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	04/21/2026

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 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 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 1 (Resident #1) of 4 residents reviewed for fall assessment after an unwitnessed fall. The facility failed to ensure LVN P appropriately assessed Resident #1 following an unwitnessed fall on 03/14/2026. This failure could affect others by placing them at risk for complications related to untreated injuries.Record review of Resident #1's face sheet dated 04/21/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and then readmitted on [DATE]. Resident #1's diagnoses included fracture of left pubis (crack or break in the hip bone area), subsequent encounter for fracture with routine healing, fracture of acetabulum (break in the hip socket), pain in left hip, muscle wasting (loss of muscle tissue), attention and concentration deficit (neurodevelopment issue where the brain struggles to filter distractions and sustain focus), cognitive communication deficit (impairment in communication skills), history of falling, dementia(decline in mental ability), anxiety disorder (uncontrol fear or worry), altered mental status (change in persons thinking, awareness, or behavior), Hypertension (high blood pressure), repeated falls. Record review of Resident #1's MDS dated [DATE], reflected a BIMS score of 13, indicating the resident was cognitively intact. The resident had impairment on one side in upper extremity (shoulder, elbow, wrist, hand) and impairment on one side of lower extremities (hip, knee, ankle, foot). Record review of Resident #1's Care Plan dated 01/02/2026 and 04/21/2026, both reveled focus Potential or injury R/T History of falls is at risk for further falls. With a goal Will have no hospitalization fall event through the next review date, interventions/task Administer meds as ordered- monitor labs- report abnormalities to MD, Assure the floor is free of glare, liquids, foreign objects, Attempt to identify cause of fall and alleviate problem to extent possible, Educated on noncompliance with safety interventions and explain possible risks/outcomes R/T noncompliance issues, Family requested to have bed against the wall. Focus; The resident is moderate risk for falls gait/balance problems. Goal: The resident will not sustain serious injury through the review date, interventions/task; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Record review of Resident #1's dated 03/14/2026 incident report was reviewed. Record Review of Resident #1's progress notes dated 03/14/2026 at 22:19 PM, revealed CIC #1 resident vitally stable, ADON, Family, Dr. Notified. Resident did not hit her head slipped onto her bottom. Record Review of Resident #1's Progress notes dated 03/15/2026 at 02:38 AM, releveled CIC #2 Resident is assessed for pain and educated to use call light for assistance, will continue monitoring. Record review of Resident #1's Progress notes dated 03/15/2026 at 03:00 AM, releveled Resident lying in bed with eyes open. She was assessed for pain and she stated me duele al [NAME] estomago (my stomach is hurting) showing left upper quadrant' Tylenol was offered and she stated no porque luego me arde el estomago (no because then my stomach hurts). She was repositioned while in bed and one hour later reassessed and she stated me siento mucho major (I feel a lot better). She continues sleeping. No documentation of pain level noted. Record Review of Resident #1's Physician Progress notes dated 03/15/2026 at 08:16 AM. revealed (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been employed at the facility for two years but has been a LVN for a total of 18 years. LVN P stated she was informed by a CNA E that Resident #1 was on the floor on 03/14/2026. LVN P stated she entered the room and found Resident #1 on the floor in a sitting position in the middle of the room and restroom. LVN P stated she asked for help and placed Resident #1 in the wheelchair and then to bed, prior to completion of a full assessment. LVN P stated that Resident #1 stated, she scooted to the middle of the room to call for help from the restroom, but no one came to help her. LVN P stated she did not recall any light on from the restroom. She said the call lights blink red and there were no lights blinking red because she attends to those as soon as possible. LVN P stated she did not assess Resident #1 before moving her because Resident #1 was so adamant about getting her up. LVN P stated she was aware she was not supposed to move a resident before conducting a head-to-toe assessment. She said her main concern was making sure Resident #1 had not hit her head, which she checked before moving her. LVN P stated she notified the physician and documented, the physician did not order any x-rays due to the resident being alert and oriented and in no pain. LVN P stated she asked Resident #1 if she was in any pain and resident stated No. LVN P stated when she conducted the head-to-toe assessment it was while resident was already in bed and she did not notice anything unusual about her legs. LVN P stated she worked the next morning, on Sunday, and she notified the NP at the facility about the fall. She said the NP entered the room to assess Resident #1 and noticed the shorting of one of the legs. LVN P stated that she called resident's primary physician to notify them of the findings and she received orders for the resident to be sent out. LVN P stated the risk of her not conducting a head-to-toe assessment prior to moving the resident could lead to other injuries. LVN P stated she had been in-serviced and trained on performing a fall assessment prior to moving the resident. In an interview on 04/21/2026 at 02:52 PM, ADON V stated she had been employed at the facility for five years on and off. ADON V stated a review of camera footage did not confirm the call light had been activated at the time of the incident. ADON V stated facility protocol required nursing staff to complete a head-to-toe assessment, obtain vital signs, conduct neuro checks, notify physician, and inform the responsible party following a fall. ADON V stated residents should not be moved prior to assessment unless necessary for safety. ADON V stated that failure to follow procedures could place the resident at risk for further injury. ADON V stated it was the responsibility of ADONs and DONs to make sure nursing staff are doing their best for the residents. ADON stated that they did not have a Quality of care policy or an unwitnessed falls policy. In an interview on 04/21/2026 at 03:23 PM, CNA E, stated she was the one who found Resident #1 on the floor on 03/14/2026. CNA E stated she was assisting a resident across the room from Resident #1 and upon coming out of the room she saw Resident #1 on the floor. She said Resident #1 was waving her down yelling Venga, Venga (come here). CNA E stated she rushed into Resident #1's room and found Resident #1 between the middle of the room and the entrance to the restroom. CNA E stated she made sure the resident was okay and rushed out to call the nurse. She stated LVN P came right away. CNA E stated that night she changed Resident #1's brief and the resident did not show any signs of pain. CNA E stated she assisted with the transfer from the floor to the wheelchair, then to the bed. CNA E stated that LVN P conducted her assessment on the bed after transfer. In an interview on 04/21/2026 at 03:44 pm, the Administrator stated he had been employed at the facility for two years. Administrator stated he became aware of the fall but can't recall the date. It was reported to him that Resident #1 did not hit her head, he is unaware if anyone witnessed the fall or who was working the day of the incident. Administrator stated that they have cameras in certain areas, but they are erased after 10 days. He stated that he reviewed the camera footage of Resident #1s hallway while conducting his investigation and stated there were no red call light flashing. The Administrator stated that staff are being trained on falls and incidents on a system called Relias (Online learning Management System) and get conducted in-services when there is an Incident/Accident that occurs. The Administrator stated the procedure when a resident fall should be to automatically assess the resident from head to toe before they get them up and if they are seriously injured to call 911. He said (continued on next page)

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