

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 04/30/2026
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident's right to personal privacy during medical treatment and personal care was provided for 2 of 8 residents (Resident #1 and Resident #2) reviewed for privacy. -The facility failed on 04/29/2026 to provide glucose reading for Resident #1 and Resident #2 in a private setting.-The facility failed on 04/29/2026 to provide insulin injection for Resident #1 in a private setting. These deficient practices could affect residents by contributing to poor self-esteem, dignity issues, diminished quality of life, and leaking of protected health information. Findings included: Resident #1 Record review of Resident #1's admission sheet dated 04/29/2026 revealed a [AGE] year-old male with an initial admission date on 01/27/2025. Record review of Resident #1's Quarterly MDS dated [DATE] revealed the resident had a BIMS of 13 with the significance being the resident was cognitively intact. Under section N the resident was coded for requiring insulin injections 6 out of 7 days a week. Record review of Resident #1's care plan dated 01/15/2026 revealed the resident had a focus area for Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar) with interventions to administer medication as ordered educate regarding medications and importance of compliance. Record review of Resident #1's physical and history dated 04/27/2026 revealed the resident was diagnosed with Type 2 diabetes with prescription orders of Insulin Aspart (100 unit/ml), BD AutoShield Duo Miscellaneous (30g x 5mm), Tresiba FlexTouch (100 unit/ml), metformin Hydrochloride (1000 mg) and Glucagon (1 mg). Record review of Resident #1's prescription orders beginning 02/18/2026 for Insulin Aspart FlexPen Subcutaneous (applied under the skin) Solution Pen-Injector 100 unit/ml with a frequency of 3 times a day at 7:30 AM, 11:00 AM, and 4:00 PM. Resident #1 was unavailable for interview on 04/30/2026 at 9:15 AM and 11:00 AM, due to participating in facility activities and meals. Resident #1 showed no signs of distress while participating in activities and meals. Resident #2 Record review of Resident #2's admission sheet dated 04/29/2026 revealed a [AGE] year-old male with an initial admission date on 04/08/2019 and a readmission date on 04/24/2024. Record review of Resident #2's Comprehensive MDS dated [DATE] revealed the resident had a BIMS of 15 with the significance being the resident was cognitively intact. Under Section N the resident was coded for requiring insulin injections 7 out of 7 days a week. Record review of Resident #2's care plan dated 04/29/2026 revealed the resident had a focus area for Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar) with interventions to administer medication as ordered educate regarding medications and importance of compliance. Record review of Resident #2's physical and history dated 09/25/2025 revealed the resident had a diagnosis of Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar), Dementia (cognitive decline including memory loss, language difficulties and behavior changes) Bipolar disorder (a chronic psychiatric condition characterized by intense mood shifts between extreme highs and lows) and Schizophrenia (a chronic psychiatric condition characterized by hallucinations, delusions, disorganized speech and impaired social/occupational functioning). Record review of Resident #2's prescription orders beginning 01/05/2026 for Insulin Aspart FlexPen Subcutaneous (applied under the skin) Solution Pen-Injector 100 unit/ml with a frequency of 3 times a day at 7:30 AM, 11:00 AM, and 4:00 PM. In an interview on (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 04/30/2026
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>04/29/2026 at 10:19 AM, Resident #2 denied having concerns with his care or treatment he received at the facility. He stated he had been at the facility for 7 years already and was happy with the services provided. He stated his guardian, Administrator, and LVN A were individuals he would report concerns of mistreatment, respect, and dignity to. In an observation on 04/29/2026, between 10:30 AM and 11:30 AM, at 10:39 AM, LVN A was observed checking glucose levels for Resident #1. LVN A proceeded to administer insulin injection to Resident #1 in front of the nursing station; at no point was redirecting or prompting for privacy offered by LVN A. At 11:28 AM, RN B was observed being approached by Resident #2 at the nurse's station to request glucose reading. RN B was observed providing services to Resident #2 while at the nurse's station; at no point was redirecting or the resident was prompted for privacy offered by RN B. In an interview on 04/29/2026 at 10:44 AM, LVN A stated Resident #1 was provided glucose reading and insulin. She stated it was completed in front of the nurse's station. She stated she usually conducted glucose readings and insulin injections in residents' rooms. She stated Resident #1 had approached her and requested to have his glucose checked. She stated there were no observed or reported symptoms for hyperglycemia (elevated blood sugar) from Resident #1 that would have required immediate administration in front of the nurse's station. She stated at no point did she offer privacy to Resident #1. She stated there was no reason for why she did not offer privacy to Resident #1 and added she just didn't think to offer. She stated that providing care in the open was not allowed because it was an infection control and HIPAA issue. She clarified it was a resident's right to privacy. She stated if care was provided at the nurse's station that everyone can see what care a resident was receiving, disclose vitals, diagnosis, and medication. She stated all staff were responsible for providing care in a private setting. She stated that the ADON and DON D was responsible for ensuring staff were providing care to residents in a private setting. She stated the last in service she received for resident rights and infection control was a month ago. In an interview on 04/29/2026 at 1:33 PM, RN B stated Resident #2 had Type II diabetes and usually was fixated on his medications. She stated Resident #2 knows when he was feeling hyperglycemic and approached the nurses in the halls and at the stations to check his blood sugar. She stated his glucose reading was in the 200's when she checked it before lunch. She stated she had checked Resident #2's glucose in his room in the morning but before lunch she checked it by the medication cart that was in front of the nurse's station. She stated it was not okay to conduct glucose readings out in the open because resident's had a right to privacy. She stated the resident's diagnosis, vitals, and medication could be leaked if staff provided care at the nurses station. She stated it should have been completed in Resident #2's room or somewhere private. She stated that she as the nurse needed to educate and redirect residents about their privacy if they approached her to request care. She stated the last in services for privacy was in March 2025. She stated the last in service for residents' rights was in March 2025. She stated all staff members were responsible for ensuring that residents received private patient care. She identified the ADON and DON D were responsible for ensuring that the staff adhered to these standards. In an interview on 04/30/2026 at 9:03 AM, LVN C stated glucose readings and insulin injections should have been completed in the residents' rooms. He stated it should have been done in the residents' room for confidentiality and infection control reasons. He stated nurses were responsible for monitoring glucose levels and administering insulin. He stated that if a resident approached him at the nurses' station he would assist them back to their room to provide care and services in a private setting. He stated it affected residents because they could have felt a lack of dignity and privacy from receiving care in the open. He stated that HIPAA would have been breached because glucose readings are usually associated with a diagnosis of diabetes. He stated nursing staff were responsible for ensuring care was provided in a private setting. He stated the facility privacy protocol was to utilize the curtain rod in the room and close the door before beginning resident care. He stated the Administrator was responsible for ensuring that nursing staff were adhering to the protocols of privacy during resident care. He stated he did not remember the last in service for resident rights. In an interview on 04/30/2026 at 11:20 AM, (continued on next page)</p>		

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 04/30/2026
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DON D stated that resident's privacy protection included document disposal, information encryption, and administer orders in a private setting. She stated that care for residents needed to be completed in the resident's room. She stated it was a HIPPA violation because it shared a resident's diagnosis information to others who might be nearby. She stated nurses and leadership were responsible for protecting residents private information. She stated that staff should redirect residents at least once back to their room and uphold their preference if they were insistent on receiving care in front of the nurse's station. She stated it was not the facility's standard to allow staff to provide glucose reading and insulin injections in the open. She stated that any staff member who saw care being provided in the open could advise the nurse to redirect the resident to their room to receive care. She stated the ADON and herself were responsible for ensuring it was being completed. In an interview on 04/30/2026 at 1:58 PM the Administrator stated that glucose reading and insulin injections should be completed in the resident's room due to privacy concerns. She stated that the resident's diagnosis and treatments were exposed if care was completed at the nurse's station. She stated the nurses were responsible for ensuring that care was completed in the resident's room. She stated it if a resident approached a nurse requesting care it was the expectation for the staff to prompt and educate residents on privacy standards before providing care in the open. She stated if the resident was insistent on receiving glucose and insulin injection at the nurse's station then the care plan needed to be updated. She stated DON D and ADON were responsible for ensuring staff were adhering to these standards. She stated the last facility wide in service for resident's rights was in November 2025. Documentation was provided by the HR coordinator on 04/30/2026 at 11:33 AM. Record review of the facility's in-service titled, Resident Rights in Nursing Facilities revealed tenured staff completed this training within the first 3 weeks of November 2025 Record review of the facility's policy titled Resident Rights undated read in part, The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. (Privacy and Confidentiality) The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment personal care.</p>		

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 04/30/2026
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 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interviews, observation, and record review, the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis. The facility failed to ensure they employed a full time or interim DON from 03/04/2026 through 03/17/2026, and 04/01/2026 to 04/19/2026. This failure could place all residents at risk of not receiving necessary care and services. Findings included: Record review of DON E's timesheet, with no date, revealed his last day working was 03/03/2026. Record review of Job Offer letter dated 03/19/2026, noted a job offer was extended to DON F for the role of the Nursing Facility's DON with start date 03/18/2026. Record review of a printed email from the Payroll Clerk dated 04/07/2026, noted DON F's termination date was 03/31/2026 due to Resignation, Health reasons. Record review of Job Offer letter dated 04/23/2026, noted a job offer was extended to DON D for the role of the Nursing Facility's DON with effective date 04/20/2026. During an observation and interview on 04/29/2026 at 08:35 AM, the Administrator stated DON D was at a sister Nursing Facility, training under another DON. DON D was not at the Nursing Facility during this State Surveyor's investigation on 04/29/26. In an interview on 04/29/2026 at 2:49 PM, the HR Coordinator stated DON E's last day of employment was 03/04/2026 and DON D was promoted to the role of DON on 04/20/2026. In an interview on 04/30/2026 at 10:48 AM, DON D stated she took the role as the Nursing Facility's DON on 04/20/2026. She stated the Nursing Facility had 2 ADONs who were assisting with overseeing residents and compensated for the lack of DON. She stated that there would be potential barriers or risks to residents if a Nursing Facility did not have a DON. DON D did not want to explain the potential barriers or risks. In an interview on 04/30/2026 at 1:10 PM the Administrator stated DON E's last day of employment was 03/03/2026, and there was no DON for two weeks, from 03/04/2026 to 03/17/2026, until DON F was hired in Mid-March 2026. She stated DON F then worked approximately 1-2 weeks; termination date noted was 03/31/2026. The Administrator stated DON F resigned due to health reasons. She stated that the Nursing Facility did not have a DON for those following two weeks, from 04/01/2026 to 04/19/2026. She stated that the Nursing Facility did advertise for the Job Opening for the Nursing Facility's DON online. She stated there were multiple Job Applicants, but many applicants were from the hospital, and she thought it would be in the Nursing Facility's best interest to have a DON with Nursing Facility experience. She stated there were possible barriers for residents if the Nursing Facility did not have a DON, including lack of supervision over the nursing staff which affects the residents. The Administrator added the potential risks to residents including residents' documentation, or residents could have a change of condition. In a follow up interview on 04/30/2026 at 2:04 PM, the Administrator stated the facility did not have a policy for the DON requirement, and the facility followed state regulations. Record review of the Texas State Regulations, it read in part: 483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p>		