STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676431	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at El Paso	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 (Residents #1) of 8 resident reviewed for accidents and supervision. The facility failed to ensure adequate supervision to prevent accidents for Resident #1 when, on 8/3/25, Receptionist A allowed him to leave the building without confirming with staff whether he could be outside independently or verifying if he was a visitor. Resident #1 made it across the border to another state and then to the port of entry to another country. Resident #1 required hospital treatment for dehydration. The noncompliance was identified as PNC. The IJ began on 8/3/25 and ended 8/4/25. The facility had corrected the noncompliance before the survey began. These failures placed residents at risk of injuries, hospitalization, and death.Findings included: Record review of Resident #1's face sheet dated 8/13/25 revealed a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #1's History and Physical dated 7/7/25 revealed diagnoses of Schizophrenia (a brain disorder that makes it hard to know what's real, sometimes causing people to hear voices or believe things that aren't true), Anxiety (a condition where a person feels overly worried or fearful, even when there's no real danger), Dementia/Alzheimer's (disease that slowly damages memory and thinking, making it hard to do daily activities), and Depression (long-lasting sadness that affects mood, energy, and interest in everyday life). Resident #1 admission MDS dated [DATE] revealed a BIMS score of 2, indicating his cognition was severely impaired, no wandering behavior was noted and was dependent on ADLs. Record review of Resident #1's elopement assessment dated [DATE] revealed he was not a risk. Record review of Resident #1's incident report dated 8/3/25 written by RN B revealed [Resident #1] was observed at breakfast time, having a meal in the morning in the dining room, around 9:30 am, med aid gave his medication. [Resident #1] is ambulatory, continent of bladder and bowel. When lunch time was coming around 11:30 hours, [Resident #1] was unable to be located, this nurse and CNA started looking for him on every room, every restroom, activities room and therapy room. After that Code Silver (missing person) was announced, Weekend supervisor and HR present at that time were notified. Searching was extended around the building and streets. RP was notified also. He was marked as oriented to person only, confused, and ambulating without assist. Record review of Resident #1's local hospital records dated 8/3/25 revealed Resident #1 was transported by ambulance to the ED from Santa [NAME] Port of Entry with heat exhaustion. He had left physical therapy, decided to walk, became lost, and was later found along the roadside. EMS reported he had been dropped off near the port and began walking in the wrong direction. On arrival at 3:27 MDT, he was alert, warm, and dry, with vitals notable for HR 122 bpm (Normal: 60-100 beats per minute; heart is beating faster than normal), RR 24 (Normal: 12-20 breaths per minute; is breathing faster than normal), SpO 89% on room air (Normal: 95-100%; Oxygen in the blood is lower than normal), and BP 98/66 (Normal: Around 120/80; The blood pressure is on the lower side but not critically low). Labs showed leukocytosis (this usually means the body is fighting an infection, stress, or inflammation), elevated creatinine (if it's high, it can mean the kidneys are under stress or not working as well as they should), low magnesium (too little magnesium can cause weakness, cramps, or irregular heartbeats), hypophosphatemia (low levels can cause fatigue, muscle weakness, or breathing problems), and elevated glucose (blood sugar is higher than normal). A chest X-ray showed central vascular congestion without consolidation (lungs are showing signs of fluid overload (like early heart failure or too much IV fluid), but there's no infection or collapse in the lung tissue). Treatment included two 1,000 mL IV Lactated Ringer's boluses (they're giving IV fluids rapidly to keep blood pressure up and prevent dehydration), oral Tylenol 1, 000 mg, and oral potassium phosphate-sodium phosphate for low phosphate. He was diagnosed with dehydration, elevated creatinine, and heat exposure. After IV fluid resuscitation and clinical improvement, he was discharged back to his prior living arrangement with instructions for follow-up and return precautions. Record review of accuweather.com revealed local weather for August 3, 2025, was a low 76F and high 105F. Record review of accuweather.com revealed bordering city and state weather for August 3, 2025, was a low 76F degrees and high 105F degrees. Record review of Maps (ipone cell phone application) revealed by car, the driving distance from the facility to the Santa [NAME] Port of Entry to Mexico was approximately 13 miles, taking about 19 minutes via I 10 and US 180.During an interview on 8/13/25 at 11:37 am, Resident #1 stated the incident happened the previous week. He stated he had been sitting outside, decided to go for a walk, got a haircut, then went to a corner store for a soda. He stated he had not planned to leave;