

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Avir at Patriot		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for 3 of 12 residents (Resident #45, #46 and #47) reviewed for call lights. The facility failed to ensure resident call lights were within reach for 3 Resident #45, #46 and #47). This failure placed residents at risk of having their needs unmet when they are unable to contact staff. Findings included: Resident #45 Record review of Resident #45's admission record dated 08/29/2025 revealed a [AGE] year-old male with an original admission date of 12/07/2023 and a readmission date of 04/27/2025. Record review of Resident #45's history and physical dated 04/27/2025 revealed he had diagnosis of unspecified convulsions (a seizure event where the specific cause is not documented in patients' medical record) and high blood pressure. Record review of Resident #45's Quarterly MDS dated [DATE] revealed in section GG Functional Abilities Resident #45 needed supervision or touching assistance meaning Helper provides verbal cues and/or touching /steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For showering, upper body dressing and lower body dressing. There was no BIMS score available. Record review of Resident #45's care plan reviewed on 04/27/2025 revealed Resident #45 was at risk for blurred vision, dizziness, headaches and nosebleeds related to high blood pressure and received medication for high blood pressure. Resident #45 was at risk of falls, and intervention included ensuring residents call light was within reach. In an observation on 08/26/2025 at 11:11 a.m., in Resident #45's room revealed residents call light was on the floor, not within reach of the resident. Resident # 46 Record review of Resident #46's admission record dated 04/25/2025 revealed a [AGE] year-old female with the original and initial admission date of 04/25/2025. Record review of Resident #46's history and physical dated 04/18/2025 revealed diagnoses of intractable epilepsy (seizures resistant to treatment), febrile illness (elevated body temperature), traumatic brain injury, and breakthrough seizures (seizure activity after a period of 12 months of not having one). Record review of Resident #46's quarterly MDS dated [DATE] revealed Resident # 46 had a BIMS score of 09, indicated moderate cognitive impairment. Section I-Active Diagnoses revealed Resident #46 was diagnosed with Anemia, Other neurological conditions, Seizure disorder, psychiatric/mood disorders, muscle weakness (generalized), unsteadiness on feet, and cognitive communication deficit. Section J-Health conditions revealed Resident #46 had two or more falls since admission without injury. Record review of Resident #46 care plan reviewed on 04/25/2025 revealed Resident #46 experienced five actual falls and ensure staff made frequent room rounds per shift and place and continue interventions on the at-risk plan. In an observation on 08/26/2025 at 10:50 AM, Resident #46's call light was wrapped around the nightstand and clipped to the drawer handle. During a revisit on 08/26/2025 at 2:46 PM, the call light was still in the same position while Resident #46 was asleep. Resident #47 Record review of Resident #47's admission record dated on 01/17/2025 revealed an [AGE] year-old female with an admission date of 11/08/2023. Record review of Resident #47's history and physical dated 01/17/2025 provided resident's diagnoses of left hip fracture, generalized weakness, Myotonic Dystrophy (A muscle disease featuring an inability to relax muscles at will), and high blood pressure. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #47's quarterly MDS dated [DATE] revealed a BIMS score of 02, indicated severe cognitive impairment. Section GG-Functional Abilities revealed Resident #47 was coded for having impairment on both sides on her upper extremity and substantial/maximal assistance for completing activities for daily living and mobility. Record review of Resident #47's care plan enacted on 01/17/2025 revealed the resident had an actual fall while attempting to ambulate on 07/07/2024 and intervention implemented was to educate the resident on the importance of utilizing the call light for assistance. Resident #47 was previously identified as a fall risk beginning on 11/29/2023. In an observation made on 08/27/2025 at 09:29 AM, in Resident #47's room, the call light was observed on the visitor chair and wrapped around the front right leg approximately hanging one foot from the ground. Resident #47 was sitting in their wheelchair facing away from the call light. In an interview on 08/28/2025 at 1:53 PM, CNA G reported the purpose of the call light is to provide residents with means of communication to staff in need of assistance, care, and emergencies. She reported that CNA's and Nurses are responsible for ensuring that call lights are within reach for the resident. Photos of call lights observed in the facility was presented to CNA G, who confirmed that the call lights were out of reach. She denied having a recent in service on call lights since beginning employment at facility. CNA G stated the resident could fall, be soiled, thirsty, amongst other outcomes if the call light is not in proximal distance for resident's access. In an interview on 08/28/2025 at 2:14 PM, LVN F said call lights are utilized for residents to communicate needs, concerns, and assistance. She confirmed that CNAs and Nurses are responsible for monitoring call lights and adjusting call light position if out of reach. LVN F stated her last in-service training for call light use and positioning was this year. She reported the effect this could have on a resident could be frustration, being left in pain, and affect resident's dignity. In an interview on 08/29/2025 at 4:30 pm, the DON said call lights was for residents to use to be able to ask for assistance. She stated that it was a form of communication between staff and residents. She stated that call lights not being within reach of residents put the residents at risk of not receiving the assistance they were requesting. She stated that all staff, especially nursing and CNAs, were responsible for ensuring that call lights were within reach of the residents. She stated that the last Inservice done was in July 2025. In an interview on 08/29/2025 at 04:33 PM, the administrator said that call lights are used to assist residents with needs and provide a form of communication for assistance. The administrator said that a resident without a call light would limit that individual's ability to communicate with staff and provided examples of what a resident might need (soiled, be in pain, cause infections and skin irritation). The administrator said that everybody who is employed at the facility is responsible for repositioning call lights, to include non-nursing staff. Additionally, the administrator said MDSS, ADONs, and DON are responsible for ensuring nursing staff and CNAs are completing rounds and positioning call lights within reach. The administrator stated the call light should be within reach for residents and be placed on the bed, rail, wheelchair, shirt, or have it in their care plan for any variance of the previously mentioned. The administrator said the last in-service for call lights was conducted 2-3 months prior. The administrator agreed the photos provided displayed call lights outside of resident's immediate reach. The administrator said this deficiency limits the residents' ability to communicate which could result in the resident feeling frustrated, embarrassed, and infringe on their dignity. Record review on 8/29/2025 at 1:05 PM of Call System, Residents does not address accessibility of call light placement in relation to the resident. The facility's policy states, Each resident is provided with means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide ADL care for 2 of 16 residents (Resident # 99 and #156) reviewed for ADLs.-The facility failed on 08/26/2025 to ensure Resident #99 and #156's fingernails were trimmed, clean and free from debris.-This failure could place residents at risk of not having their personal hygiene needs met and cause low self-esteem.The findings include: Resident # 99.Record review of Resident # 99's admission Record dated 8/27/2025 revealed a [AGE] year-old male with an admission date of 12/11/2023.Record review of Resident # 99's health and physical dated 08/11/2025 revealed medical diagnoses of anxiety disorder, panic attacks, depression, and hypertension. Record review of Resident # 99's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating the resident was cognitively intact. It indicated the resident required supervision or touching assistance with his personal hygiene. MDS indicated the resident required substantial to maximal assistance with toileting hygiene, shower, bathing and lower body dressing. Record review of Resident # 99's care plan dated 08/26/2025 revealed the resident had an ADL self-care performance deficit related to cerebrovascular accident (a medical emergency that occurs when the blood flow to a part of the brain is suddenly interrupted). The care plan interventions stated the resident had been educated on the importance of hand hygiene as needed. The care plan revealed the resident required limited assistance with personal hygiene. Resident # 156. Record review of Resident # 156's admission Record dated 8/27/25 revealed a [AGE] year-old female with an admission date of 09/13/24. Record review of Resident # 156's health and physical dated 09/10/2024 revealed medical diagnoses of anxiety disorder, major depressive disorder, muscle wasting and atrophy, diabetes mellitus (a chronic metabolic disease characterized by elevated levels of blood sugar) and unspecified dementia. Record review of Resident # 156's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. The MDS revealed the resident required substantial to maximal assistance with toileting hygiene, showering and lower body dressing. Record review of Resident # 156's care plan dated 08/26/2025 revealed the resident had an ADL selfcare performance deficit. The care plan revealed interventions from staff to assist the resident with showering and personal hygiene. In an observation and interview with Resident #99 on 08/26/2025 at 10:30 AM, the resident was lying in bed. Resident #99's fingernails were long and dirty. He stated that he did not like to have long fingernails, and that the facility did not allow the residents to have nail clippers in their possession. Resident #99 stated he tried his best to keep his nails clean but without equipment to clean them, it was difficult for him. Resident # 99 stated he had requested the facility to help him trim his fingernails in the past couple of weeks, but they had not gotten back to him. In an observation and interview on 08/26/25 at 10:50 AM Resident #156 was found lying in bed watching TV. Resident #156's fingernails were long and had debris under her nails in both hands. Resident #156 stated she did not wish to have long fingernails and had requested assistance from the staff to trim them when she was assisted to take a shower, but they had not gone back to help her. She stated she needed to wait until she was assisted with toileting or showers to wash her hands and underneath her fingernails. In an interview on 8/28/25 at 1:22 PM with CNA C, she stated it was not acceptable for residents to have long fingernails. CNA C said that if staff found long fingernails on a resident, they were to report it to an RN who would decide whether to trim the fingernails or refer the resident to a podiatrist. CNA C stated that when staff assisted a resident with a shower, they had to report to the RNs of anything abnormal with the resident's skin or physiology, including nail length. CNA C said that the facility did not allow nail clippers to be left with residents as a preventative measure, so they do not harm themselves. CNA C stated that the risk of leaving a resident with their nails long could result in a risk of infections if they ate with their hands and their nails were long and dirty. CNA C explained there was also a risk of residents scratching themselves which could result in skin infections. In an interview on 8/28/25 at (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who are incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #39) of 6 residents reviewed for incontinent care. The facility failed to ensure adequate bladder incontinence absorbent products were provided to address urine leakage and dignity for Resident #39. This deficient practice could place residents at-risk for infection; skin break down and decrease in self-worth due to improper care practices. Findings included: Record review of Resident #39's admission record dated 08/29/2025 revealed a 69 y/o male admitted on [DATE]. Record review of Resident # 39's diagnosis report dated 08/29/2025 revealed diagnosis of cognitive communication deficit and Benign prostatic hyperplasia with lower urinary tract symptoms. Record review of Resident # 39's quarterly MDS dated [DATE]th, 2025, revealed a BIMS of 15 indicating the person was cognitively intact. Section GG functional abilities revealed Resident # 39 needed substantial/ maximal assistance (helper does more than half the effort) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothing before and after voiding or having a bowel movement). Record review of Resident #39's care plan revealed resident was at risk for infections/pressure/venous/ statis ulcers, and skin desensitized to pain or pressure, slow healing process related to diabetes mellitus. He also had a potential for pressure ulcer development related to immobility. Nursing intervention was to follow the facility policy/ procedure/ protocols for the prevention/treatment of skin breakdown. He also had ADL self-care performance deficit related to dementia. Nursing intervention included extensive assistance x1 staff with all his toileting and incontinent care. In an interview on 08/26/2025 at 10:30 a.m., Resident # 39 revealed that he had trouble with the briefs that was being provided to him, he stated they did not fit, and he would have a lot of accidents. He stated that he had gotten urine on the bed sheets and his clothes, he stated that wetting himself made him uncomfortable. He stated that the briefs was small and uncomfortable around the inner thigh area and groin area. He stated that he did not recall telling staff about briefs being too small for him. In an interview on 08/29/2025 at 11:15 a.m., CNA G revealed that late July early August she had mentioned to the central supply coordinator and to ADON that Resident #39 had been found in bed with urinated sheets and clothes due to the brief not fitting properly as he had a long torso and current size brief fit him small. She had mentioned that he would benefit from a larger size. She stated after that, Resident #39 was still provided the same size brief, therefore resident was still being found urinated. In an interview on 08/29/2025 at 11:30 a.m., the central supply coordinator revealed that every morning she rounded and provided residents with their size of brief based off a list that she had listing each resident's size of brief. She stated that each resident was measured by a CNA and their size of brief was documented. She stated that if CNAs voiced to her that resident need a bigger size brief, then resident would be given the bigger size brief. Regarding Resident #39, she stated that she recalled a CNA mentioning to her about two weeks ago, that Resident #39 needed a bigger size brief due to him having a long torso and the brief being too short and it bunching up in inner thigh area. She stated that he was resized to a 2xl, however she stated that she sometimes provided the correct size and sometimes she does not and did not give a reason as to why. She stated that by not providing the right sized briefs the resident was at risk for cuts, rashes and skin breakdown. She stated that she was responsible for providing the rightsized briefs to each resident. In an interview on 08/29/2025 at 1:30 p.m., the ADON revealed that it was reported to her that Resident #39 needed a larger sized brief. She stated that she and the CNA that did weights and sizing, resized Resident #39 on 08/05/2025. She stated that he now uses a 2 extra Large. She stated that residents had the right to request the size they want even after being fitted. She stated that providing residents with the wrong sized brief could cause them to have skin break (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	down, and she stated that it was a dignity issue as well. She stated that CNA staff and nurses were responsible to communicating any changes to brief sizes to central supply coordinator and she was responsible for providing the correct sized briefs to the residents. In an interview on 08/29/2025 at 2:00 p.m., the Administrator revealed that central supply coordinator was responsible for ordering and distributing briefs to each resident. He stated that she has a list of resident sizes that she follows and that was how she knew which size to provide for the resident. He stated that he did not know about Resident #39 having an issue with the briefs. He stated that he did not see an issue with providing the wrong sized briefs to residents, especially if it was a larger size. He stated that residents needed to be changed in a timely manner to prevent any skin breakdown from happening. He stated that there were a lot of residents requesting an extra-large brief and therefore sizing was done as an intervention to help each resident know their correct size of brief and make ordering briefs easier for central supply coordinator. Per facility administrator, there was no policy on each resident receiving supplies for ADLs.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, interviews, and record reviews the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 of the facility's laundry department reviewed for patient care equipment in safe operating condition. -The facility failed to maintain 1 of 3 washers in operating condition. The failure could place residents at risk for harm by the facility's inability to provide clean sanitary linens and could place residents at risk for poor hygiene and health. Findings include: During an observation on 08/28/25 at 1:30 PM, of the facility's laundry department revealed 1 commercial washer that was not operational. During an interview on 08/28/25 at 1:32 PM with the Housekeeping Supervisor revealed that the washer had been out of service for a year now. She stated that it broke down when the other company had ownership of the facility. She stated that when the new company took over, the parts for the washer were ordered. She stated that she believed that the parts for the washer were already received by the facility. She stated that since they had two working washers, the broken one did not affect residents receiving their laundry back, therefore she did not see the risk of affecting resident. During an interview on 08/28/25 at 2:00pm with Resident #41 revealed that she had not had any delays with getting her laundry back. During an interview on 08/28/25 at 2:10 pm with Resident #42 revealed that she had not had any delays with getting her laundry back. During an interview on 08/29/25 at 1:00 pm with the Maintenance Director, revealed that the washer had been broken for a year. He stated that before the new company took over, he had asked for the washer to be fixed, however it was never granted. When the new company took over, he asked for the washer to be fixed, and he was able to order the new parts for the washer. He stated that the new parts for the washer were received about a month ago, but it had not been fixed because since there were two other washers, the third washer was not a priority and there was no excuse for that washer to still be out of service. He stated that to his knowledge, that had not delayed residents receiving their laundry back. He stated that he was the one who was responsible for ensuring the washer was in working condition. During an interview on 08/28/25 at 3:00 pm with the Administrator revealed, the washer had not been working since February 2025. He stated that they were waiting for installation. He could not confirm if the facility had received all the parts needed to fix the washer but stated that the facility would need to hire the right person to fix it as this was outside the scope of the Maintenance Director. He stated that the broken washer was mostly used to wash residents' individual clothes and napkins from the kitchen. He stated that he did not see a problem with two of the three washers being in a working condition because this had not caused a delay in residents receiving their clothes back. On 8/29/2025 at 10:30am, the Administrator stated that there was no policy regarding essential equipment.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the prompt resolution of all grievances to include providing a written summary of investigation to resident or resident representative filing the grievance for 1 (Resident #114) of 6 residents reviewed for resident rights. -The facility failed to provide a written summary of the investigation to resident or resident representative who filed the grievance as per facility policy for Resident #114. - The facility Administrator failed to follow up on grievances related to misappropriation of personal property for Resident # 114.This failure could place residents at risk of not receiving resolutions to their grievances. Findings included: Record review of Resident #114's face sheet dated 08/29/2025 revealed a 77 y/o female admitted on [DATE]. Record review of Resident #114's history and physical dated 07/23/2025 revealed Resident #114 with a diagnosis of dementia. Record review of Resident #114's quarterly MDS assessment dated [DATE] revealed a BIMS score of 02 meaning severe cognitive impairment. In an interview on 08/27/2025 at 11:30 a.m., Resident # 144's responsible party, she stated that she let facility social worker know when Resident #144's phone went missing. She filed a grievance form on 07/25/25 concerning this matter. She stated that she was advised to file a police report by the social worker. She stated that she had also asked the social worker to speak to the facility administrator, and he had yet to follow up with her, from 08/01 to present. She stated that she was frustrated due to the lack of communication on following up with her on filed grievance. She stated that she had not received any type of documentation regarding the investigation done on part of the facility regarding lost phone. Record review of Grievance report on 08/28/2025 dated 07/25/2025 revealed that the grievance form was completed by facility social worker and grievance was reported and reviewed by facility administrator that same day on 07/25/2025 per his signature. Resolution of grievance section was left blank, not noting whether resolution was reached or not. In an interview on 08/29/2025 at 10:15 a.m., the social worker said that she assisted with reviewing grievances and providing recommendations as the facility grievance officer. She stated that when a grievance was filed, she discussed with the team to include the DON and administrator to reach a solution regarding each grievance. She stated that she then talked to the family or resident to let them know what the conclusion was. She stated that if the person who filed a grievance was not happy with the outcome there was other available solutions such as offering a care plan meeting with the care team to be able to address concerns. She stated that typically resolutions were documented on grievance form along with the investigation that was done by the facility. Social worker stated that the resolution of grievance section of Resident #144's grievance form was left blank because, resident representative did not provide follow up on missing phone location as she was instructed by local Police Department and because resident representative had stopped speaking to facility social worker making it difficult to establish contact. She stated that she did not provide a written summary of findings/ resolutions to resident representative because she did not ask for it. She stated that she was not sure that as per facility policy she had to provide a written summary of findings or interventions taken by the facility to correct issues. She stated that she did not provide a written summary of findings and actions taken to person filing grievance unless they directly asked for it. In an interview on 08/29/2025 at 3:30 p.m., the Administrator said that he was made aware of this grievance on 08/26/2025 although he acknowledged signing the grievance form on 07/25/2025 and stated that he did not pay attention to what the grievance was about when he signed it. He stated that today he saw an email that was sent from Resident #144's representative on 08/26/2025 and replied to that email today 08/29/2025. He stated that typically he communicated with the social worker regarding following up on grievances but overlooked this grievance and stated that facility did not follow policy and procedure regarding grievances. He stated that social worker let him know that she provided guidance to resident (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Avir at Patriot		STREET ADDRESS, CITY, STATE, ZIP CODE 11490 Gateway North Blvd El Paso, TX 79934	
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative on steps to take to correct concern. He stated that he was not sure that a written summary of findings/investigation actions was supposed to be provided to the person filing grievance. He stated that by not following up with grievances filed, a resident and any person filing a grievance could be affected by developing lack of trust, and fear of filing a grievance due to it not being followed up promptly and not knowing the outcome of the grievance. Review of grievances/complaints, filing policy and procedure revised 04/2017 read in part . The resident, or person filling the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 (Resident #131) of 6 residents reviewed for oxygen use. The facility failed to maintain Resident #131's oxygen concentrator filter free from lint and dust. This deficient practice could place residents who receive continuous oxygen at risk for not having their air properly filtered. Findings Include: Record Review of Resident #131's face sheet dated 08/27/25 revealed a [AGE] year-old female with admission date 08/12/25. Record review of Resident #131's Nursing Home PPS (Prospective Payment System) MDS dated [DATE] revealed a BIMS score of 14, which indicated the resident was cognitively intact. Record review of Resident #131's history and physical dated 08/21/25 revealed a medical history which included: Hypertension (high blood pressure), Chronic Pain, impaired mobility and cognition. Record review of Resident #131's care plan revealed the resident received oxygen via nasal cannula (a flexible tubing with two prongs that fit into a patient's nostrils and provides continuous oxygen from an oxygen source such as a tank or concentrator). The interventions noted included for staff to keep room cool and free of irritants (smoke, dust, cleaning agents). Observation on 08/26/25 at 2:22 PM of Resident #131 in her room, revealed the resident was lying in her bed with oxygen on via nasal cannula at 4 liters per minute. The oxygen concentrator air filter was observed with dust and lint. During an interview on 08/29/25 at 10:47 AM with CNA G, she stated Sunday night shift nursing staff were responsible for cleaning the oxygen concentrator filters. She stated cleaning the oxygen concentrator filters could be completed as needed if observed dirty, including day shift nursing staff. She stated the nurses were responsible for monitoring the CNAs to ensure they completed tasks such as cleaning the oxygen concentrator filters. CNA G stated the risks of dirty oxygen filters included bacteria and potential illness to residents. In an interview on 08/29/25 at 11:36 AM with LVN F, she stated the Sunday night shift nursing staff were responsible for cleaning oxygen filter concentrators. She stated Central Supply was also responsible for the supplies including clean oxygen filters. She stated the risks of dust on oxygen filters included residents potentially being exposed to infections. In an interview on 08/29/25 at 12:13 PM with Central Supply, she stated night shift CNAs cleaned residents' oxygen concentrator filters. She stated she was not aware who was responsible for monitoring oxygen filters. She stated the risks of dirty oxygen concentrator filters included residents catching an infection. In an interview on 08/29/25 at 03:59 PM with the ADON, she stated all nurses were responsible for monitoring oxygen concentrators and their filters. She stated the ADONs and the DON were responsible for monitoring staff and residents which included residents' oxygen concentrators. She stated the risks of dusty oxygen concentrator filters for residents included infection or illness. In an interview on 08/29/25 at 4:25 PM with the DON, she stated the nurses on Sunday night shifts were responsible for cleaning oxygen concentrator filters. She stated oxygen concentrator filters were to be clean. She stated supervisors from different departments were assigned different residents which they round on daily throughout the week. She stated the residents' needs, and their environment was assessed including the oxygen concentrators. She stated the risks of dirty oxygen concentrators included bacteria and infections for residents who utilize oxygen. Record Review of the Patient Manual provided by the facility titled, Millenium M10: Respironics revealed in part: Maintenance: Cleaning and Changing the Air Inlet Filter- Cleaning the air inlet filter is the most important maintenance activity that you will perform and should be done at least once a week.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and immediately after glove removal. Use an alcohol-based hand rub containing 60% alcohol for most clinical situations: Single-use disposable gloves should be used; before aseptic procedures; when anticipating contact with blood or body fluids; The use of gloves does not replace handwashing/hand hygiene. Record review of the facility's policy titled Monitoring compliance with infection control dated 08/2019 indicated in part: Routine monitoring and surveillance of the workplace are conducted to determine compliance with the infection prevention and control policies and practices. The infection preventionist or designee monitors the compliance and effectiveness of our infection prevention and control policies and practices. Monitoring includes regular surveillance of adherence to hand hygiene practices and availability of hand hygiene supplies and the availability of personal protective equipment and its appropriate use.		