STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676468	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Patriot	11490 Gateway North Blvd. El Paso, TX 79934

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents who entered the facility received care and treatment consistent with professional standards of practice to prevent pressure ulcers and a resident with pressure ulcers receives necessary treatment and service to promote healing and/or prevent further development of skin breakdown or pressure ulcers, for one (Resident #2) of four residents reviewed for prevention and maintenance of pressure ulcers. The facility failed to ensure Resident #2's dressing was replaced when it became dislodged, allowing the sacral wound to be exposed to potential contamination with urine and fecal matter. This failure could place residents at risk of worsening of existing pressure ulcers and risk of infection. The findings included:Review of Resident #2's admission Record, dated 07/30/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Review of Hospital Physician Progress Note dated 07/07/25 for Resident #2 revealed, [AGE] year-old female with a history of dementia (a condition that causes a decline in thinking, memory, and reasoning skills) presented to the emergency room from nursing home for abdominal distention (belly is sticking out more than usual, making it look swollen or bloated). Stage 4 pressure ulcer (is a very deep crater on the skin in the area of the tailbone) present on admission. Review of Hospital Nutrition Progress Note dated 07/08/25 for Resident #2 revealed, History of Present Illness: admitted from nursing facility due to distended abdomen. Past Medical History of dementia, chronic kidney disease stage 3 (means that your kidneys have moderate damage), decubitus ulcer (is a type of skin wound that develops from prolonged pressure on the skin, usually over bony areas like the hips, heels, or tailbone), bedbound(someone is unable to get out of bed and move around due to illness, injury, or other physical limitations). Nutritional History: Spoke with CNA who reported that patient gets assistance with eating and is not consuming much of her food or liquids (only having bites and sips). Skin: Pressure injury to sacrum (is a wound that forms on the skin and underlying tissues over the tailbone). Review of Hospital Physical Therapy Wound Check dated 07/08/25 for Resident #2 revealed, Location: Sacrum. Etiology: Pressure Ulcer: Unstageable at this time. Review of Nursing Facility History & Physical dated 07/14/25 for Resident #2 revealed, History of Present Illness: This is an [AGE] year-old Hispanic female patient seen today for a Post Hospitalization where she was treated for Baseline dementia (is a condition where an individual's cognitive function does not return to normal even when all other diseases are under control), Metabolic encephalopathy/multifactorial (is a condition where the brain's function is affected due to metabolic disturbances, often caused by underlying health issues. It can cause confusion, memory loss, and altered consciousness). Per nursing the patient continues to eat very poorly. Will refer for a hospice evaluation and admission. Past Medical History Active Medical Problems: Diabetes Mellitus with PVD (means that a person with diabetes has a higher risk of developing a condition called Peripheral Vascular Disease (a condition that affects the blood vessels outside the heart and brain and lead to symptoms like painful muscle cramping, slow-healing wounds, and an increased risk of stroke or heart attack), homocysteine [NAME] (is an amino acid that plays a crucial role in protein metabolism), Chronic Kidney Disease stage 3, Alzheimer's dementia (is a group of symptoms that affect a person's ability to perform everyday activities due to a decline in cognitive functioning). Record review of Resident #2's Quarterly MDS, dated [DATE], revealed BIMS Score was 3 (severely impaired), Incontinent of bowel & bladder. Active Diagnoses: Renal Insufficiency, Diabetes Mellitus, Non-Alzheimer's Dementia, Depression, Morbid Obesity, Muscle weakness, muscle wasting and atrophy. Resident has one unhealed pressure ulcer. One Unstageable - Deep tissue injury. Pressure reducing device for chair/bed. Review of Care Plan for Resident #2's revealed:- Care Plan dated initiated: 07/24/25. Resident receiving hospice services r/t Terminal disease process. Interventions: Notify hospice nurse and MD for any decline in resident's condition. - Care Plan initiated: 06/19/25. The resident has an unstageable pressure ulcer to the coccyx and potential for pressure ulcer development r/t disease process (Muscle weakness, DMII, muscle wasting/atrophy and morbid obesity), Immobility. Interventions: Administer treatments as ordered and monitor for effectiveness. Treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Review of Hospice Certification and Plan of Care for Resident #2 revealed, Start of Care Date: 07/23/25. Diagnoses: Senile degeneration of brain, Type 2 Diabetes Mellitus, Chronic Kidney Disease. Orders and Treatment: Facility to provide wound care as ordered. Goals: Skin

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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 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. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 6 residents reviewed for accuracy and completeness.The facility failed to ensure that LVN A completed a weekly skin assessment for Resident #1 on 7/22/25 in accordance with facility policy. This failure placed residents at risk for unmet care needs, as services may be documented as provided when they were not, potentially leading to delays in treatment or unidentified changes in condition. Findings include:Record review of Resident #1's face sheet dated 07/30/25 revealed an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Record review of Resident #1's history and physical dated 6/22/25 revealed diagnoses of malfunction of nephrostomy tube (the tube placed into the kidney to drain urine isn't working properly. It might be clogged, leaking, or not staying in place), bilateral hydronephrosis (both kidneys are swollen because urine can't flow out the way it should. It usually happens when there's a blockage somewhere in the urinary system), left hydroureter (the ureter on the left side (the tube that carries urine from the kidney to the bladder) is swollen, usually because something is blocking the urine from flowing), and displacement of the left percutaneous nephrostomy tube (the tube placed into the left kidney to help drain urine has moved out of place). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 10, which indicated his cognition was moderately impaired. Section H revealed he had indwelling catheter and ostomy. Record review of Resident #1's care plan dated 5/21/25 revealed a focus care area for risk for impaired skin integrity and need for preventative measures with interventions that included skin checks per facility policy. He also had a focus area for has nephrostomy tube to his right side with interventions that included monitor/document for pain/discomfort due to the catheter. Record review of Resident #1's skin assessments for July 2025 revealed no assessment was completed for the week of 07/21-07/25. During an interview on 07/30/25 at 11:31 am, LVN A stated nurses were responsible for completing skin assessments and that they were scheduled per shift daily. LVN A stated Resident #1 assessments were scheduled every Wednesday. LVN A stated she did not complete the assessment on 7/22/25 because one had been completed on 7/19/25. LVN A stated she reviewed the skin assessment and assumed the nurse had completed a full head-to-toe assessment. When asked about weekly assessment expectations, LVN A changed her response and stated she had completed a full head-to-toe assessment on 7/22/25 because it was the resident's shower day, and she had checked the nephrostomy site but failed to document it. LVN A was unable to provide a reason for not documenting the skin assessment and remained silent, stating she should have completed the documentation. LVN A stated the risks of not completing the weekly skin assessment included lack of continuity of care and failure to complete job duties.During an interview on 07/30/25 at 11:41 am, LVN B stated she completed an assessment following an altercation involving the resident, but did not complete the scheduled weekly skin assessment because she believed the incident-related check was sufficient. LVN B stated a posted schedule at the nurse's station assigned weekly skin assessments to nurses per shift. LVN B stated that nurses were still expected to complete their assigned weekly skin assessments even if an assessment was performed during the week for another reason. LVN B stated that failing to complete the scheduled weekly assessment could impact continuity of care. LVN B stated she had received training on skin assessments but could not recall when.During an interview on 07/30/25 at 1:33 pm, DON stated the wound care nurse began conducting weekly audits on weekends to ensure all residents received weekly skin assessments. The DON stated that verification of weekly skin assessments was expected to be completed by the ADONs. The DON stated she would begin conducting spot checks moving forward. The DON stated there was no quality assurance process in place for the weekend audits conducted by the wound care nurse.Record review of facility's Charting and Documentation policy dated 2001 read in part The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for two of five residents (Residents #2 and #3) reviewed for Enhanced Barrier Precautions. The facility failed to implement their policy on Enhanced Barrier Precautions for residents with wounds and/or indwelling medical devices. These failures could place residents at risk for healthcare associated cross-contamination and at risk of the transmission of multi-drug-resistant organism (MDROs).The findings included: Resident #2 Review of Resident #2's admission Record, dated 07/30/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Review of Hospital Physician Progress Note dated 07/07/25 for Resident #2 revealed, [AGE] year-old female with a history of dementia (a condition that causes a decline in thinking, memory, and reasoning skills) presented to the emergency room from nursing home for abdominal distention (belly is sticking out more than usual, making it look swollen or bloated). Stage 4 pressure ulcer (is a very deep crater on the skin in the area of the tailbone) present on admission. Review of Nursing Facility History & Physical dated 07/14/25 for Resident #2 revealed, History of Present Illness: This is an [AGE] year-old Hispanic female patient seen today for a Post Hospitalization where she was treated for Possible aspiration pneumonia (An infection in the lungs that occurs when food, liquid, or saliva accidentally enters the lungs instead of the stomach), Baseline dementia (is a condition where an individual's cognitive function does not return to normal even when all other diseases are under control), Metabolic encephalopathy/multifactorial (is a condition where the brain's function is affected due to metabolic disturbances, often caused by underlying health issues. It can cause confusion, memory loss, and altered consciousness), During the visit the patient was awake in bed, responsive and alert. Per nursing the patient continues to eat very poorly. Will refer for a hospice evaluation and admission. Past Medical History Active Medical Problems: Diabetes Mellitus with PVD (means that a person with diabetes has a higher risk of developing a condition called Peripheral Vascular Disease (a condition that affects the blood vessels outside the heart and brain and lead to symptoms like painful muscle cramping, slow-healing wounds, and an increased risk of stroke or heart attack), homocysteine [NAME] (is an amino acid that plays a crucial role in protein metabolism), Chronic Kidney Disease stage 3, Alzheimer's dementia (is a group of symptoms that affect a person's ability to perform everyday activities due to a decline in cognitive functioning). Record review of Resident #2's Quarterly MDS, dated [DATE], revealed BIMS Score was 3 (severely impaired), Incontinent of bowel & bladder. Active Diagnoses: Renal Insufficiency, Diabetes Mellitus, Non-Alzheimer's Dementia, Depression, Morbid Obesity, Muscle weakness, muscle wasting and atrophy. Weight: 193 pounds. Resident has one unhealed pressure ulcer. One Unstageable - Deep tissue injury. Pressure reducing device for chair/bed. Review of Care Plan for Resident #2's dated 06/19/25 revealed, the resident has an unstageable pressure ulcer to the coccyx and potential for pressure ulcer development r/t disease process (Muscle weakness, DMII, muscle wasting/atrophy and morbid obesity), Immobility. Interventions: Enhanced barrier precautions. Review of Hospice Communication Log for Resident #2 revealed, 07/28/25 Patient's wound to sacrum with purulent drainage. New wound care orders provided. 07/29/25 Started antibiotics and new wound care orders. Review of Physician Order Summary dated 07/30/25 for Resident #2, revealed Order Date: 06/26/25 EBP: Staff must use gown and gloves during high contact resident care activities that could possibly to result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those who are not confirmed to have an MDRO (e.g., residents with indwelling medical devices). Order Date: 07/28/25 Wound to sacrum, clean with N/S or wound cleanser, pat dry, apply Silvadene to wound bed, cover with 4x4 gauze, secure with foam dressing, change daily and PRN when soiled for Wound protection. Observation and interview on 07/28/25 at 12:08 PM revealed there was not a sign posted on the entrance door for Enhanced Barrier Precautions and there was no PPE in Resident #2's room. Hospice CNA was in the room giving the resident a bed bath. She had on an isolation gown and gloves. The resident was lying on her back on an air mattress. CNA D and CNA F entered the room to assist the Hospice CNA to turn and reposition the resident. CNA D put on gloves and did not put on a gown, assisted the Hospice CNA to turn the resident to her left side for the Hospice CNA to continue with the bed bath. Observation on 07/28/25 at