

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 04/24/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010</p> <p>Based on interview and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical status for one (Resident #1) of 4 residents reviewed for physician notification.</p> <p>-The facility failed to immediately consult with physician and/or Nurse Practitioner when the facility did not have 4 doses of the prescribed Entresto Oral Tablet on hand to administer to Resident #1 according to physician's orders.</p> <p>This failure could place residents at risk of delayed medical treatment.</p> <p>Findings Included:</p> <p>Review of the Admission Record dated 04/20/25 revealed an [AGE] year old female that was admitted on [DATE].</p> <p>Review of the Annual History & Physical dated 03/29/23 for Resident #1 revealed diagnoses of congestive heart failure (the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and sick sinus syndrome(a type of heart rhythm disorder).</p> <p>Review of the optional state assessment MDS dated [DATE] for Resident #1, revealed no BIMS score.</p> <p>Review of the Care Plan initiated on 03/30/25 for Resident #1, revealed interventions indicating to administer medications as ordered.</p> <p>Review of the Physician Order Summary Report dated 04/20/2025 for Resident #1 revealed Order Range: 03/28/25 - 03/31/25.</p> <p>-Order Date: 03/28/25. Start Date: 03/29/25 Entresto Oral Tablet 24-25 mg (sacubitril-Valsartan) give 1 tablet by mouth two times a day for heart failure.</p> <p>Review of the schedule for March 2025 for Resident #1 revealed: Entresto Oral Tablet -Order Date: 03/29/25 for Entresto Oral Tablet 24-26 mg (Suacubitril- Valsartan) give one tablet by mouth two times a day for heart failure.</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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>MAR documented medication was not administered and coded at a 9, meaning to see nurses notes/other on 03/29/25 at 8:00 AM, and 4:00 PM; 03/30/25 at 8:00 AM, and 4:00 PM. Documented by Med Aide E</p> <p>Record Review revealed the facility did not have written documentation in Resident #1's electronic Nurses Progress Notes that documented attending the physician and/or NP were notified Entresto oral tablet 24-26 mg (sacubitril-Valsartan) give 1 tablet by mouth two times a day for heart failure was not available to administer according to physician's order on 03/29/25 at 8:00 AM, and 4:00 PM; 03/30/25 at 8:00 AM, and 4:00 PM.</p> <p>Interview on 4/20/2025 at 11:25 am with medical doctor revealed, Resident #1 was admitted to the facility from home and she was brought in by family. She stated that she was not notified of resident #1 not being administered scheduled 4 doses of Entresto medication. She stated that staff notify her of any clinical changes of conditions that residents have such as falls, unstable vital signs, and a change in baseline.</p> <p>Interview on 4/20/2025 at 1:00 pm with the DON revealed, Resident #1 was admitted to the facility on a Friday evening from home. She explained that when residents were admitted to the facility on the weekend after a certain time, the pharmacy did not deliver medications. In these cases, the facility asked family to bring in residents medications from home. She stated that the nurses were able to obtain the needed medications from the pyxis if medication was available. She stated that in the case of resident #1, residents' family was told to bring in her medications, which Entresto medication was not provided. She stated that Entresto medication was not available in the facilities pyxis. She stated that medication aides were to notify the nurse when medications were not administered, and nurses were to notify physician about medication not being administered and document the notification in progress note . She stated that medication aides and nurses were trained on this process upon hire. She stated that DON should be monitoring and staff could be reminding each other when giving and receiving report to one another. She stated that by not notifying the physician, this could cause a miscommunication in resident care.</p> <p>Interview on 4/20/2025 at 3:00pm with LVN A, revealed that she was the residents assigned nurse on the weekend of 3/29/25 and 3/30/25. She stated that medication aide was responsible for administering resident#1's medication on those days. She stated that the med aide did not report to her that Entresto medication were not being administered to resident #1. She stated that the medication aide was supposed to report any medication refusals to the nurse and nurse was supposed to report it to the physician and nurse was to document a progress note.</p> <p>Interview on 4/21/2025 at 10:00 am with medication Aide E, revealed that she did not remember resident#1., She stated that when residents refuse medications, or when medication was not administered, the nurse was to be notified and the nurse would be the one to follow up with the resident and with the physician. She stated that when medication was not administered, it was documented in the MAR by placing a number indicating that medication was not administered. She stated that it was important for nurse to be informed of medication refusals or when medication was not being administered because it could potentially cause miscommunication between caregivers. residents would not be getting medications as ordered.</p> <p>Interview on 04/21/2025 at 11:00am the with medical director, revealed that the facility policy stated that the staff must notify physicians when medications are not being administered to residents as per doctors orders.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 4/21/2025 at 2:30 pm with the regional compliance nurse, revealed that nurses were supposed to notify doctors about residents not being administered medications per doctors' orders and nurses were supposed to document that they notified physician. She stated that nursing staff was trained on this upon hire. She stated that not notifying physician about medications not being available and not being administered then physician would not be able to instruct staff in alternative treatment.</p> <p>Record Review of facilities policy titled, Medication Administration, Refusal of Medications revised 03/11/2013 read in part . The nurse will notify the physician when the resident refuses medications. The physician may reorder the prescribed medication for a different time, route, dose , or discontinue the medication. The nurse will note any new orders and reflect those orders appropriately on the MAR.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010</p> <p>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 #1) of 4 residents reviewed for pharmacy services in that:</p> <p>-The facility failed to administer Entresto Oral Tablet to Resident #1 as ordered.</p> <p>This failure placed residents at risk of inadequate therapeutic outcomes and a decline in health due to not receiving medication as ordered.</p> <p>Findings included:</p> <p>Review of the Admission Record dated 04/20/25 revealed an [AGE] year old female that was admitted on [DATE].</p> <p>Review of the Annual History & Physical dated 03/29/23 for Resident #1 revealed diagnoses of congestive heart failure (the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and sick sinus syndrome(a type of heart rhythm disorder).</p> <p>Review of the optional state assessment MDS dated [DATE] for Resident #1, revealed no BIMS score.</p> <p>Review of the Care Plan initiated on 03/30/25 for Resident #1, revealed interventions indicating to administer medications as ordered.</p> <p>Review of the Physician Order Summary Report dated 04/20/2025 for Resident #1 revealed Order Range: 03/28/25 - 03/31/25.</p> <p>-Order Date: 03/28/25. Start Date: 03/29/25 Entresto Oral Tablet 24-25 mg (sacubitril-Valsartan) give 1 tablet by mouth two times a day for heart failure.</p> <p>Review of the MAR schedule for March 2025 for Resident #1 revealed: Entresto Oral Tablet -Order Date: 03/29/25 for Entresto Oral Tablet 24-26 mg (Suacubitril- Valsartan) give one tablet by mouth two times a day for heart failure</p> <p>MAR documented medication was not administered and coded at a 9, meaning to see nurses notes/other on 03/29/25 at 8:00 AM, and 4:00 PM; 03/30/25 at 8:00 AM, and 4:00 PM. Documented by med aide E.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 4/20/2025 at 1:00 pm with DON revealed, Resident #1 was admitted to the facility on a Friday evening from home. She explained that when residents were admitted to the facility on the weekend after a certain time, the pharmacy did not deliver medications. In these cases the facility asked the family to bring in residents medications from home. She stated that the nurses were able to obtain the needed medications from the pyxis if medication was available. She stated that in the case of resident #1, medications were ordered from facility pharmacy on 3/28/2025, but since it was a weekend, the pharmacy would not be able to deliver until Monday, therefore, residents' family was told to bring in her medications, which Entresto medication was not provided. She stated that Entresto medication was not available in the facilities pyxis . She stated that medication aides were to notify the nurse when medications were not administered, and nurses were to notify physician about medication not being administered and document the notification in progress note. She stated that all medications are to be administered as per doctors orders.</p> <p>Interview on 4/20/2025 at 3:00pm with LVN A, revealed that she was the residents assigned nurse on the weekend of 3/29/25 and 3/30/25. She stated that medication aide was responsible for administering resident#1's medication on those days. She stated that the med aide did not report to her that Entresto medication were not being administered to resident #1. She stated that the medication aide was supposed to report any medication refusals to the nurse and nurse was supposed to report it to the physician and nurse was to document a progress note. She stated that all medication is administered as per doctors' orders. Not administering medications as per doctors orders could result in resident not receiving intended care as ordered.</p> <p>Interview on 4/21/2025 at 10:00 am with medication Aide E, revealed that she did not remember resident#1, she stated that when residents refuse medications, or when medication was not administered, the nurse was to be notified and the nurse would be the one to follow up with the resident and with the physician. She stated that when medication was not administered, it was documented in the MAR by placing a number indicating that medication was not administered. She stated that it was important for nurse to be informed of medication refusals or when medication was not being administered because it could potentially cause miscommunication between caregivers and residents would not be getting medications as ordered.</p> <p>Interview on 04/21/2025 at 11:00am with the medical director, revealed that the facility policy stated that the staff must notify physicians when medications are not being administered to residents as per doctors' orders. He stated that all medications are to be administered to residents as per doctor orders. He stated that depending on what medication was not being administered, and the residents' medical condition, would determine the outcome of not receiving the medications as ordered.</p> <p>Record Review of facilities policy titled, Medication Administration Procedures revised 10/25/2017 read in part .If a dose of regularly scheduled medication is withheld or refused an explanatory note is to be entered in the nursing notes or in the PRN nurses notes sections of the medication administration record</p>		