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	04/02/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 (Resident #2, Resident #3 and Resident #4) of 4 residents reviewed for pharmacy services and 3 of 4 medication carts (Halls 100, 200, and 300) reviewed for medications.- The facility failed to ensure timely acquisition of Resident #2's Lyricand was not administered per physician's orders.- The facility failed to ensure timely acquisition of Resident #3's Pregabalin and was not administered per physician's orders.- The facility failed to ensure timely acquisition of Resident #4's Tramadol and was not administered per physician's orders.-The facility failed to ensure licensed staff signed off on the Controlled Drugs-Count Records after verifying all controlled substances in the medication cart were accounted for with the on-coming nurse at the change of shift for 3 of 4 medication carts in Halls 100, 200, and 300.The failure could place residents at risk of inadequate therapeutic outcomes and a decline in health due to not receiving medication as ordered and drug diversion of controlled substances.Findings include:1. -Review of the Face Sheet dated 03/31/26 for Resident #2 revealed an original admission date of 09/15/25 and re-admission date of 12/26/25.-Review of History & Physical dated 09/17/25 for Resident #2 revealed [AGE] year-old-female with past medical history of neuropathy, severe rheumatoid arthritis, history of cervical spinal surgery.-Review of Quarterly MDS dated [DATE] for Resident #2 revealed BIMs Score 15 (cognitively intact), impairment on both sides of upper extremities, substantial/maximal assistance with toileting, shower, dressing, moderate assistance with personal hygiene. Rheumatoid arthritis, cervical disc disorder with myelopathy. Opioid.-Review of Care Plan revised on 09/19/25 for Resident #2 revealed, the resident has chronic pain r/t Arthritis. Approaches: Administer analgesic as per orders. Notify physician if interventions are unsuccessful or if current complaints is a significant change from resident's past experience of pain.-Review of Grievance/Complaint Report dated 03/19/26 for Resident #2 revealed, form was completed by the Activities Director. Description: Resident states that she has not received her Lyrica in four days. Summary Finding: New Rx sent to pharmacy per nurse request on 3/19/25.-Review of Physician's Order Summary dated 03/31/26 for Resident #2 revealed, Pregabalin (Lyrica) oral capsule 50 mg give one capsule by mouth two times a day for nerve pain. Pain assessment to be completed every shift. The Physician's order did not document an order to administer Pregabalin (Lyrica) oral capsule 50 mg give one capsule by mouth three times a day. Recommendations/Action Taken: Resident informed RX sent. Resolution of Grievance. Yes. Form completed by Administrator.-Review of Medication Monitoring/Control Record for Resident #2 revealed, Pregabalin (Lyrica) oral capsule 50 mg give one capsule by mouth two times a day documented resident ran out of medication after the 9:00 a.m. dose was administered on 3/14/26.-Review of Medication Monitoring/Control Record for Resident #2 revealed, Pregabalin (Lyrica) 75 mg one capsule by mouth three times a day did not document date medication was received from the pharmacy. The Control Record documented medication was administered from (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/25/26 to 3/30/26 as ordered.-Review of Medication Administration Record dated March 2026 revealed: -03/14/25 at 3:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/14/2026 at 9:00 a.m. documented on the MAR code 9 (Other/See Nurses Notes-03/15/2026 at 9:00 a.m. and 3:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/16/2026 at 9:00 a.m., 3:00 p.m. and 9:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes). Pain Assessments completed during the morning and evening shift documented Pain Level was zero.-03/17/2026 at 9:00 a.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/17/25 at 3:00 p.m. and 9:00 p.m. documented on the MAR code 5 (Hold/See Nurses Notes).-03/18/2026 at 9:00 a.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/18/25 at 3:00 p.m. and 9:00 p.m. documented on the MAR code 5 (Hold/See Nurses Notes).-03/19/2026 at 9:00 a.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/20/2026 at 9:00 a.m., 3:00 p.m. and 9:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/21/2026 at 9:00 a.m., 3:00 p.m. and 9:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/22/2026 at 9:00 a.m., 3:00 p.m. and 9:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/18/2026 at 9:00 a.m. documented on the MAR code 9 (Other/See Nurses Notes).-Review of Medication Administration Record dated March 2026 - Pain Assessment to be completed every shiftrevealed:-03/14/26 Pain Assessment in the morning, evening, night shift was zero.03/15/26 Pain Assessment in the morning was 4 on a scale of 1-10, 10 being the worst pain. Pain assessment in the evening, the night shift was zero.03/16/26 Pain Assessment in the morning, evening, night shift was zero.03/17/26 Pain Assessment in the morning, evening, night shift was zero.03/18/26 Pain Assessment in the morning, evening, night shift was zero.03/19/26 Pain Assessment in the morning, evening, night shift was zero.03/20/26 Pain Assessment in the morning, evening, night shift was zero.03/21/26 Pain Assessment in the morning was zero. Pain Assessment in the evening shift was at 2 on a scale of 1-10, 10 being the worst pain. Pain Assessment in the night shift documented a 6 (hospitalized).03/22/26 Pain Assessment in the morning, evening, night shift was zero.03/23/26 Pain Assessment in the morning, evening, night shift was zero.03/24/26 Pain Assessment in the morning, evening, night shift was zero.03/25/26 Pain Assessment in the morning, evening, night shift was zero.03/26/26 Pain Assessment in the morning, evening, night shift was zero.03/27/26 Pain Assessment in the morning 3 on a scale of 1-10, 10 being the worst pain.Review of IDT Progress Notes dated 03/31/26 documented Date Range: 03/01/26 to 04/01/26 revealed:-Physician Progress Note dated 3/15/26 at 11:35 a.m. written by NP C revealed, Note Text: NP Follow up Note. Lyrica 75 mg three times a day. RA: Flare up. RA: Monitor for worsening symptoms.-Review of Administration Note dated 3/14/26 at 3:50 p.m. written by Med Aide DD, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Med is not available. -Review of Administration Note dated 3/15/26 at 8:35 a.m. written by Med Aide EE, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery. -Review of Administration Note dated 3/16/26 at 10:53 a.m. written by Med Aide Y, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration Note dated 3/16/26 at 3:25 p.m. written by Med Aide Y, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration Note dated 3/16/26 at 8:14 p.m. written by Med Aide Y, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration Note dated 3/17/26 at 9:18 a.m. written by Med Aide Y, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration Note dated 3/17/26 at 5:43 p.m. written by Med Aide K, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration Note dated 3/17/26 at 9:38 p.m. written by Med Aide K, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note dated 3/18/26 at 8:24 p.m. written by LVN T documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, on order. -Review of Administration Note dated 3/18/26 at 5:22 p.m. written by Med Aide K, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration Note dated 3/18/26 at 9:16 p.m. written by Med Aide K, documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery, nurse notified. -Review of Administration Note dated 3/19/26 at 10:56 a.m. written by LVN T documented, Lyrica oral capsule 75 mg give 1 capsule by mouth three times a day for nerve pain. Pending delivery. -During an interview on 3/27/26 at 3:23 p.m. revealed Resident #2 was sitting in a wheelchair in her room by the side of the bed. The resident said, Ianted to tell you, that I did not receive my pain medication for 10-12 days. She said she had rheumatoid arthritis, and they were giving Tylenol, but it did not relieve the pain. She said someone had told her that the pharmacy took a long time to send the medications to the facility and that was the reason that they did not have her pain medication. She said she was diagnosed with Rheumatoid Arthritis when she was [AGE] years old, and now she required total assistance with her personal care. Resident said she had pain but was able to sit in her wheelchair as tolerated.-During an interview and on 3/27/26 at 3:38 p.m., LVN J assigned to the 200 Hall on the evening shift revealed, Resident #2 did not have the Lyrica for two weeks to administer for pain as ordered. She said they used an out-of-town pharmacy, and it took a long time for them to refill medication orders. She said the Lyrica was finally delivered for Resident #2 but could not remember the date. She said that the ADONs were the ones that called in the narcotic refills to the vendor pharmacy for the residents. She said that sometimes they could pull controlled substances from automated medication dispensing system the She said RN CC, attempted to pull the Lyrica from the pyxis for Resident #2 and the request was denied. She said that residents frequently run out of medications because it takes long for medications to be refilled and sent to the facility.-During an interview on 3/27/26 at 3:54 p.m., Med Aide K revealed that Resident #2 had not been administered the Lyrica for nerve pain for several days in March 2026 because the medication had not been sent to the facility by the out-of-town pharmacy. She said the resident complained of pain and was medicated with Tylenol, but the resident would complain that the Tylenol was not effective.-During an interview on 4/02/26 at 9:00 a.m., LVN T revealed Resident #2 has run out of Lyrica a few times. She said that the Med Aides only re-order the non-narcotic medications and the ADONs/nurses reorder the controlled substances. LVN T said that she was not aware of the facility's policy and procedure on re-ordering medications from the pharmacy. She said the Vendor pharmacy was out of town, and it took a long time to receive medications and that was why the residents at times ran out of medications. She said Resident #2 had an order for Lyrica to administer three times a day and for Tylenol for prn pain. She said the resident had rheumatoid arthritis and complained of generalized pain. She said the physician had not been notified that the resident did not have the Lyrica on hand to administer as ordered because the resident had orders for PRN Tylenol Extra Strength two tablets every 8 hours and the Tylenol relieved some of the pain.-During an interview on 4/02/26 at 10:05 a.m., Med Aide Y revealed Resident #2 frequently complained of generalized pain and had orders for Lyrica PRN. She said the resident had not been administered the Lyrica for approximately 10 days due to not having the medication hand to administer as ordered. She said the nurses re-ordered the controlled substances from the out-of-town pharmacy and it took a long time to receive the medications. She said that the nurses were aware that the resident was not getting the Lyrica for pain as ordered. -2. Review of the Face Sheet dated 03/31/26 for Resident #3 revealed an original admission date of 01/27/26.- Review of the History & Physical dated 01/28/26 for Resident #3 revealed [AGE] year-old male with past medical history of s/p left femoral fracture, s/p prosthetic replacement, s/p left hip arthroplasty. admitted for rehab services. Fall precautions.-Review of admission MDS dated [DATE] for Resident #3 revealed, BIMs Score 12 (cognitively moderately impaired), uses wheelchair and walker. Requires substantial/maximal assistance with toileting, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower, dressing, putting on/taking off footwear, sit to lying, sit to stand and chair/bed transfer. Hypertension, Hip Fracture, Pain in Left Hip, Falls prior to admission, one fall since admission with no injury, Hip Replacement, insulin, Physical/Occupational/Speech therapy.-Review of Care Plan initiated on 03/03/26 for Resident #3 revealed, Alteration in Comfort r/t Left Femur Fracture with surgical interventions. Approaches: Administer pain medication as ordered by physician and assess effectiveness.-Review of Order Audit Report dated 3/31/26 provided by DON for Resident #3 revealed, Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain.-Review of Medication Administration Record dated March 2026 for Resident #3 revealed, Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain was not administered on the following days.-3/25/25 at 9:00 a.m. and 9:00 p.m.-3/26/25 at 9:00 a.m. and 9:00 p.m.-3/27/25 at 9:00 a.m. and 9:00 p.m.-3/28/25 at 9:00 a.m. and 9:00 p.m.-3/29/25 at 9:00 a.m. and 9:00 p.m.-3/30/25 at 9:00 a.m. and 9:00 p.m.-3/31/26 at 9:00 a.m.Review of IDT Administration Progress Notes for Resident #3 revealed:-3/25/26 at 10:56 a.m. written by LVN FF revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain-on order.-3/25/26 at 9:46 p.m. written by Med Aide K revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. On order, pending delivery.-3/26/26 at 10:14 a.m. written by Med Aide K revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. Pending delivery.-3/26/26 at 9:12 p.m. written by Med Aide K revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. Pending delivery, nurse notified.-3/27/26 at 10:31 a.m. written by Med Aide K revealed Lyrica Oral Capsule 25 my (Pregabalin) give one capsule by mouth two times a day for pain. on order.-3/27/26 at 8:00 p.m. written by Med Aide K revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. On order pending delivery, nurse notified.-3/28/26 at 8:27 p.m. written by Med Aide DD revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. Med not available.-3/29/26 at 10:14 a.m. written by Med Aide DD revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. Med not available.-3/29/26 at 9:09 p.m. written by Med Aide DD revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. Med not available.-3/30/26at 10:25 a.m. by Med Aide DD revealed Lyrica Oral Capsule 25 mg (Pregabalin) give one capsule by mouth two times a day for pain. Med not available.-Review of Automated Medication dispensing cabinet Transaction Report for Resident #3 revealed:-Pregabalin 25 mg had been removed on 03/05/26 at 9:45 p.m. by RN CC. -Pregabalin 25 mg had been removed on 03/31/25 at 7:08 p.m. by RN CC. -Pregabalin 25 mg had been removed on 04/01/25 at 11:06 a.m. by LVN T.-Pregabalin 25 mg had been removed on 04/01/25 at 6:42 p.m. by RN CC. Review of Medication Monitoring/Control Record revealed Pregabalin capsule 25 mg one capsule by mouth twice a day was received on 04/04/26 and was started on 4/02/26 at 10:00 a.m.During an interview on 3/27/26 at 3:54 p.m., with Med Aide K revealed that Resident #3 had run out of his pain medication and the Lyrica had not been administered as ordered starting 3/25/2026 through 3/27/2026. She said the nurses were responsible for re-ordering the Controlled Substances for the residents and the Med Aides only re-ordered prescribed medications that were not controlled substances. She said the nurses were aware that the resident had run out of medication and were waiting for the pharmacy to send the medication. She said that the resident complained of pain and was medicated with Tylenol as ordered for pain.During an interview on 3/31/26 at 4:40 p.m., Resident #3 revealed he was alert, oriented to person, place, and time. He said he fell and broke a hip approximately 2 months ago. He said he is medicated for pain, and the medication was effective at times. He said he was getting pain medication and did not know the name of the pain medication. He said he was not having any pain at the time of the interview.During an interview on 3/31/26 at 4:43 p.m., Med Aide K revealed she medicated Resident #3 for pain with Tylenol as needed due to not having the Lyrica on hand to administer as ordered. She said that on 3/31/26 the resident's pain level was at 8 out of 10, 10 being the worst pain. She said the Tylenol (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decreased the pain level to 7 and the nurses were aware of this.During an interview on 4/02/26 at 9:04 a.m., LVN T revealed Resident #3 rarely complained of pain. She said he had an order for Lyrica and on Monday she had to get it from the automated medication cabinet, because he had run out of the medication. She said it took a while to wait for an approval to remove the Lyrica from the automated medication dispensing cabinet and get the triplicate prescription from the physician, so that was why the resident had run out of the Lyrica. She said the Lyrica could not be pulled from the automated medication dispensing cabinet because they did not have the approval code from the pharmacy.During an interview on 4/02/26 at 9:11 a.m., CNA V revealed Resident #3 as alert, oriented x 3, required minimal assistance with ADLs, continent of bowel and bladder, toileted independently. She said the resident did not complain of pain.During an interview on 4/02/26 at 9:14 a.m., CNA V revealed Resident #3 as alert and oriented x 3, ambulated independently in his room and used a wheelchair to propel himself to the dining room. Continent of bowel & bladder and toileted independently. She said the resident did not complain of pain.During an interview on 4/02/26 at 2:13 p.m., the DON revealed, Resident #3 had fallen at home and sustained a hip fracture. She said that the nurses are able to remove controlled substances from the automated medication cabinet dispensing cabinet when the resident does not have the medication on hand to administer as ordered. She said that the nurses would have to get an approval code to remove medications from the pyxis and get a triplicate prescription from the physician for the pharmacy to send the medication. She said this takes time and that is why the residents run out of medications.3. Review of the Face Sheet dated 03/31/26 for Resident #4 revealed an original admission date of 12/18/25.- Review of the History & Physical dated 11/27/25 for Resident #4 revealed 93-yer-old female with history of Dementia, hypertension, recurrent falls, right radial styloid fracture managed non-operatively with a brace and non-weight-bearing instructions. Osteoarthritis.Review of Quarterly MDS dated [DATE] for Resident #4 revealed, BIMs score 10 (moderately cognitively impaired), limited range of motion to one side upper extremity. Dependent with toileting, shower, dressing, sit to lying, sit to stand, chair/bed transfer and toilet transfer. Frequently incontinent of bowel and bladder. Hypertension, other fracture, Non-Alzheimer's Dementia, anxiety disorder, repeated falls and altered mental status. Frequently complains of pain. Antianxiety and antidepressant.Review of Care Plan dated 12/19/25 for Resident #4 revealed, Potential for acute pain. Approaches: Administer analgesic as ordered.Review of Physician Order Summary dated 03/31/26 for Resident #4 revealed, Pain assessment to be completed every shift.Review of Order Audit dated 03/31/26 provided by ADON A revealed Resident #3 had an order dated 03/26/26 for Tramadol HCL tablet 25 mg give one tablet by mouth two times a day for pain for 5 days.Review of the Medication Administration Record (MAR) dated March 2026 for Resident #3 revealed, Tramadol HCL tablet 25 mg give one tablet by mouth two times a day for pain for 5 days. The MAR documented that the Tramadol was not administered on the following days.-03/26/26 at 9:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes). -03/27/26 at 9:00 a.m. and 9:00 p.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/28/26 at 9:00 a.m. documented on the MAR code 9 (Other/See Nurses Notes).-03/29/26 at 9:00 a.m. documented on the MAR code 9 (Other/See Nurses Notes).Review of the Medication Administration Record (MAR) dated March 2026 revealed Pain Assessment every shift revealed:3/26/26 thorough 3/29/26 revealed resident did not have any pain.Review of IDT Administration Notes revealed:-3/26/26 at 9:18 p.m. written by Med Tech K revealed Tramadol HCL tablet 25 mg give one tablet by mouth two times a day for pain for 5 days. On order, pending delivery.-3/27/26 at 9:48 a.m. written by Med Tech K revealed on order, pending delivery.-3/27/26 at 9:29 p.m. written by LVN J revealed Tramadol HCL tablet 25 mg give one tablet by mouth two times a day for pain for 5 days. On order, pending delivery.-3/28/26 at 10:20 a.m. written by Med Aide DD revealed Tramadol HCL tablet 25 mg give one tablet by mouth two times a day for pain for 5 days. Med not available.-3/29/26 at 9:29 a.m. written by Med Aide DD revealed Tramadol HCL tablet 25 mg give one tablet by mouth two times a day for pain for 5 days. Med not available.During an interview on 3/27/26 at 3:54 p.m. with Med Aide K revealed that Resident #4 had (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	run out of her Tramadol on 3/26/26. She said she did not know if the nurses had reordered the medication.During an interview on 4/02/26 at 10:06 a.m., Resident #4 revealed that initially after the fall she was having a lot of pain. She said she occasionally had pain in her left hip area and was medicated for pain as needed. Resident said she was not having pain at the time of the interview. She had a patch the was applied to the left hip for pain and was effective.Review of facility's undated policy and procedures on Reordering medications provided by ADON A on 3/31/26 at 9:48 a.m. revealed, Policy: The facility will communicate any medication reorders, changes or discontinuations to the pharmacy in accordance with pharmacy guidelines and state /federal regulations. Communication may be transmitted through verbal, written, or electronic orders. Procedure: All orders must be clearly communicated to the pharmacy by the facility. Refills can be requested by placing the refill strip portion of the medication on the Refill Order Form and faxing it to the pharmacy. In the event a medication is requested too soon, the pharmacy will send a Refill Too Soon Communication Form to the facility. The facility will automatically receive the medication when it is due unless the form is signed by a nurse and faxed to the pharmacy for immediate delivery. Electronic Orders: Refill orders can be submitted from a prescriber through their escribing software or through a facilities EMAR system as long as the order is not discontinued.During an interview on 3/31/26 at 4:53 p.m., the Administrator, in the presence of the DON and ADONs revealed that he was not aware of any concerns voiced by the Nurses regarding re-ordering of medications and timely delivery of medications. He said their Vendor was out of town and did not have a contract with a local pharmacy. He said having an out-of-town Vendor pharmacy always causes problems with timely delivery of re-ordered medication. The DON said that all the licensed staff were agents which meant the licensed staff could re-order-controlled substances from the pharmacy. She said sometimes the delivery of controlled substances is delayed because some of the medications require a triplicate from the physician. She said that at times the pharmacy would not refill the prescriptions for the controlled substances because it was too soon to ask for a refill. She said she was not aware of the facility's policy and procedure specified when medications needed to be reordered. The Administrator said he had not read the Vendor Pharmacy contract and did not know what it said about re-ordering medications. The state surveyor asked for a copy of the Vendor pharmacy contract. Controlled Substances:During an observation on 3/27/26 at 4:03 p.m., of the Controlled Drug Binder on Hall 300 revealed the Controlled Drugs-Count Record dated 3/26/26 had not been signed by the nurse going off on the 2-10 shift.During an observation and interview on 3/27/26 at 4:03 p.m., of the Controlled Drug Binder on Hall 100 revealed Controlled Substances had already been initialed by RN CC as the Nurse off on the 2-10 shift prior to counting controlled substances with on-coming nurse on the 10-6 shift. He said, I already signed off because I'm going to be here when the night nurse comes. He said they had been trained to count controlled substances at the change of shift with the on-coming nurse at the start of the shift to verify the controlled counts were correct.During an interview and record review on 3/27/26 at 4:14 p.m., the DON, in the presence of the Administrator and ADON B revealed:-RN CC on the 100 Hall had initialed the Controlled Drugs-Count Record prior to counting controlled substances with the on-coming nurse on the 10-6 shift. She said, RN CC already came to tell me what he had done.-The nurse on Hall 200 on the 6-2 shift had not signed the Controlled Drugs-Count Record on 03/08/26 with the off going 10-6 nurse at the start of the 6-2 shift and at the end of the 6-2 shift with the on-coming 2-10 nurse.-The nurse on Hall 300 at the end of the 6-2 shift had not signed off on 3/26/26 at the end of the 2-10 shift. The DON said the nurses had been trained on-going to count controlled substances at the change of shift with the off-going nurse and the on-coming nurse after they had verified that controlled substance counts were correct at the change of shift.The state surveyor requested a copy of the facility's policy and procedure on Controlled Substances.During an observation on 3/31/26 at 4:51 p.m., revealed Controlled substances had been counted at the change of shift on the 300 Hall, and the Controlled Drugs-Count Record had not been signed by the off- going and the on-coming nurse.Review of Vendor Pharmacy Contract dated (continued on next page)

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	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at El Paso	7441 Paseo Del Norte El Paso, TX 79911

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/25/2025 did not document they had contract with a local pharmacy to provide pharmacy services after hours. Review of the facility's policy and procedures on Controlled Substances revised on November 2022 provided by ADON A on 3/30/26 at 12:05 p.m. revealed, Policy Statement: The facility complies with all laws, regulations and other requirements related to handling, storage, disposal and documentation of controlled medications (listed as Schedules II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Policy Interpretation and Implementation: Control substances are counted upon delivery. The nurse receiving the medication along with the person delivering the medication must count the controlled substances together. Both individuals signed the designated controlled substance record. Dispensing and Reconciling Controlled Substances: Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow -up. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing Services.