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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676468 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>08/29/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avir at Patriot |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>11490 Gateway North Blvd.<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 nurse medication carts (400) reviewed for medication storage. The nurse medication cart used for hall 400 was inspected on [DATE] and had an insulin vial that had an open date of [DATE] which meant the insulin had already expired. This failure could place residents at risk of receiving medications that were expired and not produce the desired effect. The findings were: During an observation and interview on [DATE] at 11:46 AM revealed the nurse medication cart for hall 400 was inspected with LVN B present. In the top drawer of the medication cart was a 10ml insulin vial that had been opened and had an open date of 06-30-25. LVN B said she had not noticed the vial had expired and that it was each nurse's responsibility to monitor for that. LVN B said she would remove the vial from the cart as it had expired since they were only good for 30 days after being opened. LVN B said if that insulin was used on a resident, then it could lead to the medication not being as effective. During an interview on [DATE] at 1:22 PM the DON said the expectation was for nursing staff to remove expired insulins from the medication carts. The DON said once the insulin container was opened, they were usually good for 28 to 30 days. The DON said if insulin that had expired was used then it could lead to adverse effects and not be as effective. The DON said it basically was each nurse's responsibility to inspect their medication cart for any expired or undated medications and discard them. During an interview on [DATE] at 1:54 PM the Administrator was made aware of the observation of the expired insulin vial found in the nurse medication cart. The Administrator said it was expected for the nursing staff to remove the expired insulins from the cart. The Administrator said if that insulin was used it could lead to adverse effects and not the desired effect. Record review of the facility document titled Insulin administration and dated 2001 indicated in part: Steps in procedure - Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening). Record review of the facility document titled Medication storage and dated 01/25 indicated in part: Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. Record review of the insulin manufacturer instructions dated 2022 indicated in part: After vials have been opened: Store opened vials in the refrigerator or at room temperature up to 86 F (30 C) for up to 31 days. Keep away from heat and out of direct light. Throw away all opened vials after 31 days, even if there is still insulin left in the vial.</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>                 |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #44) reviewed for incontinent care in that; CNA A failed to change her gloves after they became contaminated during incontinent care while assisting Resident #44. The failure could place resident's risk for cross contamination and the spread of infection. Finding included: Record review of Resident #44's electronic admission record dated 08/26/2025 indicated she was admitted to the facility on [DATE] with diagnoses of muscle weakness, muscle wasting and atrophy (waste away). She was [AGE] years of age. Record review of Resident #44's quarterly MDS dated [DATE] indicated in part: BIMS = 15 indicating the resident was cognitively intact. Bladder and bowel: Urinary continence = Always incontinent. Bowel continence = Occasionally incontinent. Record review of Resident #44's care plan indicated in part: I am Frequently incontinent of Bowel and Bladder. I will remain free from skin breakdown due to incontinence and brief use through the review date. INCONTINENT: Check me every 2hrs and as required for incontinence. Provide Incontinent care as needed. Change clothing PRN after incontinence episodes. Date Initiated: 07/08/2022. During an observation on 08/26/2025 at 9:28 AM revealed CNA A performed incontinent care for Resident #44. CNA A entered the resident's room, sanitized her hands and put some gloves on. CNA A proceeded to undo the resident's brief and took some wet wipes and wiped the resident's vaginal area while her gloved hands came in touch with the resident's vagina. CNA A then turned the resident on her side and with some wet wipes wiped the resident's rectal area. The CNA's gloved hand was noticed to come in contact with the resident's buttocks and rectal area during the wiping. CNA A then took a bottle of lotion from the resident's dresser while wearing the same gloves. CNA A then took a clean brief and fastened it to the resident while still wearing the same gloves. During an interview on 08/27/2025 at 1:04 PM CNA A said she should have changed her gloves before she took the clean brief and placed it on the resident. The CNA said not changing her gloves could lead to cross contamination and re-contaminating the new brief and other items touched with the contaminated gloves. CNA A said she just forgot to change her gloves and that she had been trained on when to change her gloves but again she just forgot to. During an interview on 08/28/25 at 1:22 PM the DON was made aware of the observation of the incontinent care performed by CNA A. The DON said it was expected for the CNA to change her gloves once they became contaminated to prevent cross contamination. The DON said that she was not sure as to why the CNA had not changed her gloves. The DON said ADON H was the infection preventionist and she would conduct random training and return demonstration for CNAs regarding infection control. The DON said they would be conducting more training. During an interview on 08/28/25 at 1:38 PM ADON H said she was the infection preventionist. The ADON was made aware of the observation of the incontinent care performed by CNA A. ADON H said CNA A should have changed her gloves, sanitized her hands and put on a pair of new gloves after the CNA had cleansed the resident's private areas. The ADON said if the CNA had not done that then she was contaminating the items she touched with those gloves. ADON H said that the CNA not changing her gloves could lead to cross contamination and the spread of infections for example UTI's. The ADON said she would conduct more training and in-services regarding incontinent care. During an interview on 08/28/25 at 1:55 PM the Administrator was made aware of the observation of the incontinent care performed by CNA A. The Administrator said it was expected for the CNA to change their gloves once they became contaminated to prevent cross contamination. Record review of the facility's policy titled Perineal Care dated 2001 indicated in part: Purpose - The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation and to observe the resident's skin condition. If resident is heavily soiled with feces, turn resident on side and clean away feces with tissue, wipes or incontinent brief. Discard soiled gloves along with the soiled brief and/or wipes in trash bag. Cover the resident, provide safety measures and wash hands with soap and water. Sanitize hands and put on gloves (PPE as indicated). Record review of the facility's policy titled Handwashing/Hand hygiene dated 2023 indicated in part: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Indications for hand hygiene - Hand hygiene is indicated after contact with blood, body fluids or contaminated surfaces; after touching a resident; Before moving from work on a soiled body site to a clean body site on the same resident</p> |   |  |