

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Avir at Tierra Este		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement quality of life for two (Residents #7, and #9) of eight residents who were reviewed for dignity. The facility failed to provide adequate access to disposable briefs, and wipes for Resident #9. The facility failed to provide mechanical lift nets to their assigned resident within a reasonable timeframe causing the resident to stay in bed for prolonged period of time. The facility failed to promote dignity while dining when staff did not serve Resident #7 lunch almost 15 minutes after their tablemates were served during initial dining room observation on 09/02/25. These failures could place the residents at risk of poor self-esteem and decreased self-worth. Findings included: Briefs & Wipes. Record review of Resident #9's face-sheet dated 09/02/25, revealed a [AGE] year-old female with an admission date 07/18/24, and re-admission date of 01/30/25. Record review of Resident #9's Quarterly MDS dated [DATE], revealed a BIMS score of 15, indicating resident was cognitively intact. Record review of Resident #9's history and physical dated 06/25/25, revealed a medical diagnosis of: Chronic Obstructive Pulmonary Disease (a lung and airway disease that restrict your breathing), schizophrenia, congestive heart failure, depressive disorder, anxiety disorder, and fibromyalgia (a chronic condition causing pain throughout your muscles and soft tissues). Record review of Resident #9's care plan with revised date 06/21/25, included resident was at risk for UTI's and skin breakdown, which noted interventions for staff including using incontinent briefs as needed. In an interview on 09/02/25 at 10:46 AM with Resident #9, she stated there was a limit of briefs provided to residents for every shift. She stated staff were always looking in other resident rooms looking for briefs or wipes on a daily basis because they do not have access to supplies. Resident #9 stated the nursing facility should be sufficiently supplied due to briefs and wipes being basic rights. She stated it was harder for the weekend staff to gain access to supplies, so the delay in care was longer. Resident #9 stated she felt the delay in care was a dignity issue. An observation on 09/05/25 with the ADON was conducted of the Central Supply room. A surplus of wipes, briefs, and supplies were observed. In an interview on 09/04/25 at 11:40AM with LVN E, they stated that wipes and briefs had been harder to obtain for approximately 3 months, and exceptional difficulties occurred over the past month. LVN E confirms residents who are not provided adequate supplies or have trouble obtaining them infringe on the resident's rights. LVN E denies any history of resident's stock piling supplies in the past to set on this new policy. In an interview on 09/04/25 at 01:41 PM with CNA A, she stated if supplies finished, they were to request more with Central Supply because they would only provide certain amounts of briefs and wipes on the floor for each shift. She stated the concern had been rising since approximately 3 months, and it was reported to the ADON's and the DON before. She stated the Administrator was also aware but there had been no resolution or change. CNA A stated the administration were responsible for ensuring staff were well supplied and stocked for the shift. She stated it was for patient care, and supplies being secured in the Central Supply closet was delaying care for residents. In an interview on 09/04/25 at 02:09 PM with CNA B, she stated there (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 745038
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the resident, or skin integrity issues. She stated the CNA's and nurses were responsible for monitoring their residents throughout their shift and transferring the residents in and out of bed. In an interview on 09/05/25 at 02:13 PM with the Administrator, she revealed she had ordered mechanical lift nets at the end of July 2025. She stated, if the issue was that mechanical lift nets were not being washed immediately, or placed in laundry for it to be washed, then it could delay the washing process. She stated this could delay the residents' care by delaying them getting transferred out of bed. The Administrator stated the risks for residents not being transferred in or out of bed as ordered, included the risks for pressure sores, or weakening of the muscles which can contribute to risk for falls. She stated nursing was responsible for ensuring mechanical lift nets were getting to laundry so the nets could get washed, and the Laundry department was responsible for washing/drying resident belongings, including the Mechanical lift net, in a timely manner. Dining room Record review of Resident #7's face-sheet dated 09/02/25 revealed resident was a [AGE] year-old male with an admission date 11/03/23. Record review of Resident #7's Quarterly MDS dated [DATE], revealed a BIMS score of 3, indicating severe cognitive impairment. Record review of Resident #7's history and physical dated 08/07/25, revealed a medical history of bipolar disorder (a chronic mental condition that is characterized by extreme highs and extreme lows), dementia (cognitive decline that can affect activities of daily living such as behaviors, thinking, and memory), and cognitive communication deficit. Observation on 09/02/25 of initial lunch meal serving to residents, revealed 3 of 4 residents were served at 12:30 PM. Resident #7, one of the four residents at the table, was observed waiting for his lunch tray and stated he would like a tray. This surveyor informed staff and Resident #7 was served his lunch tray at 12:43 PM. 2 of 3 of his tablemates were observed finished with their meal when Resident #7 was served. In an interview on 09/04/25 at 01:28 PM with CNA A, she stated the nurses were responsible for confirming all residents in the dining room were served during mealtimes. CNA A stated the nurses confirm which residents were in the dining room to be served during mealtimes, versus residents whose trays were sent to their rooms. She stated the risk for the resident being served after his tablemates was a self-esteem issue as it could make them feel bad to eat last. In an interview on 09/05/25 at 11:09 AM with LVN F, she stated all nursing staff were responsible for ensuring residents had their trays during mealtimes. LVN F stated CNA's pass out trays to residents while nurses confirm trays for residents. She stated the risk for residents being served at different times could affect the resident's self-esteem. In an interview on 09/05/25 at 01:05 PM with the DON, she stated the nurses and CNA's were responsible for ensuring trays were served to residents in a timely manner. She stated that herself, and the ADON's, or the charge nurses, assisted with serving trays as needed. The DON stated the risk for the resident included a dignity issue. In an interview on 09/05/25 at 02/07/25 with the Administrator, she stated there were multiple staff members responsible for ensuring all residents were served their meal tray. She stated that included the charge nurse, and herself. She stated it was important for residents to be served within a small timeframe because it can cause the resident not eating, to be uncomfortable watching other residents eating. Record review of Nursing Facility's policy 'Resident Rights' read in part: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: A. a dignified existence; B. be treated with respect, kindness, and dignity; C. be free from abuse, neglect, misappropriation of property, and exploitation.		

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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 (Resident # 94 and Resident #97) of 12 residents reviewed for ADLs. The facility failed to maintain Resident # 94 and Resident #97's fingernails clean and free from debris. This failure could place residents who required assistance with ADL's and resided on secure units of unmet care needs. Findings included: Resident #94 Record review of Resident #94's admission Record dated 09/05/2025 revealed a 63- year-old female with an initial admission date of 07/28/2023 and a readmission date of 12/09/2024. Record review of Resident #94's Diagnosis Information dated 09/05/2025 revealed diagnosis of hemiparesis to right side due to cerebral vascular accident. Record review of Resident #94's Quarterly MDS dated [DATE] revealed a BIMS of 11 indicating moderate cognitive impairment. Section GG indicated resident was dependent meaning helper does all of the effort when performing personal hygiene. Record review of Resident # 94's Care Plan revised on 08/21/2025 revealed resident had an ADL self-care deficit related to disease process and hemiparesis to right side due to previous cerebral vascular accident. An observation and interview on 09/02/2025 at 11:47am with Resident # 94 in Resident # 94's room revealed resident with long dirty fingernails to left hand. She stated that she wanted them cleaned and trimmed. Resident #97 Record review of Resident # 97's admission Record dated 09/04/2025 revealed a [AGE] year-old male with an admission date of 08/19/2025. Record review of Resident #97's Diagnosis Information dated 09/04/2025 revealed diagnoses of unspecified dementia. Record review of Resident # 97's admission MDS dated [DATE] revealed a BIMS score of 05 indicating severe cognitive impairment. Section GG indicated that resident needed set up or clean up 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 when performing personal hygiene. Record review of Resident #97's care plan dated 08/20/2025 revealed resident had a self-care performance deficit related to dementia. An observation on 09/02/2025 at 10:14am in Resident # 97's room revealed residents' fingernails to be long, about one inch off of nail bed on hands bilaterally. In an interview on 09/04/2025 at 11:13 AM with CNA G reported that CNAs were responsible for cleaning and trimming the nails of residents who were not diabetic. CNA G stated that if a resident was diabetic nursing was responsible for cutting their nails due to adverse risks to the resident's health. CNA G reported that CNAs were still responsible for maintaining the cleanliness and filing nails down no matter a resident's diagnosis. CNA G stated that if a resident denies having their nails clipped, nurses must talk to the resident and document the conversation. CNA G reported that the ADON and DON were responsible for ensuring staff were tending to residents' nail care. In an interview on 09/05/2025 at 9:39 AM, with LVN H, reported CNAs were responsible for filing, cleaning, clipping nails for nondiabetic residents. LVN H stated this task should be completed daily and reviewed by all nursing and CNA staff. LVN H confirmed the last in service for nail care was three months prior. LVN H reported potential outcomes for residents could result in resident breaking their skin and becoming infected from dirty nails. LVN H added that long nails could pose a threat to staff and other residents as well. LVN H closed that from a dignity perspective, residents could feel unheard and neglected if staff did not cut their nails after prompting. In an interview on 09/05/2026 at 1:30 p.m., with DON, she stated that residents' fingernails were trimmed as needed., she stated that CNA's would check if nails needed trimming when residents were showered. She stated that CNAs could trim residents' fingernails if they were not diabetic. She stated that it was CNA's and nurses' responsibility to ensure residents fingernails were kept trimmed and clean. She stated that risks of long fingernails included poor hygiene and infection since residents touch their faces and mouths. Record review of facility policy and procedure titled Fingernails/Toenails, Care of revised on 02/2018 read in part Nail care includes daily cleaning and regular trimming. Proper nail care can aid in prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3 (Residents #5, 29, and 58) of 6 residents reviewed for oxygen use. The facility failed to maintain Resident # 5, 29 and 58's oxygen concentrator filter free from lint and dust on 09/02/2025 This failure could place residents who receive continuous oxygen at risk for not having their air properly filtered. Findings Include: Resident #5 Record Review of Resident # 5's admission Record dated 09/05/25 revealed a [AGE] year-old male with an original admission date of 07/10/2025 and a readmission date of 06/23/2025. Record Review of Resident # 5's Medical Diagnosis record dated 09/05/2025 revealed medical diagnosis of Acute respiratory failure with hypoxia (lungs fail to adequately provide oxygen to the body, resulting in low blood oxygen levels). Record Review of Resident #5's Quarterly MDS dated [DATE] revealed Section O special treatments, procedures and programs noted resident on oxygen therapy. Record Review of Resident #5's Care Plan revised on 07/17/2025 revealed the resident was receiving oxygen therapy. An observation on 09/02/2025 at 9:58am, in Resident #5's room revealed resident lying in bed receiving oxygen via a nasal canula at 2 liters per minute. The oxygen concentrator air filter was observed with dust and lint. Resident #29 Record Review of Resident # 29's admission Record dated 09/05/2025 revealed an [AGE] year-old male with an admission date of 08/24/25. Record Review of Resident # 29's History and Physical dated 08/25/2025 revealed medical diagnosis of Acute respiratory failure with hypoxia (lungs fail to adequately provide oxygen to the body, resulting in low blood oxygen levels).Record Review of Resident # 29's 5-day MDS dated [DATE] revealed a BIMS score of 00, indicating a severe cognitive impairment. Section O special treatments, procedures and programs noted resident on oxygen therapy.Record Review of Resident #29's care plan revised 08/27/2025 revealed the resident was receiving oxygen therapy.An observation on 09/02/2025 at 10:14am, in Resident #29's room revealed resident lying in bed receiving oxygen via a nasal canula. The oxygen concentrator air filter was observed with dust and lint. Resident #58 Record Review of Resident # 58's admission Record dated 09/05/2025 revealed an [AGE] year-old female with an original admission date of 02/05/2025 and a readmission date of 06/20/2025. Record Review of Resident #58's History and Physical dated 06/19/2025 revealed a medical diagnosis of history of pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid). Record Review of Resident #58's Quarterly MDS dated [DATE] revealed Section O Special treatments, Procedures, and Programs revealed Resident # 58 was receiving oxygen therapy. Record Review of Resident #58's care plan revised 07/17/2025 revealed resident had a potential for altered respiratory status/difficulty breathing related to chronic pulmonary edema and history of pneumonia. Interventions included administration of oxygen as per doctor's orders. An observation on 09/02/2025 at 11:15 am in Resident #58's room revealed resident lying in bed receiving oxygen via a nasal canula. The oxygen concentrator air filter was observed with dust and lint.In an interview on 09/04/2025 at 11:30 am with LVN F revealed that any nurse can check the oxygen concentrator air filter especially if it starts to beep, the air filter is the first thing that is checked to ensure there was no obstruction. She stated that air filters were checked on and cleaned every Sunday night on the 10pm - 6am shift. She stated that the risks of having dirty air filters was that the oxygen was not delivered the way it is supposed to be delivered. She stated that there was an Inservice on keeping oxygen filters clean approximately a couple of months ago. In an interview on 09/05/2025 at 1:30 pm with DON revealed that she was not sure who was responsible for cleaning the oxygen concentrator filters. She stated that she believed that the central supply person was the person that would monitor the air filters along with the nurses on the floor. She stated that dirty air filters interfere with the function of the machine itself. She stated that the noise of the concentrator could get loud, which could be uncomfortable for residents. She stated that it also (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	affects the quality of oxygen being delivered to residents. She stated that there had been no Inservice to staff regarding clean air filters. Record Review of the Oxygen Concentrator Manual provided by the facility, revealed in part Cleaning of outer cabinet recommended interval of 7 days. Cleaning of air filter recommended cleaning interval of 7 days.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 14 residents (Resident #38 and Resident #72) reviewed for pharmacy services. Resident #38 and Resident #72 had an unlabeled clear plastic cup at bed side with Zinc Oxide pomade (skin ointment) and a tongue depressor in it, exposed, and within reach of other residents. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. Findings included: Record review of Resident #38's admission record dated 09/03/25 revealed she was admitted on [DATE]. Record review of Resident #38's history and physical dated 08/12/25 revealed a [AGE] year-old female diagnosed with primary osteoarthritis (a chronic degenerative joint disease referred to as wear-and-tear arthritis, as it typically develops over time due to the breakdown of the protective cartilage that cushions the ends of bones in a joint) to right ankle and foot, pain in joints, chronic kidney disease, difficulty walking, wheelchair bound and bilateral foot drop (a medical condition characterized by the inability to lift the front part of both feet). Record review of Resident #38's admission MDS assessment dated [DATE] revealed she had a BIMS score of 15 indicating his cognition was intact. The MDS indicated under section GG, for Functional Abilities, the resident required moderate assistance with toileting hygiene, shower, lower body dressing, and putting on footwear, sit to stand and transfers to toilet and shower. Record review of Resident #38's care plan dated 08/28/25 revealed Resident # 38 was allergic to Latex and the care plan called for interventions on recording other allergies in the resident records. Record review of Resident # 72's admission record dated 09/02/25 revealed she admitted on [DATE]. Record review of Resident # 72's history and physical dated 07/13/25 revealed a [AGE] year-old female diagnosed with urinary tract infection, severe obesity, Parkinson's disease (a chronic, progressive neurological disorder that primarily affects the nervous system and motor functions), and hypertension. Record review of Resident # 72's admission MDS dated [DATE] revealed he had a BIMS score of 15 indicating her cognition was intact. The MDS under section GG, for functional abilities, revealed the resident required moderate assistance with upper body dressing. She required substantial assistance with toileting hygiene, lower body dressing and putting on footwear, and she was dependent on staff for bathing. Record review of Resident # 72's care plan, dated 07/18/25, revealed Resident # 72 had a potential for decreasing ADLs related to increased tremors due to Parkinson's disease. The care plan indicated interventions to assist with ADLs as needed which included maintaining her current level of functioning in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. In an observation and interview on 09/02/2025 at 9:44 AM with Resident #72, the resident was working on a puzzle while sitting on her wheelchair. Behind the resident, there was a nightstand and on top of the nightstand, there was a clear and unlabeled cup; the cup contained white cream with a tong depressor inside. The resident stated that the cup contained a cream that was applied to her by the CNAs to help with a rash she had for wearing her briefs. Resident #72 stated that usually staff would leave the cream like that to reuse whenever she was assisted with changing her briefs through the day. In an observation and interview on 09/02/2025 at 9:57 AM with Resident #38, the resident was in bed watching TV. To the right side of the resident on her nightstand, there was a clear plastic cup with white cream residues and a tong depressor inside. Resident #38 stated that the cream was applied to her earlier that morning while being changed to treat a rash she developed on her skin due to wearing her briefs. Resident #38 stated she did not know how long the cup had been there, but that CNAs left cups with the cream on top of her nightstand regularly. In an interview on 09/02/2025 at 10:35 AM (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the CMA, she stated the contents of the plastic cup was antifungal cream which was applied to the residents to treat or prevent skin rash. CMA said staff should not leave any medication or cream at the resident's side table uncovered and unlabeled. The CMA stated that staff were expected to throw the cup containing any residual cream into the trash. The CMA stated there could be a risk of infection if the medication gets contaminated because it was left uncovered and if it was then used or applied onto a resident. She stated there was also a risk for another resident who was confused and wandered into that room and ate the cream which would make them sick to their stomach or spread infection. In an interview on 09/02/2025 at 10:45 AM with LVN C, he stated that the contents of the clear and unlabeled cup was zinc oxide which was for preventing brief rash on those residents who wore them. LVN C said staff were expected to dispose of any cream left in the cup once it was applied to the resident. LVN C explained the cup and medication was supposed to be covered to prevent contamination and said that if the contents of the cup were used on the resident, and it had been contaminated either with dust or debris, there was a risk of infection and contamination. LVN C stated if the oxide zinc was contaminated, and it was applied to a resident's rash; it could make it worse and cause more discomfort to the residents. In an interview on 09/03/2025 at 2:49 PM with the DON, she stated the contents of the clear and unlabeled cup was oxide zinc to treat rashes and for skin protection which was applied to residents when the residents are changed from briefs. The DON stated It was not correct to leave any medications at bed side because it was within reach of the residents, and anyone could get their hands on it. The DON stated there was a risk for the medication to get contaminated, and if it was applied to the resident, the rash could get worse, and it could evolve into major infection affecting a resident's health and well-being. In an interview on 09/03/2025 at 2:58 PM with the IP, she stated the cream should not be left at bedside because it was unlabeled and there was no way of knowing what it was. The IP said there was a risk of particles falling into the cream or medication which could contaminate it, and if the resident had a rash and they applied it to the affected area, it could potentially make it worse. The IP explained there was also a risk for another resident to wander into the room and confuse the content of the cup with food and they could ingest the contents which could result in residents getting sick from their stomach. In an interview on 09/04/2025 1:51 PM CNA A, she stated the cup was more than likely containing zinc oxide which was used to prevent and treat rashes on residents. She stated it was not acceptable to leave the cup at bed side because the medication was exposed and not labeled. She stated there was a risk of the cream being contaminated for being exposed, and if it was used on a resident, there was a risk of infection or making the rash worse. In an interview on 09/04/2025 at 2:16 PM with CNA B, she stated the clear cup contained [NAME] oxide and explained it should not be exposed or uncovered and unlabeled. CNA B stated the medication should be a smaller portion to prevent wasting the medication and if there was any left in the cup, it should be thrown into the trash. CNA B stated if the medication was left open and exposed, it could be confused as food and a resident could ingest it which could make them sick. CNA B stated that there was a risk of contamination of the contents of the cup and if it was applied to a resident, the rash could get infected or worsen. In an interview on 09/05/2025 at 2:03 PM with the Administrator, she stated that medications should never be left at bedside of the residents. She stated there was a potential risk for the medication to be contaminated if anything was to fall inside of the cup and if applied to the resident having a rash, the rash could potentially get worse. She stated there were also confused residents within the facility who could wander into the room and if the medication was within reach, they could potentially put it into their mouth, and it could lead to infection or sickness to their stomach. In an interview on 09/03/25 at 10:15 AM with the DON revealed the facility did not have any policies addressing leaving medications at residents' bedside.		

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NAME OF PROVIDER OR SUPPLIER Avir at Tierra Este		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 Pebble Hills Blvd El Paso, TX 79938	
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2 of 6 residents (Residents #1, and #21) reviewed for call lights. The facility failed to ensure resident call lights were within reach for 2 Residents #1, and #21. This failure placed residents at risk of having their needs unmet when they are unable to contact staff. Findings included: Resident #1 Record review of Resident #1's admission record dated 09/05/2025 revealed a 74- year-old female with an original admission date of 10/17/2024 and a readmission date of 05/04/2025. Record review of Resident #1's history and physical dated 8/18/2025 revealed diagnoses of dementia and seizure disorder. Record review of Resident #1's annual MDS dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. Record review of Resident # 1's care plan revised on 11/08/2024 revealed resident was at risk for injury related to seizure disorder, she was receiving anti-convulsant medications and was at risk for side effects, adverse reactions and toxicity of medication. Nursing intervention included keeping call light within reach. In an observation and interview on 09/02/2025 at 2:36 p.m., during initial screening, call light was observed on the floor while resident was asleep in the bed. At 2:58PM CNA D entered the room briefly and located resident asleep and proceeded to leave room. CNA D was asked about call light placement for Resident #1. Upon entering the room, call light was still found on the floor. CNA D confirmed this was not appropriate and the call light should've been within the resident's reach. CNA D confirmed when she initially checked on the resident, she did not ensure call light was within reach before exiting room. Resident # 21 Record review of Resident #21's admission record dated 09/05/2025 revealed an 80- year-old female with an original admission date of 12/29/2023 and a readmission dated of 06/27/2025. Record review of Resident #21's history and physical dated 07/28/2025 revealed diagnoses of hemiparesis (partial paralysis of one side of the body), and acute right sided weakness. Record review of Resident #21's quarterly MDS dated [DATE] revealed a BIMS of 02 indicating severe cognitive impairment. Record review of Resident # 21's care plan revised on 01/21/2025 revealed resident had a potential for selfcare deficit in ADLs related to history of cerebral vascular accident with right sided hemiparesis. Nursing interventions included keeping pad call light within reach. An observation and interview on 09/02/2025 at 2:04 PM revealed Resident #21 required a touch pad call light for communication purposes which was out of reach for the resident during initial observation. Call light pad was attached to the top right of the bed clipped to the bedliner. Resident had limited range of motion on right side and could not reach call light if needed. Interview with CNA D, revealed the call light was out of reach for the resident, based on condition. In an interview on 09/04/2025 at 11:33 AM with LVN C revealed Call lights were used for residents to communicate needs. He stated that the call light was supposed to be kept within reach of the resident without them having to extend their arms. A risk of the call light not being within reach would be needs could go unanswered, they could fall trying to get the call light, they could feel distress and feel abandoned. He stated that call lights were answered as soon as possible and nurses and CNA's were to round every 2 hours or sooner. He stated that angel rounds were done every morning by supervisors to ensure call lights were within reach. In an interview on 09/05/2025 at 11:25 AM with the ADON revealed call light was used to notify staff that a resident needed help or was in need of something. It was used as a form of communication. She stated that any staff member could respond to a call light and notify specialized staff to address resident's needs. Nursing staff and CNAs were required to reposition call light if found out of reach of resident. She stated that angel rounds were done between 8-9AM conducted by department heads as a way to provide an extra set of eyes to residents. The ADON stated charge nurse, ADON, DON were responsible for ensuring call lights were being responded to. She stated that pad call lights were used as intervention for individuals with limited range of motion and varied on individuals with their care plan, range of motion (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and severity of paralysis. She reported August 2025 was the last in-service done on call lights. She stated that residents could be in danger if they did not have access to the call light, especially in nonverbal residents because it was a vital form of communication. She stated that it was a potential for residents to be neglected. The ADON stated the resident could feel anxious, anger, embarrassment dependent on situation. In an interview on 09/05/2025 at 11:51 AM with the DON she stated a call light was a device used for a patient to request assistance. She stated that call lights were supposed to be placed within residents' reach meaning as long as it was within arm reach. She stated that everybody was responsible for ensuring call lights were within reach. All staff were capable of positioning call lights in reach. She stated rounds were made every two hours, allowing more frequent opportunities to ensure call light is within reach, review environment. Residents with severe contractors and limited ranges of motion. Residents with call pads should have it within their reach. The DON educate staff on call lights on clipping call lights to residents' bed. In both photos call light is not in reach. Residents could feel anxious, potential for neglect if a resident doesn't have call light in reach. In an interview with the Administrator on 09/05/2025 at 12:15 PM revealed, the call light was used to notify staff that the resident needed something, it was used for an array of things to substantiate communication. She stated that call lights should be within easy reach of the residents. She stated that as long as the arm extremity can reach it without torso movement it was considered within reach. She stated that all staff were responsible for answering call lights to include the varying departments. All staff and department head's that conducted angel rounds were responsible for ensuring the call light was within reach. She reported rounds were done every two hours by nursing staff. She stated that call lights not being with reach could pose a risk for residents needs to not be met in a timely manner. This could lead to skin issues, feeling anxious, mad, and feeling of helplessness. She stated that last Inservice for all light was done two weeks ago. Record review of facility policy titled Call System, Residents updated 01/2025 read in part Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical and nursing needs for one (Resident #13) of six residents reviewed for care plans. The facility failed to have a comprehensive person-centered care plan for Resident #13 to address Resident's urinary indwelling foley catheter. This failure could place residents at risk for unmet care needs, complications with urinary catheter use, and a decline in their overall health and quality of life. Findings Include: Record review of Resident #13's face sheet dated 09/03/25 revealed resident was an [AGE] year-old female with an admission date 06/02/25. Record review of Resident #13's Quarterly MDS dated [DATE] revealed a BIMS score of 1, indicating severe cognitive impairment. The Quarterly MDS, under Section H-Bladder and Bowel, revealed Resident #13 had an indwelling catheter. Record review of Resident #13's history and physical dated 08/11/25 revealed a medical history of: Acute Urinary retention (sudden involuntary inability to completely empty the bladder causing discomfort and can lead to complications) postoperatively requiring Foley catheter placement (a flexible and sterile tube through the urethra, helps continuously drain urine from the bladder), AKI (Acute Kidney Injury, a decline in kidney function causing a decline in the kidney's function of filtering waste from blood), and Dementia. Record review of Resident #13's care plan [SP1] did not include or address the resident's indwelling foley catheter. During an observation on 09/02/25 at 10:45 AM, Resident #13 was in bed with her foley catheter placed on the side of bed. In an interview on 09/05/25 at 11:12 AM with LVN F, she stated MDS nursing were responsible for the care plan. She stated care plans were evaluated quarterly, and as needed. She stated the residents having care plans without information addressing the residents' conditions such as a foley catheter meant the staff would not be able to provide care specific to the catheter. In an interview on 09/05/25 at 12:05 PM with the MDS Nurse, she stated nursing was responsible for compiling the resident's care plan regarding their medical needs such as a foley catheter. She stated MDS Nursing staff monitored the residents' care plans every 3 months, or quarterly. The MDS Nurse stated residents' foley catheters needed to be included in the care plan because it was the plan of care centered to the resident including their conditions. She stated there was a risk resident would get improper care if their conditions were not care-planned. In an interview on 09/05/25 at 01:01 PM with the DON, she stated care plan's purpose was for staff to provide the resident's plan of care specific to the resident. The DON stated resident conditions, such as resident's having an indwelling foley catheter, needed to be included in residents' care plan. She stated MDS nursing were responsible for care plans, which were reviewed upon admission and every 3 months or as needed. The DON stated the risks for the residents of their conditions such as indwelling catheters included in their care plan, was potential for incomplete patient care. In an interview on 09/05/25 at 02:11 PM with the Administrator revealed care plans were the responsibility of all departments such as nursing, social services, therapy, and dietary departments all include their plans of care for the resident. The Administrator stated IDT (interdisciplinary team) meetings were conducted weekly and they evaluated residents' care plans. She stated the risks of incomplete care plans included inaccurate care for residents such as staff being unaware of monitoring for symptoms of infection, for example for foley care. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, with no date read in part: Policy Statement- A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. It also noted, The comprehensive, person-centered care plan: c. includes the resident's stated goals upon admission and desired outcomes; e. reflects currently recognized standards of practice for problem areas and conditions.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident # 51) of 6 reviewed for medication administration. The facility failed to ensure Licensed Staff signed the individual control drug record for Resident #51's after administering controlled medication on 09/02/2025 and 09/03/2025. This failure could place residents at risk for not receiving the intended therapeutic response of prescribed medications and drug diversion of controlled substances. The findings include: Resident # 51Review of Resident #51' s admission Record dated 09/04/2025 revealed [AGE] year-old male with an initial admission date of 02/14/2025 and readmission date of 07/05/2025. Review of Resident #51's Diagnoses dated 09/04/2025 revealed a diagnosis of insomnia (persistent problems falling asleep and staying asleep). Review of Resident #51 's 5-day MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment. Review of Resident #51 's Care Plan revised 08/21/2025 revealed resident was on sedative/ hypnotic therapy (Temazepam) related to insomnia. Review of Resident #51's Medication Administration Record (MAR) dated September 2025 revealed Temazepam Oral Capsule 7.5 MG (Temazepam) Give 1 capsule by mouth at bedtime for insomnia. Review of Resident #51's individual control drug record for medication Temazepam on 09/04/25 at 11:35 am revealed two missing nurse signatures on 09/02/2025 and 09/03/2025. An interview on 09/05/2025 at 1:30PM with the DON, revealed that nurses were trained to look at residents' orders, make sure it was the right medication for the right resident and administer medication, and sign the individual control drug record it as soon as the nurse was done administering medication. She stated that this was done to create a clear record of who administered the medication, when and to whom, allowing tracking of controlled medication. She stated that she did not know the risks of not signing the individual narcotic sheet. She stated that the ADON's and herself were responsible for ensuring that all narcotic records were adequately completed. She stated that the ADON's and herself completed random audits throughout the week to ensure they were filled out correctly. She stated that there had been an in-service to staff regarding this recently in August. In an interview on 09/05/2025 at 1:50 PM with RN J, she stated that the purpose of the individual narcotic record was to have a count of narcotic medications, to know that it was the right resident, right dose and to make sure that the correct medication of resident was being given. She stated that she was trained to look in the book, locate the individual narcotic record for the resident and to ensure the count matched the sheet before being given. Nurses were to sign and document as soon as the medication was pulled. She stated that signing the narcotic sheet was a form of acknowledging that the medication was given at the right time and the correct amount was given. She stated that narcotic sheets should be filled out in their entirety to avoid drug diversion. She stated that the facility did provide an in-service regarding this, she could not recall the date. An interview with the Administrator on 09/05/25 at 2:39 PM, revealed that the purpose of an individual narcotic sheet was to keep track of the narcotics being administered and to ensure that drug diversion was not happening. She stated that it kept track of the times they were given, and who was administering them. She stated that it was important for the nurses to sign the sheet when administering the medication, because if there was an issue with the medication, they knew what nurse last gave it. She stated that diversion of medications was the risk because it would not be known who had access to it last. She stated that she did not recall if an in-service was done regarding this. Record Review of the facility's policy titled Controlled Substances dated 01/2025 read in part When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage . Date and time of administration, amount administered and the signature of the nurse administering the dose.		

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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 observations, interviews, and record review, the facility failed to establish and maintain an infection 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 (Resident # 63) of fourteen residents observed for infection control in that: Resident #63's catheter drainage collection bag was left on the floor, and the wheel of her side table was on top of the bag. This deficient practice could result in cross contamination, spread of infection and could result in a urinary tract infection. The findings included: Record review of Resident #63's admission record dated 09/03/2025, revealed the resident was admitted on [DATE]. Record review of Resident #63's history and physical revealed the resident was an [AGE] year-old female with a past medical history of significant dementia (a decline in memory and other thinking skills), chronic kidney disease (long-term loss of kidney function), atrial fibrillation (an irregular and often rapid heart rate), coronary artery disease (a buildup of plaque in the arteries that supply blood to the heart). Record review of Resident #63's admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 0 indicating the resident's cognition was severely impaired. The MDS revealed under section GG, for functional abilities, the resident needed maximal assistance (where the helper does more than half the effort) with eating, oral, toileting, showering and dressing. Under section H, for Bladder and Bowel, MDS indicated under urinary continence, the resident was occasionally incontinent, and under bowel continence, the resident was always incontinent. The MDS revealed for the care area assessment (CAA) summary, the resident triggered for urinary incontinence and indwelling catheter (a thin, flexible tube that is inserted into a person's body and left in place for a period of time to drain fluids, such as urine from the bladder, or to deliver medication). Record review of Resident #63's care plan dated 08/01/2025 revealed the resident was at risk of urinary tract infections related to incontinent bladder and bowel and stated the goal was for the resident to be in a clean, dry state to prevent complications of incontinence by checking and changing the resident at regular intervals. It revealed that Resident #63 was at risk for edema (swelling caused by excess fluid in the body's tissues), SOB (shortness of breath), fluid volume overload (a condition where the body has too much water and sodium), related to a diagnosis of renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluids). In an observation and interview on 09/02/2025 at 10:35 AM with the CMA, Resident #63's catheter drainage collection bag was observed on the floor, and the wheel of her side table was on top of the bag. CMA stated the side table's wheel was dangerously clamping the bag, posing a risk for it to tear and spill. The CMA stated this would create an infection control issue, and if someone stepped on the spilled contents, they could slip and sustain a fall or injury. The CMA explained that the resident could contract an infection because the bag was on the floor, risking contamination. In an interview on 09/02/2025 at 10:45 AM with LVN C, he stated the bag was improperly touching the floor, and the side table's wheel shouldn't be on top of the foley bag. LVN C said the bag could tear, spilling its contents and creating an infection risk for the resident, staff and visitors in the facility due to contamination. In an interview on 09/03/2025 at 2:53 PM with the DON, she stated it was unacceptable for the foley bag to be on the floor, where it was being pinched by the wheel from the resident's side table. The DON said this created a pathway for bacteria to enter, which could cause an infection to the resident. The DON stated the spilled contents could also lead to a potential fall hazard to anyone in the facility who entered the room and would create an infection hazard if the resident had infections that could be transmitted to other residents. In an interview on 09/03/2025 at 3:03 PM with the IP, she stated the foley bag was not supposed to be touching the floor. She said the wheel on top of the bag could tear it and spill its contents creating an infection control issue. The IP said foley bags should never touch the floor because germs could get in or out, causing an infection and potentially leading to the resident becoming septic. In an interview on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/04/2025 at 1:23 PM with CNA A, she stated the foley bag was touching the floor, creating a risk of contamination to the resident. She said the wheel of the side table was on top of the bag and could tear it, spilling the contents. CNA A explained this could create a cross-contamination risk, as staff move throughout the facility and could carry infections to other places. In an interview on 09/04/2025 at 2:21 PM with CNA B, she stated the foley bag was directly on the floor, creating a risk for infection control. She said foley bags should never touch the floor because of the risk of infection to the resident. She also stated that with the wheel on top of the bag, if the resident was repositioned, staff might not notice the bag was underneath the wheel, which could be very painful for the resident if the tubing was pulled. CNA B said there was a risk of the bag being torn by the wheel, spilling its contents and creating an infection control issue. She said the floors could become contaminated, and staff could transport bacteria to the entire facility, and even to their families' homes on their shoes if the resident had an infection. In an interview on 09/05/2025 at 2:10 PM with the Administrator, she stated that the foley bag should never touch the floor because of the risk of infection to the resident from bacteria on the floor, which could worsen their condition. She also stated there was a risk of infection to other residents, staff, and visitors if the bag was torn by the side table wheel, and its contents spilled. The Administrator said there was also a fall risk if the contents spilled, and someone walked through it. Record review of the facility's policy and procedure updated in July 2024 titled Catheter Care, Urinary, read in part: Purpose The purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control. Be sure the catheter tubing and drainage bag are kept off the floor.		