STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455493	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Hills Health Care Center	1599 Lomaland Dr El Paso, TX 79935

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455493	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Hills Health Care Center	1599 Lomaland Dr El Paso, TX 79935

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 1 reviewed for quality of care. The facility failed to ensure staff acted in a timely manner to transfer Resident #1 to a hospital after radiologist confirmed a spiral femur fracture on 05/29/2025 at 11:51 PM and delayed response until 05/30/2025 at 06:32 AM. This failure resulted in the resident receiving delay in emergency care services for a fractured femur and placed the resident at risk of further harm and injury.Findings included: Record review of Resident #1's admission record dated 10/15/2025 revealed an [AGE] year-old female with an initial admission date on 09/22/2023 and readmission date on 06/03/2025. Resident #1 was discharged from facility at family's request on 06/09/2025. Record review of Resident #1 physical and health dated 06/05/2025 revealed the resident had a diagnoses of advanced dementia (a degenerative neurological condition that affects an individual's emotional regulation, memory, an ability to complete ADLs), dysphagia (an impairment in speech production due to disease or damage), PEG tube in place (a feeding tube for individuals who are orally limited), and was recovering from post-surgery from a right distal femur fracture (lower end of the femur near the knee). As per documentation, patient is a very poor historian with altered mental status, unable to participate in exam or questioning. Record review of Resident #1 MDS assessment dated [DATE] revealed under section C - cognitive patterns the resident did not have a BIMS score as it was coded resident is rarely/never understood. Under section GG - ADL self-care/mobility the resident was coded at a 1 which signified the resident was dependent on staff to complete activities for care and ambulation. Under section H - Bladder and Bowel, the resident was coded at a 3 which signifies the resident is always incontinent.Record review of Resident #1 care plan dated 06/20/2025 (date of cancellation) stated the resident had a cognitive and communication impairment with interventions being consult with family, provide an ideal environment, and ongoing monitoring for change in condition. Per her care plan, the resident had a potential for pain with interventions recommending to evaluate the effectiveness of pain interventions, identify and record previous pain history, and record and treat the resident's existing conditions.Record review of Resident #1's SBAR dated 5/29/25 written by RN G at 10:29 pm revealed situation had blood pressure of 136/70, pulse was 75, respirations were 18 per minute, oxygen level was 96 at room air. It was noted that there was a functional status change of swelling, redness, and pain to right knee. The symptoms had started on 05/29/25 and STAT 2 vies right knee was ordered. It was suggested to continue monitoring and administer PRN pain medication every 4 hours for pain. Record review of Resident #1's Event note dated 5/29/25 written by RN G at 11:03 pm revealed the location of event was in [Resident #1's] room, she was cognitive impaired, her right knee appeared to be painful to touch, and she noted that CNA C notified her of right knee appearance. She noted that Resident #1 right knee appeared swollen, some redness, warmth and painful to touch. She documented her vitals to be blood pressure was at 136/70, temperature was 98.8 Fahrenheit, pulse was 75 beats per minute, respirations were 18 per minute. Initial treatment provided was administer as needed Tylenol 325mg 2 tablets every 4 hours for pain and STAT x-rays were ordered. Record review of Resident #1's MARS for month of May 2025 revealed she was administered Tylenol 325 mg 2 tablets for pain level of 2 and was signed off as effective at 11:38 pm. Record review of Resident #1's the x-ray provider Patient Report dated on 05/29/2025 revealed she had a spiral femur fracture and osteo-degeneration that was signed off by the Radiologist on 05/29/2025 at 11:51PM.Record review of Resident #1's EMS care report dated 05/30/2025 revealed Resident #1 had right knee deformity and pain an exert from Narrative stated caregiver (family) stated occurred yesterday trying to move patient around and heard a pop, possible fall/ no head strike or LOC reported. The record added Resident #1's vitals were stable with a blood pressure of 118/86, oxygen saturation at 96% with 2 liters per minute on home concentrator, heart rate 86, oriented to smiles, sounds, and interactions, and MAP at 97. Resident #1 arrived at the local hospital and transferred into care on 05/30/2025 at 07:22 AM.Record review of the hospital discharge for Resident #1 dated 05/30-31/2025 revealed Resident #1 with a history of Alzheimer's dementia (a degenerative neurological condition that affects an individual's emotional regulation, memory, an ability to complete ADLs), PEG-tube dependence (a feeding tube for individuals who are orally limited), hypertension (high blood pressure), hypothyroidism (a endocrine diseases in which the thyroid gland does not produce enough thyroid hormones), depression (a psychiatric disorder in which an individual was experiencing sadness that interfered with daily living), and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455493	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Hills Health Care Center	1599 Lomaland Dr El Paso, TX 79935

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455493	A. Building B. Wing	10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Hills Health Care Center	1599 Lomaland Dr El Paso, TX 79935

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 3 residents reviewed for repositioning.The facility failed to ensure adequate supervision and safe handling techniques were provided during routine repositioning to prevent injury for Resident #1 who sustained a spiral fracture of the distal right femur while being repositioned in bed by a CNA C.This failure could place residents at risk for injuries.The noncompliance was identified as PNC-IJ. The facility had corrected the noncompliance before the survey began.Findings included: Record review of Resident #1's admission record dated 10/15/2025 revealed an [AGE] year-old female with an initial admission date on 09/22/2023 and readmission date on 06/03/2025. Resident #1 was discharged from facility at family's request on 06/09/2025.Record review of Resident #1 physical and health dated 06/05/2025 revealed the resident had a diagnoses of advanced dementia (a degenerative neurological condition that affects an individual's emotional regulation, memory, an ability to complete ADLs), dysphagia (an impairment in speech production due to disease or damage), PEG tube in place (a feeding tube for individuals who are orally limited), and was recovering from post-surgery from a right distal femur fracture (lower end of the femur near the knee). As per documentation, patient is a very poor historian with altered mental status, unable to participate in exam or questioning. Record review of Resident #1 MDS assessment dated [DATE] revealed under section C - cognitive patterns the resident did not have a BIMS score as it was coded resident is rarely/never understood. Under section GG - ADL self-care/mobility the resident was coded at a 1 which signified the resident was dependent on staff to complete activities for care and ambulation. Under section H - Bladder and Bowel, the resident was coded at a 3 which signifies the resident is always incontinent.Record review of Resident #1 care plan dated 06/20/2025 (date of cancellation) stated the resident had a cognitive and communication impairment with interventions being consult with family, provide an ideal environment, and ongoing monitoring for change in condition. Per her care plan, the resident had a potential for pain with interventions recommending to evaluate the effectiveness of pain interventions, identify and record previous pain history, and record and treat the resident's existing conditions.Record review of Resident #1's SBAR dated 5/29/25 written by RN G at 10:29 pm revealed situation had blood pressure of 136/70, pulse was 75, respirations were 18 per minute, oxygen level was 96 at room air. It was noted that there was a functional status change of swelling, redness, and pain to right knee. The symptoms had started on 05/29/25 and STAT 2 vies right knee was ordered. It was suggested to continue monitoring and administer PRN pain medication every 4 hours for pain. Record review of Resident #1's Event note dated 5/29/25 written by RN G at 11:03 pm revealed the location of event was in [Resident #1's] room, she was cognitive impaired, her right knee appeared to be painful to touch, and she noted that CNA C notified her of right knee appearance. She noted that Resident #1 right knee appeared swollen, some redness, warmth and painful to touch. She documented her vitals to be blood pressure was at 136/70, temperature was 98.8 Fahrenheit, pulse was 75 beats per minute, respirations were 18 per minute. Initial treatment provided was administer as needed Tylenol 325mg 2 tablets every 4 hours for pain and STAT x-rays were ordered. Record review of Resident #1's MARS for month of May 2025 revealed she was administered Tylenol 325 mg 2 tablets for pain level of 2 and was signed off as effective at 11:38 pm. Record review of Resident #1's the x-ray provider Patient Report dated on 05/29/2025 revealed she had a spiral femur fracture and osteo-degeneration that was signed off by the Radiologist on 05/29/2025 at 11:51PM. Record review of Resident #1's EMS care report dated 05/30/2025 revealed Resident #1 had right knee deformity and pain an exert from Narrative stated caregiver (family) stated occurred yesterday trying to move patient around and heard a pop, possible fall/ no head strike or LOC reported. The record added Resident #1's vitals were stable with a blood pressure of 118/86, oxygen saturation at 96% with 2 liters per minute on home concentrator, heart rate 86, oriented to smiles, sounds, and interactions, and MAP at 97. Resident #1 arrived at the local hospital and transferred into care on 05/30/2025 at 07:22 AM.Record review of the hospital discharge for Resident #1 dated 05/30-31/2025 revealed Resident #1 with a history of Alzheimer's dementia (a degenerative neurological condition that affects an individual's emotional regulation, memory, an ability to complete ADLs), PEG-tube dependence (a feeding tube for individuals who are orally limited), hypertension (high blood pressure), hypothyroidism (a endocrine diseases in which the thyroid gland does not produce enough thyroid hormones), depression (a psychiatric disorder in which an individual was