. Record Review of Resident #2's History and Physical dated 4/24/25 revealed diagnoses of atrial fibrillation (An irregular and often rapid heart rate that can lead to symptoms like palpitations, shortness of breath, and fatigue), hypothyroidism (A condition in which the thyroid gland doesn't produce enough crucial hormones. Symptoms can include fatigue, weight gain, constipation, dry skin, and increased sensitivity to cold), morbid obesity and falls with recent right humerus fracture (A break in the humerus bone, which is the long bone in the upper arm that extends from the shoulder to the elbow), impaired gait and mobility (deviation from a normal, healthy walking pattern), generalized weakness, sarcopenia (A progressive and generalized skeletal muscle disorder involving the accelerated loss of muscle mass and function). Record Review of the admission MDS dated [DATE] revealed a [AGE] year-old female with a diagnoses of anxiety disorder and depression. MDS revealed under section GG for Functional Abilities that Resident #2 had limited ROM on lower extremities and required a wheelchair for mobility. It revealed Resident #2 required substantial assistance with personal hygiene and upper body dressing, sitting to standing, transferring to toilet and from chair to bed and for walking ten feet on uneven surfaces. Functional Abilities revealed Resident # 2 was dependent on staff for toileting hygiene, showering, lower body dressing and putting on footwear. MDS revealed under section V for Care Area Assessment that Resident #2 triggered for cognitive loss, dementia, and falls. Record Review of Resident #2's Care Plan initiated on 4/23/25 revealed Resident #2 had care areas as follows: *episodes of anxiety and was at risk for fluctuations in mood related to a diagnosis of bipolar disorder (a mental health condition that causes extreme and unusual shifts in a person's mood, energy, activity levels, and concentration), episodes of adverse behaviors evidenced by being verbally aggressive, cursing and using racial slurs, yelling and screaming and being physically aggressive evidenced by hitting, pinching, kicking and throwing objects. *tendency for fabricating facts, manipulating staff, and displaying accusatory behavior towards staff. * at risk of complications due to refusing assistance with ADLS and refusing medications. *on psychotropic medications and was at frequent fall risk. In an Interview on 6/26/25 at 8:45 AM with the DON revealed she received a report from the admissions coordinator that a family member had called the receptionist from the facility stating Resident # 2 was down the street and was requesting assistance. DON stated the ADON, and other staff left the building to look for Resident # 2 and they were able to find her about a block away and after taking her to the store, staff returned to the facility along with Resident # 2. DON stated the incident should have been recorded at least in a progress note, but to her knowledge, there was nothing recorded about the incident. In an Interview on 6/26/25 at 8:50 AM with ADON A stated the family members were talking to an LVN at the nurse's station. She said that later at 1:46 PM, the Administrator sent a group text message to staff informing them that Resident #2 was away from the building exiting the parking lot and requesting their assistance to locate Resident # 2. ADON A said the Admissions Coordinator told her that the family had gone back to the facility to request assistance because Resident # 2 was refusing to get into her vehicle and was propelling herself in her wheelchair to the store. ADON A stated she and the Admissions Coordinator went looking for Resident #2 and found her at a business parking lot next to the facility. Resident # 2 was arguing with her family member and was shouting and refusing to get into the family's vehicle. ADON A said she stood with the resident for about ten minutes, trying to de-escalate and convince her to go back to the facility, but Resident # 2 declined and insisted on being taken to the store. In an Interview on 6/26/25 at 10:14 AM Resident # 2, revealed she remembered the incident that happened on 6/23/25. Resident # 2 said her family had gone to the facility to pick her up and take her to the store. She stated after having lunch, her family kept talking to a nurse and were taking too long to take her out and she became upset. Resident # 2 said she exited through the front door while a man (name unknown) opened the door, and she took off in her wheelchair to try to get to the store. Resident # 2 said one of her family members came running after her and</p>