STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745038	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Tierra Este	14300 Pebble Hills Blvd El Paso, TX 79938

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 interview and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infection and to restore continence to the extent possible for one of (Resident #1) six residents reviewed for catheter care.- The facility failed to ensure LVN A appropriately monitored and assessed Resident #1 following catheter removal, responded timely to repeated reports of urinary retention, and ensured proper catheter reinsertion resulting in prolonged urinary obstruction, traumatic catheterization, septic shock, hemodynamic instability, and ICU hospitalization.- The facility failed to ensure LVN K removed Resident #1's catheter on 03/20/26 during the day shift when Bladder Training was completed according to physician's orders.- The facility failed to ensure Licensed staff monitored Resident #1's urinary output for 24 hours when LVN A removed the catheter 03/23/26.The visit was re-opened after Enforcement Review on 05/16/26 at 8:14 a.m.An immediate jeopardy situation was identified on 05/16/26. The Immediate Jeopardy template was provided to the facility on [DATE] at 4:12 p.m. While the Immediate Jeopardy was removed on 05/18/26, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for minimum harm, due to the facility's need to evaluate the effectiveness of their corrective systems.This failure could place residents at risk of delayed treatment/intervention, decline in health and/or risk of death.Findings included: Closed Record review of the Face Sheet dated 04/27/26 for Resident #1 revealed admission Date was 03/09/26 and was discharged to acute care hospital on [DATE] at 10:03 p.m.Review of Hospital transfer admission paperwork sent to the facility prior to admission on [DATE] revealed a Consult Note dated 02/26/26 for Resident #1 revealed, Chief Complaint: Patient has lingering pain to his right flank/hip area. Pain is exacerbated with movement. Reason for Consultation: Acute urinary retention. Patient presented to emergency room for right flank pain and low blood pressure. Urology was consulted due to acute urinary retention. Computed Tomography abdomen does note distended urinary bladder with mild bilateral ureteral and renal pelvic prominence. Upon examination patient does have indwelling catheter draining yellow-colored urine with trace of blood. Assessment and Plan: Bladder outlet obstruction. Acute urinary retention, Gross hematuria (visible blood in the urine) Plan: Keep indwelling Foley catheter in place. Patient will need to discharge home with indwelling Foley catheter due to large initial urinary output.Review of Hospital Patient Depart Summary dated 03/09/26 at 8:13 p.m. for Resident #1 revealed, follow-up with Urologist within 10-14 days.Review of History & Physical dated 03/10/26 written by attending physician for Resident #1 revealed [AGE] year-old male with past medical history of, anxiety (a feeling of fear, dread, unease, or worry, often accompanied by physical symptoms like a rapid heartbeat or tension) , PTSD (a mental health condition triggered by experiencing or witnessed a terrifying, life threating or traumatic event), and right flank pain. Physical Exam: Genitourinary: Non-distended bladder. Summary of Findings: Anxiety, Abdominal Pain. Plan: Psych consult if worsening symptoms. The History and Physical did not document resident had a history of Obstructive and Reflux Uropathy (is a blockage preventing urine from leaving. It can lead to infection, high blood pressure and permanent scarring if not treated. Reflux (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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Uropathy is urine flowing backward from the bladder to the kidneys) or Acute Kidney FailureThe sudden loss of kidney function typically occurs within hours or days. It causes a rapid buildup of waste products and toxins in the blood and disrupts fluid/electrolyte balance).Review of the Physician Progress Note dated 03/24/26 at 7:39 p.m. written by the physician after Resident #1 had been sent to the hospital via EMS at 5:36 p.m. revealed, Reason for Visit: Follow up and no urine output. History: This is a [AGE] year-old male with a past medical history significant for anxiety, PTSD (a mental condition triggered by experiencing or witnessing a terrifying, shocking, or dangerous event). Current Status: Patient with no urine output following foley catheter removal. Noted abdominal distention, though patient denied discomfort or pain. Foley catheter was reinserted due to failure to void. Upon insertion, no urine output was obtained; a blood clot was noted in the catheter upon removal nursing staff were instructed to reinsert the foley and irrigate with normal saline. Following reinsertion and irrigation, there was still no urine output. A STAT bladder ultrasound was ordered, which demonstrated approximately 1500 ml urinary retention and evidence of left-sided hydronephrosis (the swelling of the kidney caused by a backup of urine). Due to persistent obstruction despite catheter reinsertion and irrigation, and significant retention with upper tract involvement, the patient was transferred to the ER for urgent urologic evaluation and definitive Foley placement. Date of Service: 3/24/26.Review of Hospital paperwork dated 3/25/26 for Resident #1 revealed, Chief Complaint: Patient coming from long term care facility for frank bloodn urine from foley exchange yesterday. Per family, patient had a Foley catheter exchange yesterday and now has approximately 100 cc of frank blood in the foley bag. Presented with markedly distended bladder and non-draining Foley. History of Present Illness: prior urinary retention (inability to completely empty the bladder, or in some cases, to pass urine at all)/bladder outlet obstruction (is a partial or complete blockage at the base of the bladder that slows or stops urine from exiting the body), and chronic anticoagulation (taking blood thinner medication on a long-term basis to prevent dangerous blood clots from forming or getting larger) presents from nursing facility with urinary retention, gross hematuria (blood in the urine that is visible to the naked eye), and shock (the body's severe, toxic overreaction to an infection). Resident was recently hospitalized from [DATE] to 03/09/26 for urinary retention/bladder outlet obstruction. He now presents from nursing facility after a traumatic foley catheter that was not draining, with markedly distended bladder and gross hematuria. On arrival he was noted to be tachycardic (an abnormal fast resting heart rate), tachypneic (rapid and shallow breathing), and in increased respiratory distress/work of breathing, which improved after Foley exchange and bladder decompression. Approximately 45 minutes prior to arrival, pt. became increasingly lethargic (having absolutely zero energy, feeling incredibly sluggish, and being unable or unwilling to move or do anything). Diagnoses: Septic Shock due to Acute UTI (a sudden bacterial infection in the urinary system), Acute blood loss anemia (a sudden and dangerous drop in red blood cells caused by rapid bleeding) transfuse supportively as needed. Bladder outlet obstruction, Gross hematuria. Admit to ICU in critical but stable condition with urology consultation.Review of admission MDS dated [DATE] for Resident #1 revealed Entry Date: 03/09/26 admitted from acute care hospital; Clear speech makes self-understood and understand others. BIMS Score 15 (Cognitively intact). Indwelling catheter. Active Diagnoses: Anxiety Disorder (mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations), Renal Failure (is when the kidneys stop working properly, are unable to filter waste, remove excessive fluid, and balance chemicals in the blood), Obstructive Uropathy. High Risk Medications: Antianxiety, antidepressant, anticoagulant.Review of the Care Plan dated 03/10/26 for Resident #1 revealed Resident had an indwelling catheter r/t obstructive and reflux uropathy. Interventions: Catheter as ordered. Monitor and document intake and output as per facility policy. Monitor for signs and symptoms of discomfort on urination and frequency. Monitor for pain and discomfort due to catheter. Monitor/record/report to MD signs and symptoms of UTI, pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	status, change in behavior, and change in eating pattern.Review of Care Plan Conference dated 03/17/26 at 12:00 p.m. for Resident #1 revealed, Attendance at Meeting: RN, SW, Therapy, Resident Representative/Family, and Activities. Meeting Type: New Resident Conference. Diagnoses: Obstructive and Reflux Uropathy, Acute Renal Failure. ADON discussed with spouse about the foley catheter and being seen by Urologist. Family: Agreed. Signed by: Social Worker.Review of Physician Order Summary dated 04/30/26 provided by DON, for Resident #1 revealed Diagnoses: Obstructive and Reflux Uropathy, Acute Renal Failure. Document urinary output every shift.Review of Physician Telephone Order 03/17/26 for Resident #1 Date: 03/17/26 written by LVN A revealed OKAY TO START BLADDER TRAINING x 3 DAYS, THEN DC FOLEY AFTER four times a day for BLADDER TRAINING for 3 Days AND four times a day for Bladder Training for 3 Days.Review of 24-Hour Report Sheets revealed:-03/17/26 revealed 6am-2pm LVN A documented Resident #1 start bladder 3 days.-03/17/26 revealed 2pm -10pm LVN K documented start bladder training.Review of Nurse Medication admission Record dated March 2026 for Resident #1 revealed;-Okay to start Bladder Training x 3 days, then DC foley after four times a day for Bladder Training for 3 days. Start Date: 03/17/26 at 4:00 p.m. by LVN K. Clamp at 4:00 p.m., 10:00 a.m., 4:00 p.m. and 10:00 p.m. MAR documented Bladder Training was completed on 03/20/26 at 10:00 a.m. by LVN K.Review of Nurse Treatment Administration Record dated March 2026 for Resident #1 revealed output every shift:-03/23/26 at 6:00 a.m. - 2:00 p.m. shift 500 cc-03/23/26 at 2:00 p.m. - 10:00 p.m. shift n-03/23/26 at 10:00 p.m. -6:00 a.m. shift void x1-03/24/26 on the 6-2 shift was left blank by LVN A.Review of NTAR dated March 2026 for Resident #1 revealed Pain Assessment to be completed every shift:-03/24/26 on Day Shift LVN A documented no pain.Review of Medication Record dated March 2026 for Resident #1 revealed:-Start Date: 03/12/26 Tramadol HCL Oral Tablet 50 mg give 1 tablet by mouth every 8 hours as needed for pain.-03/24/26 Pain level 8 administered Tramadol HCL Oral Tablet 50 mg give 1 tablet by mouth administered by LVN T.Review of IDT Note dated 03/23/26 at 1:15 p.m. written by ADON F for Resident #1 revealed Urinary catheter intact.Review IDT Note dated 03/23/26 at 1:50 p.m. written by LVN A for Resident #1 revealed Late Entry: As per ordered, residents foley discontinued, resident tolerated procedure well, oncoming nurse informed to monitor urine output, resident calm, 0 c/o pain, will continue to monitor.Review IDT Note dated 03/24/26 at 6:00 a.m. written by LVN T for Resident #1 revealed Pt. voided x 1 wet brief.Review IDT Note dated 03/24/26 at 1:00 p.m. written by LVN A for Resident #1 revealed unable to urinate throughout shift and abdomen distended, informed NP, new order to reinsert foley, foley reinserted without any difficulties, observed no urine output with minimal blood output, resident's abdomen still distended. NP alerted, new order to flush foley with NS and for STAT ultrasound of bladder and abdomen, orders carried out, pending ultrasound to be done, oncoming nurse informed, resident calm, resting in bed, RP informed of new orders.Review of SBAR dated 03/24/26 at 1:30 p.m. written by ADON F for Resident #1 revealed Situation: Change in Condition: Abdominal pain. Diagnoses: Obstructive and Reflux Uropathy, Acute Renal Failure. New order for foley catheter and bladder ultrasound. Abdominal pain, distended abdomen. Does the resident have pain? Yes. Resident is on anticoagulant other than warfarin: No [sic].Review of IDT Note dated 03/24/26 at 4:43 p.m. written by LVN K for Resident #1 revealed, reported feeling nauseous and anxious. MD notified, new order for Zofran and a one-time dose of Xanax.Review of IDT Note dated 03/24/26 at 4:50 p.m. written by LVN K for Resident #1 revealed, vomited, so I gave another Xanax to help with his anxiety. ADON/MD.Review of IDT Note dated 03/24/26 at 5:02 p.m. written by LVN K for Resident #1 revealed, MD/NP was notified of abnormal ultrasound findings by staff. The resident reported abdominal pain, Blood noted in the foley. Ultrasound staff noted no Foley catheter was present and urine retention of 1500. new order was issued to send the resident to the hospital for evaluation and foley placement. 911 was called, and final ultrasound results are still pending.Review of the Radiology report dated 03/24/26 Ultrasound of Bladder for Resident #1 revealed, pre-void volume 1586 cc. No foley catheter identified in the bladder on today's study. Impression: Suspect urinary retention (a condition in which a person is unable to (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	empty all the urine from the bladder), 1586 cc in bladder. A Foley catheter is not identified in the bladder on today's exam.Review of the Radiology report dated 03/24/26 Ultrasound of Abdomen for Resident #1 revealed, Impression: Moderate right-sided hydronephrosis (the swelling of one or both kidneys caused by a buildup or urine that cannot drain properly into the bladder).Review of IDT Note dated 03/24/26 at 5:23 p.m. written by LVN K documented Paramedics, arrived at the resident's room, and transported him to the hospital at 5:45 p.m. The family member was present, the Resident #1's Family Member was informed, and the ADON was made aware.Review of the EMS Care Report dated 03/24/26 for Resident #1 revealed, Symptoms Onset Date & Time: 03/24/26 at 5:23 p.m. Chief Complaint: Hematuria (having blood in the urine, originating from any part of the urinary tract, kidneys, bladder or urethra. It is a sign of an underlying issue, such as an infection, kidney stones, or injury) and Pain. Primary Symptom: Hemorrhage and pain. Medical History: Chronic Kidney Disease. Medications: Apixaban (an oral anticoagulant - blood thinner). Arrived at Patient: 5:23 p.m. Vital signs: B/P 70/42, heart rate 145, SpO2 83, respirations 18. Position: Sitting, opens eyes, alert, obeys commands. Exam/Assessment: Bleeding-Urethral Pain. Abdomen normal pain. Narrative: EMS responded to a long-term care facility. For a [AGE] year-old male presenting with gross hematuria noted within the urinary catheter collection bag. Upon arrival, the patient was conscious and alert, oriented to person place an event. The family member provided collateral history. Family member reported that an indwelling Foley catheter had been removed the previous day and replaced earlier that morning, noting that the procedure appeared to have been performed with excessive force, likely resulting in urethral trauma. Family Member further disclosed that the patient had an active prescription for an anticoagulant therapy, increasing concern for significant hemorrhage. The patient verbalized complaint of acute genital and lower abdominal pain. The patient continued to report severe, unrelenting pain and requested analgesic. Analgesic was administered per protocol. However, the patient continued to report inadequate pain relief. The patient was transported emergently to local hospital. Arrived at the emergency room at 5:43 p.m.Review of the facility's Provider Investigation Report dated 04/10/26 for Resident #1 completed by the facility's Administrator for an allegation of Resident Neglect revealed:-Review of email sent to facility's Marketer on 04/07/26 at 10:24 a.m. from Resident #1's family member attached to the Provider Investigation Report revealed, I am writing this letter because I know by now you are aware of the very traumatic and negligent incident that took place on March 24, 2026. I have not heard from you or anyone representing the facility. On March 24th [Resident #1] had been having problems urinating and he was getting very bloated. On this day, [LVN A] came into the room and proceeded to remove the foley catheter. The family member said they did not know where LVN A got the order to do that. When he did that, Resident #1 started bleeding from the tip. LVN A called the doctor and was instructed to re-insert the foley and order an ultrasound. LVN A was having problems re-inserting the foley and even commented that he was not even supposed to remove the foley in the first place. He kept re-inserting and forcing the foley in and causing bleeding. Another family member arrived and noted Resident #1 was bleeding, in severe pain, and vomiting. The family asked the nurse to call an ambulance and was immediately sent to the hospital ER. They immediately treated him and his pulse was 153 and his blood pressure was dropping. The resident was diagnosed with Traumatic Foley Insertion, Hematuria, Acute Sepsis, Acute UTI, and Anemia which required blood transfusion.-Review of a written statement written by CNA B in Spanish dated 04/08/26 translated by state surveyor, was attached to the Provider investigation report revealed, she was assigned to Resident #1 in the 300 Hall on 03/24/26 and the nurse was LVN A. During the day shift Resident #1 had no episode of incontinence, and she communicated this to LVN A throughout course of the day. Resident #1 said he felt the sensation to urinate but was unable to do so. I checked the brief on three occasions and he was dry. At 1:30 p.m. later, before the last round before the end of the shift, [LVN A] and I entered the room, and he inserted the urinary catheter.-Review of written statement written by ADON LVN Fated 03/25/26 attached to the Provider's Investigation Report revealed, on 03/24/26 LVN A called requesting assistance after receiving an order for Foley catheter (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	removed on 3/23/26 by LVN A as ordered by the NP. She said that she did not know if the nurses had monitored the resident's output x 24 hours according to physician's orders. She said she was in the room on 03/24/26 when LVN A had re-inserted the foley catheter and noted multiple beads of blood on the meatus (the external opening of the urethra (a tube that carries urine from the bladder out of the body). She said, He stopped and placed a call to the NP and was given a new order for an Ultrasound of the bladder, check if the foley was in place and to flush the foley catheter with normal saline. She said that she was not present when LVN A had irrigated the foley catheter.During an interview on 04/27/26 at 4:18 p.m., the DON said that she was not aware that CNA B had reported to LVN A four times during the day shift on 03/24/26 that Resident #1 had not voided since 6:30 a.m. and was complaining of abdominal pain and of being unable to urinate. She said that LVN A should have immediately assessed Resident #1 and notified the physician and/or NP. She said LVN A was responsible for checking if Resident #1 had not voided after the foley catheter was removed. She said the nurses made rounds every two hours and should check and assess the residents as needed. The DON informed the state surveyor that their corporate staff had said that they did not have a policy and procedure on Bladder Training with Foley Catheter. The DON said she had not found any documentation on Bladder Training with a foley catheter that had been completed for the licensed staff. She said, I checked everywhere and did not find any training for the nurses on Bladder Training.During a telephone interview on 04/27/26 at 3:48 p.m., family member said Resident #1 had not voided throughout the morning on 03/24/26 and was complaining of abdominal pain and kept saying that he felt like urinating and was unable to urinate. She said LVN A had inserted the foley catheter on 03/24/26 and there was no urine return. The family member said Resident was sent to the emergency room at the family's request and were informed that the resident had had a traumatic foley insertion and had a large amount of urine in his bladder. The family member reported that the resident had hemorrhaged and was given blood transfusions. The family member said the Resident #1 was admitted to ICU and was in critical condition. The family member said Resident #1 had been discharged from the hospital and was at home and receiving Home Health Services. During an interview on 04/27/26 at 4:00 p.m. with the DON in the presence of the Administrator, it was revealed that she had confirmed with the facility's corporate staff that the only policy they had was on Catheter Care, Urinary revised in July 2024 and that they did not have a policy and procedure on Bladder Training with foley catheter.During a telephone interview on 4/27/26 at 4:45 p.m. with NP G she said she could not remember when the bladder training had been completed for Resident #1. She said an order was given for Bladder Training on 03/17/26 x 3 days and to discontinue the foley catheter after the Bladder Training was completed, and to monitor the resident's output x 24 hours for urine retention. She said LVN A had sent her a text message on 03/24/26 at 12:08 p.m. to report Resident #1's foley catheter had been removed on 03/23/26 in the afternoon and Resident #1 had not voided during his shift on 03/24/26. She said she replied to his message and gave an order to insert the foley catheter back. She said she was aware that Resident #1 had a history of urinary retention and the foley should not have been removed on 03/23/26 if the resident was having urinary retention. She said LVN A had reported to her that there was a little bit of blood noted when catheter was inserted and she gave an order to flush the catheter and gave an order for an ultrasound of the bladder and the abdomen on that day. She said the ultrasound revealed Resident #1 was retaining a lot of urine. She said that if the catheter was not in the bladder, there would be no urine return and if there was an obstruction, the nurse needed to remove the catheter and try again, and if the second attempt was unsuccessful, LVN A needed to notify the physician/NP right away. She said, I don't know what happened on that day. She said that the potential complication of urinary retention could cause the bladder to rupture and the resident would need to have a permanent suprapubic (is a soft tube placed directly into the bladder through a small opening in the lower abdomen, just above the pubic bone) She said she could not remember if the family member had approached her and asked to discontinue the foley catheter. She said she was not aware that the resident had an order to be seen by the urologist within 10-14 days when discharged

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	745038	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Tierra Este	14300 Pebble Hills Blvd El Paso, TX 79938

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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 maintain clinical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices, for 1 of 6 residents (Residents #1) reviewed for medical records.- The facility failed to ensure LVN A documented in Resident #1's electronic clinical record on 3/24/26 when he assessed the resident for urinary retention and signs and symptoms of urinary tract infection throughout the morning shift.- The facility failed to ensure LVN A documented in Resident #1's electronic clinical record on 3/24/26 when he completed the bladder irrigation.These failures place residents at risk of having incomplete and accurate clinical records.Findings included:Closed Record review of the Face Sheet dated 04/27/26 for Resident #1 revealed an admission date of 03/09/26 and discharged date to acute care hospital on [DATE] at 10:03 p.m.Review of History & Physical dated 03/10/26 written by attending physician for Resident #1 revealed [AGE] year-old male with past medical history of, anxiety (a feeling of fear, dread, unease, or worry, often accompanied by physical symptoms like a rapid heartbeat or tension) , PTSD (a mental health condition triggered by experiencing or witnessed a terrifying, life threating or traumatic event), and right flank pain. Physical Exam: Genitourinary: Non-distended bladder. Summary of Findings: Anxiety, Abdominal Pain. Plan: Psych consult if worsening symptoms. The H&P did not document resident had a history or Obstructive and Reflux Uropathy (is a blockage preventing urine from leaving. It can lead to infection, high blood pressure and permanent scaring if not treated. Reflux Uropathy is urine flowing backward from the bladder to the kidneys), Acute Kidney Failure (The sudden loss of kidney function, typically occurring within hours or days. It causes a rapid buildup of waste products and toxins in the blood and disrupts fluid/electrolyte balance).Review of the Physician Progress Note dated 03/24/26 at 7:39 p.m. written by the physician after Resident #1 had been sent to the hospital via EMS at 5:36 p.m. revealed, Reason for Visit: Follow up and no urine output. History: This is a [AGE] year-old male with a past medical history significant for anxiety, PTSD. Current Status: Patient with no urine output following foley catheter removal. Noted abdominal distention, though patient denied discomfort or pain. Foley catheter was reinserted due to failure to void. Upon insertion, no urine output was obtained; a blood clot was noted in the catheter upon removal nursing staff were instructed to reinsert the foley and irrigate with normal saline. Following reinsertion and irrigation, there was still no urine output. A STAT bladder ultrasound was ordered, which demonstrated approximately 1500 ml urinary retention and evidence of left-sided hydronephrosis (the swelling of the kidney caused by a backup of urine). Due to persistent obstruction despite catheter reinsertion and irrigation, and significant retention with upper tract involvement, the patient was transferred to the ER for urgent urologic evaluation and definitive Foley placement. Date of Service: 3/24/26.Review of Hospital paperwork dated 3/25/26 for Resident #1 revealed, Chief Complaint: Patient coming from long term care facility for frank blood in urine from foley exchange yesterday. Per family, pt. had a Foley catheter exchange yesterday and now has approximately 100 cc of frank blood in the foley bag. Presented with markedly distended bladder and non-draining Foley. History of Present Illness: prior urinary retention(inability to completely empty the bladder, or in some cases, to pass urine at all)/bladder outlet obstruction (is a partial or complete blockage at the base of the bladder that slows or stops urine from exiting the body), and chronic anticoagulation (taking blood thinner medication on a long-term basis to prevent dangerous blood clots from forming or getting larger) presents from nursing facility with urinary retention, gross hematuria (blood in the urine that is visible to the naked eye), and shock (the body's severe, toxic overreaction to an infection). Resident was recently hospitalized from [DATE] to 03/09/26 urinary retention/bladder outlet obstruction. He now presents from nursing facility after a traumatic foley catheter that was not draining, with markedly distended bladder and gross hematuria. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered per protocol. However, the patient continued to report inadequate pain relief. The patient was transported emergently to local hospital. Arrived at the emergency room at 5:43 p.m.During an interview on 04/27/26 at 9:57 a.m., LVN A said he had checked Resident #1, one to three times during his shift on 03/24/26 and he had not assessed and/or asked the resident if he had voided. He said Resident #1 had not voiced any concerns to him on that day. He said he had not documented in the resident's clinical record when he had checked the resident during his shift. He said it was very important to assess the resident after the removal of the foley catheter to check if the resident had voided, because if the resident had not voided, that would be very concerning because the bladder could rupture if it got too full of urine. He said he had reported to CNA B on 3/24/26 at approximately 7:00 a.m. that the foley catheter had been removed and to let him know if Resident #1 was not urinating. He said that the CNAs made rounds every two hours and that he remembered CNA B had only reported to him on that day at approximately 1:00 p.m. that Resident #1 had not urinated. He said the CNAs had been trained to immediately report changes of condition to the nurses. He said, I did not check Resident #1 during my shift on that day to see if he was urinating, I just took the CNA's words for it. He said that after CNA B had reported to him that the Resident #1 had not voided, he went to assess the resident and noted that the resident had abdominal distention, and he had called the NP to get orders to re-insert the foley catheter. He said that when he had reinserted the foley catheter there was no urine return. He said a family member, ADON F and CNA B were in the room when he had inserted the foley catheter. He said he had notified the NP there was no urine return when he had inserted the urinary catheter and gave an order to flush the urinary catheter with normal saline and ordered a stat ultrasound of the abdomen and bladder to verify the placement of the urinary catheter. He said he had informed the DON of the situation on that day. He said that he had assessed Resident #1 and he was not having any symptoms of infection, no bloody or cloudy urine, no complaints of burning with urination, and the resident had not voiced to him any concerns about not being able to void. He said he had not documented his assessment in the resident's electronic clinical record or when the ultrasounds of the bladder and abdomen were completed and that ultrasound results were still pending at the end of his shift. He said he was provided with 1:1 training on 4/07/26 by the DON on Foley insertion/Foley care. He said the licensed staff had been trained to document assessments in the resident's electronic record.During an interview on 04/27/26 at 10:49 a.m., CNA B said she was assigned to Resident #1 on 3/24/26 during the 6:00 a.m. - 2:00 p.m. shift and remembered that the resident did not have a foley catheter on that day at the start of shift. She said that the nurses do not give report to the CNAs unless it is something major, such as when a resident is at risk for falls. She said the CNAs get report from the night CNAs at the change of shift. She said, I remember that the night CNA reported to me on 03/24/26 at 6:00 a.m. at the change of shift that Resident #1 had a quiet night, but I do not remember if she told me if the resident had urinated during the night shift. She said she made rounds every two hours and that she remembered she had reported to LVN A on 3/24/26 at 6:30 a.m., 9:30 a.m., 11:30 a.m. and at 1:00 p.m. that the resident had not voided throughout the shift on that day and was complaining that he felt like urinating and the urine would not come out. She said LVN A had said, ok let me talk to my ADON. She said the CNAs had been trained to immediately report any changes in condition to the nurses, because failure to report could worsen the resident's condition. She said she also remembered Resident #1's Family Member was in the room on that day when she had entered the resident's room at 1:00 p.m. to check if the resident's brief to needed to be changed and to apply the moisture barrier on the resident's buttocks at which time she noted the resident's brief was clean and dry. She said she had immediately reported this to LVN A, and he had said that he needed to insert a foley catheter. She said LVN A had re-inserted the foley catheter on 3/24/26 at approximately 1:00 to 1:30 p.m. and asked her to let him know if the resident was not urinating. She said a family member, ADON LVN F and her were in the room when LVN A inserted the foley catheter and no urine came out. She said LVN A had also irrigated the catheter and no urine came out. She said the resident continued to complain of having abdominal discomfort and kept (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saying that he could not urinate.During a telephone interview on 4/27/26 at 4:45 p.m., NP G said she could not remember when the bladder training had been completed for Resident #1. She said an order was given for Bladder Training on 03/17/26 x 3 days and to discontinue the foley catheter after the Bladder Training was completed, and to monitor the resident's output x 24 hours for urine retention. She said LVN A had sent her a text message on 03/24/26 at 12:08 p.m. to report Resident #1's foley catheter had been removed on 03/23/26 in the afternoon and Resident #1 had not voided during his shift on 03/24/26. She said she replied to him and gave an order to place it back. She said she was aware that Resident #1 had a history of urinary retention and the foley should have not being removed on 03/23/26 if the resident was having urinary retention. She said LVN A had reported to her that there was a little bit of blood noted when catheter was inserted and she gave an order to flush the catheter and gave an order for an ultrasound of the bladder and the abdomen on that day. She said the ultrasound revealed Resident #1 was retaining a lot of urine. She said that if the catheter was not in the bladder, there would be no urine return and if there was an obstruction, the nurse needed to remove the catheter and try again, and if the second attempt was unsuccessful, LVN A needed to notify the physician/NP right away. She said, I don't know what happened on that day. She said that the potential complication of urinary retention could cause the bladder to rupture and the resident would need to have a permanent suprapubic. She said she could not remember if the family member had approached her and asked to discontinue the foley catheter. She said she was not aware that the resident had an order to be seen by the urologist within 10-14 days when discharged from the hospital on [DATE]. She said, if I had known, I would have followed the prescriber's order.During an interview on 4/28/26 at 10:30 a.m., LVN A said he had reinserted the foley catheter on 03/24/26 per NP's order, due to Resident #1 having abdominal distention. He said Resident #1 never voiced any concerns to him on 03/24/26 about having abdominal discomfort and not being able to void. He said he had sent a Group Text to the physician and the NP, on 03/24/26 and the NP had responded and gave an order to reinsert the foley catheter. He said there was no urine return when the catheter was inserted and when the catheter balloon was inflated, there was watery tinged drainage with blood on the meatus. He said he had notified the NP, and she gave an order to leave the catheter in place and irrigate the foley with [NAME] saline. He said he had irrigated the foley catheter as ordered with normal saline and had not documented in the resident's clinical record. He said the Ultrasound results had been sent to the facility after he had completed his shift. He said the resident was sent to the hospital during the evening shift. The state surveyor requested a copy of the screen shot of the text message sent to NP G on 03/24/26 by LVN A.Review of the screen shot of the text message sent to NP G on 03/24/26 at 12:08 p.m. by LVNA revealed, Resident #1 ?s foley was d'cd yesterday afternoon. He hasn't voided on my shift yet. NP responded at 12:10 p.m., place it back if he doesn't void.Review of the facility's policy and procedures on Charting and Documentation revised July 2017, provided by the DON revealed, Policy Statement: All services provided to the resident, progress towards the care plan goals, or any change 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. Policy Interpretation and Implementation: Documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record: Objective observations; Medications administered; Treatment or services performed; Changes in the resident's condition. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. Entries may only be recorded int the resident's clinical record by licensed personnel (e.g., RN, LVN, physician, therapist, etc.) in accordance with state law and facility policy. Certified nursing assistants may only make entries in the resident's medical chart as permitted by facility policy. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the procedure/treatment; how the resident tolerated the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting.

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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. **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 one of four residents (Resident #4) reviewed for Enhanced Barrier Precautions.-The facility failed to implement their policy on Enhanced Barrier Precautions (EBP) for Resident #4 who had indwelling medical devices.-The facility failed to ensure that PPE was readily available for the staff to use when providing direct care to those residents on EBP.This failure 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:Record review of the Face Sheet dated 04/27/26 for Resident #4 revealed Original admission Date was 12/24/25 and readmission date was 04/17/26.Review of the History and Physical dated 12/25/25 revealed [AGE] year-old male with past medical history of Multiple Sclerosis (is a chronic autoimmune disease where the immune system mistakenly attacks the myelin sheath, the protective covering of nerve fibers in the brain and spinal cord. This damage disrupts nerve signals, causing various symptoms like numbness, weakness, balance problems, vision issues, and cognitive difficulties, as the messages between the brain and body are slowed or blocked), BPH with urinary retention (an enlarged prostate had grown large enough to squeeze the tube that carries urine out of the body, making it impossible or very difficult to empty the bladder, leading to pain and need for a catheter) with chronic foley catheter (a device that drains urine from the bladder into a collection bag outside of the body when a person cannot urinate on their own or various medical reasons), frequent UTIs (is a common bacterial infection in the system that makes and stores urine. It causes painful, frequent urges to urinate, burning sensation, cloudy urine, or lower stomach pain. It occurs when bacteria enter the urinary tract), neuromuscular neurogenic bladder dysfunction (is a loss of bladder control caused by nerve damage, meaning the brain, spinal cord, and bladder cannot communicate properly resulting in inability to store or empty urine correctly, leading to leaks, urgency, or difficulty urinating). Review of the Significant change in status MDS dated [DATE] for Resident #4 revealed, Reentry date 04/17/26. BIMs Score 14 (cognitively intact), functional limitation in range of motion to upper/lower extremities. Wheelchair. Toileting-substantial/maximal assistance. Bed Mobility- substantial/maximal assistance. Indwelling catheter. Diagnoses: Neurogenic Bladder ((occurs when nerve damage disrupts the communication between the brain and the bladder), Multiple Sclerosis (an autoimmune disease where the body's immune system mistakenly attacks the central nervous system, damaging the protective covering of nerve cells) Review of the Care Plan dated 03/05/26 for Resident #4 revealed: Resident Has a suprapubic catheter r/t Multiple sclerosis, Neuromuscular dysfunction of bladder, And overactive bladder. Interventions: Change catheter every month or as needed for MD orders. Monitor and document intake and output. Monito for signs and symptoms of discomfort on urination and frequency. Monitor for signs and symptoms of UTI Pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increase pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change of behavior, change in eating patterns.Observation on 04/27/26 at 11:35 a.m. revealed Resident #4 was lying in bed awake; HOB elevated 45 degrees. It was observed that resident had an indwelling catheter and was draining light yellow urine. He was able to answer questions by moving his head and/or index finger for yes and no. The urinary drainage bag was placed in a dignity bag and was hanging on the side to the bed. There was an EBP sign posted on the door to the entrance to the room. There were isolation, gowns, and gloves in the room.During an observation and interview on 04/27/26 at 11:37 a.m. with LVN C assigned to Resident #4 revealed resident had a suprapubic catheter and a G-Tube. There was a sign posted on the door for Enhanced Barrier Precautions. Upon entering the room, the nurse did not wash her hands, did not use hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitizer, did not put on gloves and a gown prior to uncovering the resident and demonstrating to the state surveyor that the resident did not have a dressing on the stoma where the G-Tube was inserted in the stomach. The stoma had moderate amount of dried yellow drainage. She said, I have not cleaned the site yet. I do not place any type of dressing on the stoma because it makes him itch. She demonstrated to the surveyor that the resident had a suprapubic catheter and did not have a dressing on the stoma. She said they had been trained to use a gown and gloves when they provide direct care with resident that have any type of indwelling devices and/or history of drug-resistant organisms to prevent cross contamination and prevent the spread of infections. She said, I forgot to put on the PPE when I entered the resident's room to show you the stoma sites.During a second interview on 4/27/26 at 12:38 p.m. with Resident #4, it revealedat he could talk and answer questions. He said that the nurses never cleaned the G-Tube site or the suprapubic site. He said that the nursing staff never used the gowns and gloves when they entered the room to assist him with personal care.During an interview on 4/27/26 at 12:42 p.m. with CNA D working in the 100 Hall said that the residents that had an EBP sign posted on the door had some type of indwelling device such as a catheter, feeding tube, pressure ulcer or some type of infection. She said they had been trained to put on a gown and gloves when they provided direct care to prevent cross contamination and the spread of infection. She said the PPE was kept by the entrance to the rooms. During an observation and interview on 04/29/26 at 4:01 p.m. with CNA U and CNA V revealed that they did not always know which residents were on EBP especially when they get new admissions. They said they were rotated to different assignments daily and that made it very hard to know the needs of each resident. They said for example in room [ROOM NUMBER] there were two residents and they did not know which one of the residents was on EBP. They said the PPE should be by the entrance to the resident's room. There was a sign posted on the door to the entrance of the room that documented Stop Enhanced Barrier Precautions. There was a box of gloves by the entrance to the room and there was no PPE (gowns and masks) stored in the resident's drawers. They also checked the cabinets in the hallway and there was no PPE readily available for use.During an observation and interview on 04/29/26 at 4:12 p.m. with ADON LVN I said the staff needed to follow EBP on those residents that had G-Tube, foley, wounds, and any type of indwelling devices. She said the nursing administration and the nurses checked during rounds that the nursing staff were following EBP when providing direct care to those residents that needed to be on EBP to prevent cross-contamination and the spread of infection. The state surveyor asked the ADON to show her where the PPE was stored. The ADON entered room [ROOM NUMBER], there was an EBP sign posted on the door to the entrance of the room that documented Stop Enhanced Barrier Precautions. [NAME] said they have small, square plastic bins where they store the gowns and mask. She checked the closet, dresser drawers and there were no gowns and masks in the room. The Resident in B bed told the ADON that the CNAs had used all the gowns in the morning.During an observation and interview on 04/29/26 at 4:16 p.m. with the DON said EBP precautions was used when providing direct care to those that had foleys, G-Tubes, PICC lines and wounds. She said ADON LVN F was the Infection Control Preventionist and she posted the EBP signs on the doors and stocked the PPE in the resident rooms. She said the PPE was kept in small square containers in the residents' room and were stored in the drawers or in the closet. She said she randomly checked that the staff followed the EBP protocols to prevent the spread of infection and cross contamination. It was observed that there was an EBP sign posted on the door in room [ROOM NUMBER]. The DON attempted to enter room [ROOM NUMBER] to check if there was PPE in the room and that resident did not allow the DON to enter the room. During an observation and interview on 04/29/26 at 4:20 p.m. in room [ROOM NUMBER] with DON revealed, there was an EBP sign posted on the door to the entrance of the room. The DON entered the room and pulled out the plastic bin out of the drawers and said, there were no gowns and mask in the room. The DON said Resident #6 had a suprapubic catheter and was on EBP.During an observation and interview on 04/29/26 at 4:24 p.m. in room [ROOM NUMBER]-B with DON revealed, there was an EBP sign posted on the door to the entrance of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745038	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Tierra Este	14300 Pebble Hills Blvd El Paso, TX 79938

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. The DON entered the room and pulled out the plastic bin out of the drawers and said, There were no gowns in the room.During an interview on 04/29/26 at 4:27 p.m. with ADON LVN F revealed EBP signs were posted on the doors for those residents that have history of drug-resistant organisms, any type of indwelling devices, and wounds. She said the nursing administration made constant rounds to check the nursing staff were following EBP protocols to prevent cross contamination and the spread of infection. She said that she and central supply re-stocked the PPE on the units and in the residents' rooms. She said the staff were trained to let her and/or central supply where they had run out of PPE. The surveyor requested copies of Infection Control Policies and Policy on EBP. During an interview on 04/29/26 at 4:31 p.m. with ADON LVN F said the CNAs should immediately let the DON/ADONs, or central supply, that they were out of PPE so they can restock the PPE.During an observation and interview on 04/29/26 at 4:35 p.m. with ADON LVN F, took the state surveyor to the 400 Hall to show her the medical supply storage room where they stored PPE for the staff to restock as needed. She said all the staff knew the combination of the storage room. Upon entering the supply room, she said, We do not have any PPE stored in the storage room today but there was PPE in the central supply room.During an observation and interview on 4/29/26 at 4:36 p.m. with ADON LVN F revealed there were only three boxes of surgical masks that had 50 masks in a box and two cases of gowns stored in the Central Supply Room. She said central supply ordered PPE weekly.During an interview on 4/29/26 at 4:45 p.m. with Central Supply W he said he ordered PPE weekly on Mondays/Tuesdays and was delivered on Wednesday or Thursday. He said ADON LVN F re-stocked the PPE on the nursing units. He said that in the event the orders were not delivered on time, he could borrow PPE from his sister facilities.During an interview on 4/29/26 at 4:55 p.m. with the Administrator and DON revealed Central Supply ordered PPE on a weekly basis and shipments were delivered to facility on Thursdays or Fridays. The administrator said that if shipments were delayed, they could always borrow PPE from their sister facilities in town. She said that she was not aware of PPE not being readily available for the staff to use when residents were on EBP.Review of facility's policy and procedure on Enhanced Barrier Precautions Revised February 2025 provided by ADON LVN F ADON/Infection Preventionist on 04/29/26 revised on February 2025 revealed, Policy Statement: Enhance Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Policy Interpretation and Implementation: Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the transmission of multidrug resistant organisms to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise. Gloves and gowns are applied prior to performing the high contact resident care activities (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-risk contact resident care activities requiring the use of gowning gloves for EBPs Include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing brief or assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, etc.); and wound care (any skin opening requiring a dressing). EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with a CDC targeted or epidemiologically important MDROs. EBP are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds. (ie., pressure ulcers, diabetic foot ulcers, venous stasis ulcers and unhealed surgical wounds), not shorter lasting wounds such as skin breaks or skin tears. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs), indwelling urinary catheters, feeding tubes and tracheostomy tubes. Peripheral Ivy catheters are not considered an indwelling medical device for purposes of EBPs. EBPs (continued on next page)

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