

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Vista Hills Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</p> <p>Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 (Resident #5) of 7 residents whose records were reviewed for assessments.</p> <p>Resident #5 was not listed as having behaviors on her annual MDS assessment.</p> <p>This failure to ensure comprehensive and accurate assessments could affect residents by placing them at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services.</p> <p>Findings included:</p> <p>Record review of Resident #5's face sheet dated 9/17/24 revealed a [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses of generalized anxiety, major depressive disorder, and mild cognitive impairment.</p> <p>Record review of Resident #5's annual MDS assessment dated [DATE] revealed BIMS score of 15, indicating her cognitive was intact and the behaviors section revealed no history of any behavior.</p> <p>Record review of Resident #5's comprehensive care plan dated 8/27/24 revealed a focus area for frequently requesting HIPPA information on other residents; wants to put staff in trouble with state and get them fired; tends to be going into other residents' rooms asking for information and making notes on her notepad with interventions that included Give a clear explanation of daily care activities prior to and as they occur during each contact. Encourage as much participation and interaction by the resident as possible and redirect and remind resident of certain information is HIPPA protected.</p> <p>Record review of Resident #5's progress notes dated 7/30/24 read in part This Nurse was notified by ADON that there was someone at the front looking for this resident to deliver some medication that she instructed no Nurse or staff from this facility can received except her. Resident tends to get prescriptions without letting this Nurse Know, due to resident voiced to other staff members that is not an 'RN which does not make her feel safe. DON and administrator notify. No prescription was delivered or notified from any DR's office.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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: 455493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Vista Hills Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/17/24 at 2:39 pm, the MDS Nurse stated she was familiar with Resident #5 and knew about her behavior. The MDS Nurse stated her behavior consisted of asking questions about other residents, their medications, their doctor appointments, and at time their family members information. The MDS Nurse stated Resident #5 required a lot of redirection and education on HIPAA. The MDS Nurse stated she had not thought of including her behavior on her MDS assessment due to the examples provided were more on the verbal aggressive side. The MDS Nurse stated the behaviors that were addressed in MDS as behaviors that would warrant a medical diagnosis with medication.</p> <p>During an interview on 9/17/24 at 3:04 pm, the DON stated Resident #5 had history of fabricating stories, false allegations, she does not like the ADON and LVN A and would try to find anything she thought they might do wrong to try and get them terminated. The DON stated Resident #5 also had history of asking for HIPAA information for other residents. The DON stated Resident #5 required a lot of education on HIPAA rules. The DON stated Resident #5's type of behavior were hard to capture in MDS due to the wording of the assessment, they were more on the aggressive, combative, and insulting side.</p> <p>During an interview on 9/17/24 at 3:36 pm, the Administrator stated she was familiar with Resident #5 history of behavior which included meddling in residents care, false accusations against staff to attempt to get them fired and asking for residents HIPAA information. The Administrator stated since Resident #5 became [NAME] President of resident council she has gone around and been asking residents for HIPAA information i.e., their doctor appointments, health issues, and family member information. The Administrator stated Resident #5 was questioned on those behaviors and her response was she wanted to ensure they were receiving the proper care. The administrator stated Resident #5 required a lot of redirection and education. The Administrator stated she was not well versed on MDS assessment, but her basic understating of behaviors accounted for on the MDS assessment were to bill for.</p> <p>Record review of CMS's RAI version 3.0 manual dated October 2016 page E-10 read in part E0600: Impact on others: health related quality of life- behaviors identified in item E0200 put others at risk for significant injury, intrude on their privacy or activities and/or disrupt their care or living environments. The impact on others code here in item E0600. Steps for assessment: 2- to code E0600, determine if the behaviors identified put others at significant risk of physical illness or injury, intruded on their privacy or activities, and/or interfered with their care of living arrangements. Coding instructions for E0600B. Did any of the identified symptoms significantly intrude on the privacy or activities of others? Code 1, yes if any of the identified behavioral symptoms kept other residents from enjoying privacy or engaging in informal activities. Includes coming in uninvited, invading, or forcing oneself on other's private activities.</p>		