

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/10/2026
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 6 (Resident #1) residents reviewed for base line care plans. The facility failed to develop Resident #1's baseline care plan within 48 hours of re-admission on [DATE]. This failure could place newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff, increasing resident safety and safeguarding against adverse events that are most likely to occur right after admission. Finding included: Record review of Resident #1's face-sheet dated 06/09/26 revealed a [AGE] year-old female with admission date 06/02/26 and initial admission date 05/23/26. Record review of Resident #1's history and physical dated 04/06/26 revealed a medical history of the following: Traumatic Brain Injury severe with IPH status (intraparenchymal hemorrhage (IPH) is bleeding that occurs directly within the brain); Cranial Diabetes Insipidus (a condition characterized by persistent thirst and frequent urination); Respiratory failure (serious condition that occurs when the lungs cannot adequately exchange gases, leading to insufficient oxygen in the blood or excessive carbon dioxide); Peg tube status (a surgically placed feeding tube inserted through the abdominal wall directly into the stomach to provide nutrition when oral intake is insufficient or unsafe); and, severe physical deconditioning (refers to a decline in physical function, endurance, and muscle mass). Record review of Resident #1's Nursing home PPS MDS 05/23/26 revealed the there was no BIMS score. Under Section K- Swallowing/Nutritional Status, Resident #1 was noted with a feeding tube on admission and while a resident in the nursing facility. Under Section O-Special Treatments, Procedures, and Programs, Resident #1 was noted with Continuous Oxygen therapy on admission and while a resident in the nursing facility. Record review of Resident #1's Order Summary report dated 06/10/26, revealed the following physician orders: -NPO diet, nothing by mouth, start date: 06/02/26-Enteral Feed Order every shift Glucerna 1.5 at 20 cc/hr via g-tube stationary pump. Start date: 06/02/26-Head of Bed to remain 30-45 degrees related to risk for aspiration. Start date: 06/02/26-Oxygen at 2 Liters per Minute via Nasal Cannula (a thin, flexible tube with two small prongs that fit into a person's nostrils, directly administering oxygen to a person from an oxygen source such as an oxygen concentrator). Start date: 06/02/26 Record review of Resident #1's care plan with initiated date 06/09/26, and date of admission [DATE], revealed the only focus area included was Resident #1 required encouragement for attend activities by having nursing facility to ensure that the activities the residents were attending were compatible with physical and mental capabilities. The care plan did not include or address Resident #1's medical diagnoses or conditions. In an interview on 06/10/2026 at 10:15 AM, RN A stated that the MDS nurse was responsible for the baseline Care Plan after residents were admitted. RN A stated the MDS nurse reviewed residents care plans on a quarterly basis. RN A stated the purpose of care plans was to have a plan of care that met that specific resident's needs and to make sure the nursing staff were aware. RN A stated if certain medical conditions or resident needs were not included in the care plan, staff would not be aware of the resident's needs, which could place the (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident at risk. In an interview on 06/10/2026 at 10:34 AM, LVN B stated that the floor nurses were responsible for the baseline care plan when the residents were admitted into the nursing facility. LVN B stated the purpose of care plans was for direct care staff to be aware of the residents' needs. LVN B stated if a resident was on a feeding tube, it was to be included in the care plan as it would include the type of formula per the physician's order. LVN B stated that the ADON and the MDS nurse were responsible for monitoring resident care plans after admission but was unsure of the timeframe or how often they monitored care plans. In an interview on 06/10/26 at 11:11 AM, the MDS Nurse stated floor nurses were responsible for initiating the baseline care plan for residents upon admission. The MDS Nurse stated Resident #1 was initially admitted to the Nursing Facility on 05/23/26 but was sent to the hospital that same day, per the family's request. The MDS Nurse stated Resident #1 was re-admitted from that hospitalization to the Nursing Facility on 06/02/26 and had been in the facility since. The MDS Nurse stated she was unsure of the Nursing Facility's policy was, or the time frame when completing the Baseline Care Plan. The MDS Nurse stated a baseline care plan would have addressed Resident #1's G-tube status and also mean the resident was a risk for aspiration. She stated potential risk of not including medical conditions in a baseline care plan included risk for falls or injury due to Resident #1's medical history. The MDS Nurse stated Resident #1's care plan only addressed Activities. In an interview on 06/10/26 at 12:35 PM, the DON stated the floor nurse admitting the resident was responsible for initiating the resident's Baseline Care Plan. The DON stated Resident #1 was first admitted to the Nursing Facility on 05/23/26, but left within hours per Resident #1's family's request. The DON stated Resident #1 was re-admitted later, 06/02/26, and had been in the Nursing Facility since then. The DON stated the baseline care plans were developed using the resident hospitalization information provided from the hospitals, such as medical diagnoses, diet or feeding orders. The DON stated it was unacceptable for Resident #1 to not have her medical information not included in the care plan. The DON stated the potential risk to residents of not having their baseline care plan completed, including nursing staff not being aware of the residents' needs. In an interview on 06/10/26 at 1 PM, the Administrator stated that the floor nurse who was admitting the resident was responsible for creating the baseline care plan. The Administrator stated the Care Plan was a plan of care that nursing facility staff utilized to be aware of the residents' needs. The Administrator stated the potential risk of not including a resident's medical diagnoses in the care plan was a potential delay of care. The Administrator stated he was not aware of the Nursing Facility's policy regarding the time frame a resident's care plan was to be completed. Record review of the Nursing Facility's Care Planning- Interdisciplinary Team Policy, dated 03/2022, read in part: The Interdisciplinary team is responsible for the development of resident care plans. Under Policy Interpretation and Implementation, it read in part: 1. Resident care plans are developed according to the timeframes and criteria established by 483.21. Code Federal Regulation S 483.21 - Comprehensive person-centered care planning, read in part: (a) Baseline care plans. (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 1 of 6 residents (Residents #2) reviewed for records.-The facility failed to ensure RN C documented attempts to contact the family of Resident #2 after their fall on 05/26/26.-RN C inaccurately documented she notified the family of Resident #2 after their fall on 05/26/26 at 7AM.This deficient practice could place residents at risk of not having accurate documentation.Findings include:Record review of Resident #2's face-sheet dated 06/09/26 revealed an [AGE] year-old female resident with admission date 08/26/24, and initial admission date 05/09/24.Record review of Resident #2's history and physical dated 06/03/26 revealed the following medical history: Dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities); Muscle wasting; and history of falls.Record review of Resident #2's Comprehensive MDS dated [DATE] revealed a BIMS of 5, indicating severe cognitive impairment. Under Section I- Active Diagnoses, it noted Resident #2 had the following medical diagnoses: muscle weakness, muscle wasting, dementia, difficulty walking, and unsteadiness on feet.Record review of Resident #2's Care Plan with revision date 12/30/25, revealed a focus area including Resident #2 was a fall risk relating to fall history and nursing facility was to follow the facility fall protocol.Record review of Resident #2's Nursing Progress Note dated 05/26/26 at 03:21 AM, documented by RN C, read: At approximate 02:20 [AM] [Resident] was sitting on the floor beside her wheelchair near bathroom door following unwitnessed fall, when asked what happened she stated, ?slipped off the wheelchair trying to get to the bathroom [Patient] denied hitting her head and denies pain or discomfort no visible injuries noted this time [Vital Signs] [Blood Pressure] 137/77 [Pulse] 82 [Temperature] 97.7 F [Oxygen] 94% [Room Air] Neurological checks initiated. ADON and NP notified. In the Nursing Progress Notes, it was not noted if Resident #2's family or Responsible Party was notified or attempted to be contacted after Resident #2's fall.Record review of Resident #2's Incident Report dated 05/26/26 at 2:30 AM, prepared by RN C, read under Incident Description: At approximate 02:20 [AM] [Resident] was sitting on the floor beside her wheelchair near bathroom door, alert and responsive no visible injuries noted resident denies hitting head or pain vital signs stable no acute distress noted. It was noted as an unwitnessed fall. Under Immediate Action Taken, the Description read: Resident assessed for injuries vital signs and [neurological] check initiated Resident assisted back to bed safely NP . and ADON notified. [Family Member] informed. Under Agencies/ People Notified, Resident #2's family member was noted as notified on 05/26/26 at 7 AMPhone interview attempts were made to Resident #2's family on 06/09/2026 at 09:59 AM, 12:19 PM, and 12:20 PM. This investigator was unable to leave a Voice Mail as the system was not set up per phone recording.In an observation on 06/09/26 at 10:45 AM of Resident #2 in a religious service in the Nursing Facility Activity room, participating and interacting with the staff and residents without issue or concern identified.In a phone interview on 06/09/26 at 3:32 PM, RN C stated she recalled Resident #2's fall during her night shift. RN C stated Resident #2 was found on the floor in her room by the bathroom door, Resident #2 was observed next to her wheelchair. RN C stated she assessed Resident #2 and asked her what caused the fall. RN C stated Resident #2 reported wanting to go to the bathroom and slipping out of the wheelchair which caused her to fall. RN C she did not recall any injuries observed, and Resident #2 denied pain or hitting their head. RN C stated she notified the Physician after her assessment and notified the ADON. RN C stated she attempted to call Resident #2's family member to notify them of the fall, but was unable to recall how many attempts or the times of the attempts. RN C stated she documented what she had done during the shift. RN C stated she did not speak with Resident #2's family member until the next (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled night shift. In an interview on 06/10/26 at 10:18 AM, RN A stated the fall protocol included the nursing staff to notify the listed family contacts in the electronic charting system of the residents having any change of condition, including a fall. RN A stated nursing staff was to attempt to call the family until there was an answer, and if there was no answer, it was to be documented. RN A stated the purpose of calling the family members of residents that had a fall, so it was for them to be aware of what was going on with the resident. He stated the purpose of documenting attempts was to show the Nursing Facility care staff that the nurse did attempt to notify the family and at what time. RN A stated a failure to document contact attempts to family would reflect the nurse did not make those attempts. RN A stated documenting you notified family when you did not, was false documentation. In an interview on 06/10/26 at 12:33 PM, the DON stated the ADONs and herself, as the DON, reviewed nursing documentation daily, every morning. The DON stated they were to review the nursing progress notes along with the 24-hour report also used by the nursing staff and reviewed accuracy. The DON stated that every nurse was responsible for their own documentation and accuracy. The DON stated documenting actions that were not actually done were considered false documentation. In an interview on 06/10/26 at 1:10 PM, the Administrator stated nurses were expected to document their unsuccessful attempts to contact resident families after a resident had a fall. The Administrator stated a nurse documenting she had notified the family when she did not was false documentation. The Administrator stated the dayshift nurse notified the family member of Resident #2's fall that morning at 7 AM, which is why it was documented in the incident report. Record review of the Nursing Facility's policy, Charting and Documentation, dated 07/2017, read in part: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Under Policy Interpretation and Implementation, it read in part: 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		