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	02/11/2026

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 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 observations, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 3 (Resident #33, Resident #43 and Resident #68) of 16 residents observed for oxygen management. The facility failed to clean the oxygen concentrator air filter for Resident # 33, and Resident # 43 while the oxygen was in use, concentrators was observed with air filters with dust, and lint collected on them on 02/09/2026.The facility failed to ensure Resident #68's dirty nasal cannula was replaced when it was observed on the floor on 02/09/26 and CNA F used a wipe to clean the nasal cannula.This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health.Record review of Resident # 33's admission record dated 02/10/2026, revealed a [AGE] year old male with an admission date of 01/13/2026.Record review of Resident# 33's History and Physical dated 01/28/2026, revealed a medical history of acute bronchitis(short-term inflammation of the airways in the lungs).Record review of Resident # 33's admission MDS dated [DATE], revealed a BIMS score of 15 indicating intact cognition. Section O-special treatments, procedures, and programs revealed oxygen therapy was in use.Record review of Resident # 33's orders dated 01/13/2026, revealed oxygen at 2 liters per minute via nasal canula as needed for shortness of breath.Record review of Resident #33's care plan with initiation date on 01/14/2026 revealed resident had oxygen therapy as needed.An observation on 02/09/2026 at 10:36 a.m., revealed Resident #33's oxygen concentrator filter to be dusty and have lint.Resident # 43Record review of Resident # 43's admission record dated 02/10/2026 revealed a [AGE] year-old female with an admission date of 06/19/2025.Record review of Resident # 43's local hospital History and Physical dated 06/19/2026, revealed a past medical history of chronic obstructive pulmonary disease(a group of long-term diseases that make it difficult to breathe due to narrowed airways).Record review of Resident # 43's Annual MDS dated [DATE], revealed a BIMS of 15 indicating intact cognition. Section O- Special treatments, procedures and programs revealed resident was utilizing oxygen therapy.Record review of Resident #43's order summary report dated 02/10/2026, revealed Oxygen at 3 liters per minute via nasal cannula for shortness of breath order date 09/01/2025.Record review of Resident #43's care plan with a revision date of 01/13/2026, revealed resident had oxygen therapy. Interventions included oxygen at 3 liters per minute per nasal cannula.Record review of Resident #68's face-sheet dated 02/11/26 revealed a [AGE] year-old male with admission date 03/31/23.Record review of Resident #68's health and physical dated 09/26/23 revealed the following medical history: dysphagia (difficulty swallowing), Traumatic Brain Injury (brain injury caused by an outside source), Diabetes mellitus type II, Cognitive Communication deficit , Dementia, Seizure disorder, and tracheostomy status (surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), expressive aphasia ((partial loss of the ability to produce language,(spoken, manual, or written))Record review of Resident #68's quarterly MDS dated [DATE] revealed a BIMS of 15, indicating resident #68 was cognitively intact.Record review of Resident #68's care plan included is on Oxygen Therapy and to administer oxygen per physician's orders.An observation and interviews on 02/09/26 at 09:15 a.m., - Resident #68 was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed laying in his bed, his nasal cannula was observed on the floor. CNA F was observed to lifting the nasal cannula and cleaning it with a wipe. CNA F stated she cleaned the nasal cannula with a wipe because she did not have anything else to clean the cannula with. Resident #68 stated that was the first time he had seen staff clean the nasal cannula with a wipe.An observation on 02/09/2026 at 11:30 a.m., revealed Resident # 43's oxygen concentrator filter to have dust collected on it.During an interview on 02/11/26 at 10:55 a.m., CNA E stated CNAs were responsible for ensuring nasal cannulas were stored and sealed in bags. She stated that if nasal cannulas were observed on the floor, it was to be replaced, and the nurse was to be notified. She stated the risks of residents using a nasal cannula that was observed on the floor was infection or illness. She stated she was unsure who cleaned the oxygen concentrator filters, but if she was to observe one dirty, she would notify the nurse. She stated dirty oxygen concentrator filters were a risk for infection to residents and could cause them to be sick. She was unsure who monitored the oxygen concentrator filters.During an interview on 02/11/2026 at 11:17 a.m., CNA F stated she had not seen a dirty concentrator filter, and was not sure who was responsible for cleaning them. She stated if she noticed a dirty filter, she would report it to the nurse. She stated dirty filters could put residents at risk of respiratory problems. She stated she could not recall the last in-service regarding oxygen concentrator filters. She stated CNAs were responsible for storing nasal cannulas in a sealed bag. She stated if a nasal cannula was on the floor, it was considered contaminated and would put the resident at risk for illness. She stated it was not correct to wipe the nasal cannulas if they were dirty, she stated all staff were responsible to replace them.During an interview on 02/11/2026 at 12:09 p.m., LVN I stated the night shift nurses were responsible for cleaning the oxygen concentrator filters. He stated he was not sure who followed up and monitored the oxygen concentrator filters were clean. He stated having dirty filters on oxygen concentrators for residents included them being at risk for bacteria exposure and possible respiratory illness since the resident would be breathing in the oxygen being delivered from the concentrator. He stated nursing staff were responsible for ensuring nasal cannulas were stored in a sealed bag. He stated nursing was responsible for ensuring nasal cannulas that were not in use were stored in a sealed bag. He stated it was not acceptable for staff to attempt to clean a nasal cannula that touched the floor with a wipe, it was to be replaced due to infection control concerns. During an interview on 02/11/2026 at 4:28 p.m., the Administrator stated oxygen filters were checked weekly and on weekends. She stated staff assigned for ensuring oxygen concentrators were clean was central supply staff. She stated staff conducted weekly rounds to ensure that filters were clean and free of dust. She stated weekend nurses oversaw the maintenance of oxygen concentrator filters. She stated that residents with dirty oxygen filters were at risk of allergies. She stated she initiated an in-service regarding oxygen concentrator filters and nasal canula storage and disposal this week. On 02/11/26, the DON and Corporate Compliance Regional Nurse stated there was no policy addressing oxygen concetrator filters or the nasal cannulas.

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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 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 2 of 16 residents (Resident #12 and Resident #17) reviewed for pharmacy services. The facility failed to ensure skin ointment was not left at bedside and within reach of Resident #12 and Resident #17 and other residents on(02/09/2026) . The facility failed to maintain their treatment cart free from the Antimicrobial soap's red fluid spillage and red-dried drippings observed on the Antimicrobial soap on 02/11/26. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. Findings included:Record review of Resident #12's face sheet dated 2/9/2026, revealed a [AGE] year-old male initially admitted on [DATE] with a re-admission date of 12/26/2025. Record review of Resident #12's History and Physical dated 4/3/2025, revealed diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss and inability to think or function independently), aphasia following cerebral infarction (loss of ability to speak or understand language after a stroke), hemiplegia and hemiparesis affecting the left non-dominant side (paralysis and severe weakness on one side of the body), chronic kidney disease stage 4 (severe loss of kidney function), end stage renal disease on dialysis (kidneys no longer function requiring dialysis treatments to survive), chronic respiratory failure with hypoxia (long-term breathing condition where the body does not receive enough oxygen), dysphagia following cerebral infarction (difficulty swallowing after a stroke), and gastrostomy status (presence of a feeding tube placed directly into the stomach for nutrition and medications). The documentation indicated the resident had expressive aphasia and was unable to participate in examination or questioning. The record further indicated the resident was non-ambulatory and required supportive care. Record review of Resident #12's MDS annual assessment dated [DATE], revealed a BIMS score of 0, which indicated severe cognitive impairment. Section B revealed the resident rarely or never made himself understood and rarely or never understood others. Section GG (Functional Abilities and Goals - Self-Care) revealed the resident was dependent on staff for upper body dressing and lower body dressing, requiring total assistance for dressing tasks. The documentation indicated the resident required extensive assistance for mobility and was non-ambulatory. Record review of Resident #12's care plan dated 1/1/2026 revealed the resident had bowel incontinence related to immobility and required staff assistance for toileting and peri care (cleaning the genital and anal area). The care plan indicated staff were to apply barrier cream after every incontinent episode. Interventions further stated Apply barrier cream after each incontinent episode, assigned to certified nursing assistants.In an observation on 02/09/2026 at 10:44 AM in Resident #12's bedroom, a cup containing a white substance and a tongue depressor inside the cup, was found on top of the resident's dresser. The cup was not labeled, and the contents were unknown.Record review of Resident # 17's admission record dated 02/11/2026, revealed a [AGE] year-old male admitted on [DATE].Record review of Resident #17's History and Physical dated 09/25/2025, revealed a past medical history of high blood pressure, and type II diabetes.Record review of Resident # 17's Quarterly MDS dated [DATE], revealed a BIMS score of 14 indicating intact cognition. Section H- Bladder and Bowel indicated resident was occasionally incontinent.Record review of Resident #17's care plan revised 01/28/2026 revealed resident had bowel incontinence, interventions included applying barrier cream after every incontinent episode.An observation on 02/09/2026 at 11:45p.m., of Resident #17's room revealed a clear plastic medicine cup not labeled with a white creamlike substance on the bedside table.In an interview with on 02/09/2026 at 1:50 p.m., Resident #17 stated the nurse had given him that ointment because he had a rash on his thigh (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area he stated that he at times applied it on himself and the staff applied it on him as well. He did not know the name of the ointment. During an interview on 02/09/2026 at 10:45 a.m., LVN C said that the ointment was not supposed to be there because it was not labeled and there was no way to know what its contents were. stated if the cream was to be applied to the resident after being left exposed could result in an adverse reaction such as a rash or worsening a wound if the cream was contaminated. During an interview on 02/09/2026 at 10:45 a.m., LVN D stated the leftover cream should have been disposed of immediately after staff had applied it to the resident to prevent infection control. Stated there were some residents in the facility with dementia who could get into the room and take it with them or ingest it which could make them sick. During an interview on 02/09/2026 at 10:45 a.m. CNA E said staff were supposed to throw away any leftovers of cream and dispose of it in the waste basket as biohazard. She said that crem left in the room was wrong because it was an infection control issue which could spread to other residents or if a resident with dementia ingested the cream it would make them sick. During an interview on 02/10/2026 at 2:14 p.m., ADON A stated that she had been informed about the medication left at bed side. She stated it was not acceptable because it was an infection control issue and there was a possibility that another resident could get the cream and ingest it which could result in that resident getting sick. During an interview on 02/11/2026 at 3:10 p.m. the DON stated all medication being administered was to not be left at bedside to include any topical medication. He stated that topical medication was to be disposed of after application. He stated if it was left at bedside, it would be a risk for cross contamination and could potentially cause harm to residents because the medication was not dated, or labeled and depending on the resident, it could be misused by the resident. He stated that it was the responsibility of whoever was administering the medication to ensure that it was properly disposed of and not left behind. He stated - an in-service was initiated regarding leaving medications at bedside. During an interview on 02/11/2026 at 3:32 p.m., the Administrator stated all medication being administered were to not be left at bedside to include any topical medication. She stated this was to be done to prevent the risk of the residents misusing the mediation and to prevent contamination. She stated that it was the responsibility of whoever was administering the medications to ensure medications were not left at bedside. She stated that an Inservice was initiated this week regarding leaving medications at bedside.Record review of the facility policy and procedure titled Medication Storage in the Facility read in part . Medications and biologicals are stored safely, securely and properly following manufacture's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .During an observation on 02/11/26 at 9:15 a.m, with Wound Care Nurse of the treatment cart, the Antimicrobial soap was on its' side, and observed with red fluid spillage from the bottle with the bottle cap being covered with red fluid.During an interview on 02/11/26 at 1:15 p.m. the Wound Care nurse stated the wound care nurse on shift was responsible for reviewing and cleaning the treatment cart. She stated this was done throughout the shift, including when starting the shift. She stated the ADONs review the treatment cart weekly. She stated it was not acceptable to have the antimicrobial soap with spillage in the cart, she stated she was to clean the cart and disinfect. She stated using soap with observed dried drippings and spillage was a risk for contamination and infection to residents.During an interview on 02/11/26 at 02:00 p.m. the ADON B stated the wound care nurses were responsible for their treatment carts including cleanliness. She stated the DON oversees and reviews the carts for clean carts, but was unsure how often. She stated it was not acceptanle to keep using soaps or bottles with observed spillage as it was no longer aseptic technique. She stated the risk of staff using a soap with observed spillage included infection to the resident.During an interview on 02/11/26 at 2:29 p.m., the DON stated the wound care nurse on shift was responsible for the cleanliness. He stated the ADONs and self, as the DON, would audited the carts for cleanliness. He stated it was done weekly, and the Regional Compliance Nurse also did random checks. He stated it was not acceptable for staff to have the antimicrobial soap in the cart if (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was observed spillage, he stated it should have been thrown away. He stated possible risks for the residents included risk of infection.On 02/11/26 at 09:15 AM, the DON stated there was no policy for treatment carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage.-The facility failed to keep the deep fryer free of food particles, grease accumulation, and burnt oil, and the stove wall next to the fryer was not free of oil splatter and food particles.-The facility failed to keep the oven door free of grime and oil spatter.-The facility failed to keep the refrigerator clean.-The facility failed to dispose of moldy vegetables.-The facility failed to store frozen vegetables in a sealed bag inside the freezer to prevent food contamination and freezer burn.These failures had the potential to place all residents who received meals from the main kitchen at risk for foodborne illness due to unsanitary food preparation surfaces, improper food storage practices, and failure to discard contaminated produce.Findings included:During observations conducted on 02/09/2026 between 8:30 AM and 9:00 AM, the following were observed:-The deep fryer was observed with significant grease accumulation along its upper edges. The accumulated grease contained dry, adhered food particles consistent with prior cooking residue. The grease appeared darkened and old. The wall directly behind the deep fryer and the adjacent oven on the right side were observed with visible grease splatter, layered grime, and dry food particles adhered to the surfaces. The splatter appeared dried and longstanding, indicating the surfaces had not been effectively cleaned.-The oven exterior was observed with green and white discoloration consistent with corrosion, along with visible grease buildup. The presence of corrosion and grease residue indicated failure to maintain the equipment in a sanitary condition.-Inside the refrigerator located next to the pantry door, the back interior wall contained white, dried, smeared residue. The bottom interior surface of the refrigerator contained multiple dried smeared stains and scattered dry food particles. The buildup of residue and food debris indicated that the refrigerator had not been maintained in a clean and sanitary condition.-Inside the freezer, a one-gallon zip-top bag containing green beans was observed open and unsealed. The bag was not properly closed to protect the contents from exposure. Ice particles were observed inside the bag, indicating potential freezer burn and improper storage. Failure to seal the bag exposed the contents to potential contamination and compromised food integrity.-Underneath the kitchen sink, a sack of onions was observed stored. Inside the sack, three large onions were noted with visible dark circular mold growth. The moldy onions were stored among other onions intended for food preparation. The facility failed to remove and discard visibly contaminated produce.In an interview on 02/09/2026 at 8:45 a.m., DS G stated that food items stored in the freezer must remain sealed or properly closed to prevent contamination. When informed of the open bag of green beans observed in the freezer, DS G stated that leaving food exposed in that manner was not correct and could allow contamination. DS G stated that contaminated food could be served to residents and potentially make them sick. DS G further stated that refrigerators, ovens, and deep fryers were required to be cleaned routinely. When informed of the grease buildup in the fryer, the soiled oven door, and staining inside the refrigerator, DS G stated those conditions were unacceptable and could contaminate food surfaces, potentially causing resident illness.In an interview on 02/09/2026 at 12:40 AM with DS H, stated that all food stored in the freezer must be protected from exposure and that open packaging increased the risk of contamination. When informed of the open bag of green beans, DS H stated that the bag should have been sealed and secured and that serving contaminated vegetables could make residents sick. The DS H stated that dirty equipment, including the refrigerator, oven, and deep fryer, could contaminate food during storage or preparation and place residents at risk of illness.During an interview on 02/09/2026 at 10:29 a.m., the Dietary Director stated that food safety required all products to be stored and prepared in a manner that prevented contamination. When informed of the open bag of green beans in the freezer, the Dietary Director stated the product should have been sealed and that leaving it open created the potential for (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contamination and foodborne illness. The Dietary Director stated that grease buildup in the fryer, soilage on the oven door, and staining inside the refrigerator indicated sanitation procedures were not being followed and could result in cross-contamination of food served to residents. During an interview on 02/11/2026 at 4:12 p.m., the Administrator stated the facility was responsible for ensuring food was stored and prepared under sanitary conditions to protect residents from harm. When informed of the open bag of green beans, the Administrator stated leaving food unsealed was not acceptable because it could become contaminated and potentially cause illness. The Administrator stated that unsanitary kitchen equipment and food storage conditions could contaminate food and place all residents receiving meals prepared in the kitchen at risk of becoming sick.Record review of the facility's Dietary Services Policy and Procedure Manual dated 2012 titled Food Storage and Supplies stated in part: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry, and protected from vermin, and insects. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. Cleaning the Refrigerator. Refrigerators are maintained in a clean. sanitary condition free of offensive odors. Cleaning of the reach in refrigerator will be done on a daily or as needed basis. Wash walls and base with water and detergent. Give special attention to the floor of the box, corners, doors, openings, gaskets, hinges and latches. Clean all wire shelves carefully. Wipe down all heavily soiled exterior surfaces with a solution of warm water and an all purpose cleaner. Wipe dry with a clean cloth. Use a stainless steel cleaner to remove streaks. On perishable foods, microorganisms such as molds, yeasts, and bacteria can multiply and cause food to spoil. Spoiled foods will develop an off odor, flavor or texture due to naturally occurring spoilage bacteria. If a food has developed such spoilage characteristics, it should not be eaten. There are two types of bacteria that can be found on food: pathogenic bacteria, which cause foodborne illness, and spoilage bacteria, which causes foods to deteriorate and develop unpleasant characteristics such as an undesirable taste or odor making the food not wholesome, but do not cause illness. Perishable foods have been processed/treated and sealed to eliminate pathogenic bacteria, but spoilage bacteria can multiply and this is what causes the food to deteriorate in quality and taste. If perishable food items are not stored at the proper temperature, spoilage bacteria can grow faster than anticipated and food becomes spoiled and should not be served. Food items such as loaves of bread or dairy products with a stamped best-by or use by date do not need to be labeled when opened as this will not affect the date by which they should be used. However, if possible food spoilage is observed prior to the best by date, the product will be discarded.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 of his or her quality of life, recognizing each resident's individuality for 1 of 8 residents (Residents #12) reviewed for dignity. -The facility failed to assist Resident #12 to dress with personal clothing instead of a hospital gown. -The facility failed on 02/09/2026 to ensure Resident #12's door was closed to provide privacy while resident's lower extremities were exposed. The deficient practice could affect residents by contributing to poor self-esteem, dignity issues and diminished quality of life. The findings included:Record review of Resident #12's face sheet dated 2/9/2026, revealed a [AGE] year-old male initially admitted on [DATE] with a re-admission date of 12/26/2025. Record review of Resident #12's History and Physical dated 4/3/2025, revealed diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss and inability to think or function independently), aphasia following cerebral infarction (loss of ability to speak or understand language after a stroke), hemiplegia and hemiparesis affecting the left non-dominant side (paralysis and severe weakness on one side of the body), chronic kidney disease stage 4 (severe loss of kidney function), end stage renal disease on dialysis (kidneys no longer function requiring dialysis treatments to survive), chronic respiratory failure with hypoxia (long-term breathing condition where the body does not receive enough oxygen), dysphagia following cerebral infarction (difficulty swallowing after a stroke), and gastrostomy status (presence of a feeding tube placed directly into the stomach for nutrition and medications). The document indicated the resident had expressive aphasia (a condition where a person knows what they want to say, but has trouble getting the words out) and was unable to participate in examination or questioning. Record review of Resident #12's MDS annual assessment dated [DATE], revealed a BIMS score of 0, which indicated severe cognitive impairment. Section B revealed the resident rarely or never made himself understood and rarely or never understood others. Section GG (Functional Abilities and Goals - Self-Care) revealed the resident was dependent on staff for upper body dressing and lower body dressing, requiring total assistance for dressing tasks. The MDS indicated the resident required extensive assistance for mobility and was non-ambulatory. Record review of Resident #12's care plan dated 1/1/2026, revealed interventions addressing advanced dementia (progressive loss of memory and reasoning), hemiplegia, and impaired communication related to stroke. The care plan included interventions for enhanced barrier precautions (extra protective clothing when providing hands on care such as gloves and gows), PEG tube care (feeding tube placed into the stomach for nutrition), oxygen use related to respiratory failure (difficulty maintaining adequate oxygen levels), dialysis treatments for renal failure (machine-assisted blood filtration due to kidney failure), and total assistance with ADLs.An observation on 02/09/2026 at 10:44 a.m., Resident #12 was observed in his bedroom with door open lying in bed wearing a hospital gown. His lower body and brief were exposed. The resident was non-verbal and unable to communicate During an interview on 02/09/2026 at 10:45 a.m., LVN C stated he was unaware why Resident #12 was wearing a hospital gown or why his door was open while partially exposed. He stated residents are expected to wear personal clothing unless there are specific medical orders. LVN C stated that leaving the resident exposed with the door open could negatively impact the resident's dignity, cause embarrassment, and affect his wellbeing. During an interview on 02/09/2026 at 10:55 a.m., LVN D stated Resident #12 should not have been dressed in a hospital gown without a clinical reason and staff were responsible for ensuring residents were dressed appropriately in their personal clothing. He stated that allowing the resident to remain partially exposed with the door opened compromised the resident's dignity and privacy and was not consistent with facility expectations During an interview on 02/09/2026 at 11:02 a.m., CNA E stated it (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was inappropriate for the resident to be wearing a hospital gown and not his personal clothes, especially since he was non-verbal and unable to advocate for himself. She stated it was unacceptable for the resident's door to remain open while he was uncovered, as this could result in embarrassment and violated his privacy. A follow-up observation on 02/10/2026 at 9:36 a.m., Resident #12 was observed lying in bed wearing regular clothing. During an interview on 02/10/2026 at 2:14 p.m., ADON B stated residents had the right to wear their own clothing and to have their privacy protected. She stated leaving a resident exposed with the door open could constitute a violation of privacy and dignity. ADON B stated that staff should anticipate the needs of non-verbal residents by ensuring they were properly dressed, covered, and provided privacy at all times. ADON B stated that protecting resident rights and dignity was the responsibility of all staff. In an interview on 02/11/2026 at 2:14 p.m., the SW stated not having documentation about the residents' preferences and him being dressed on a hospital gown, there was a dignity issue because he could not advocate for himself. The SW stated Resident #12 could have potentially felt embarrassed if he was uncovered, and if people saw him from outside his room, and he was not able to voice his concerns. During an interview on 02/11/2026 at 3:10 p.m., the DON stated it was unacceptable for Resident #12 to be in bed wearing a hospital gown, partially uncovered, with the door open. He stated residents have the right to dignity and privacy at all times, regardless of their cognitive or communication status. The DON stated that leaving the resident exposed created a privacy concern and did not reflect expected standards of care. He stated staff should have monitored Resident #12 more closely and ensured he was appropriately covered and provided privacy. During an interview on 02/11/2026 at 4:00 p.m., the Administrator stated it was not acceptable for Resident #12 to be in a hospital gown, uncovered in bed, with the door open, as this compromised the residents' dignity and privacy. She stated that with the door open, staff, residents, and visitors could potentially view the resident, which constituted a violation of his privacy rights. The Administrator stated that all facility staff were responsible for protecting residents' dignity and privacy and stated that leadership was responsible for ensuring policies and practices were followed consistently. She stated safeguarding resident rights was a fundamental expectation of care within the facility of all staff. Record review of the facility's Policy and Procedures undated, titled Resident Rights read in part: Resident Rights, 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 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.-Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.- Respect and dignity-The resident has a right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

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	455493	A. Building B. Wing	02/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 1 of 10 residents (Resident #68) reviewed for call lights. The facility failed to ensure Resident #68's call light was within reach on 02/09/2026. This failure placed residents at risk of having their needs unmet when they were unable to contact staff.Findings included:Record review of Resident #68's face-sheet dated 02/11/26 revealed a [AGE] year-old male with admission date 03/31/23.Record review of Resident #68's health and physical dated 09/26/23 revealed the following medical history: dysphagia (difficulty swallowing), Traumatic Brain Injury (brain injury caused by an outside source), Diabetes mellitus type II, Cognitive Communication deficit (), Dementia, Seizure disorder, and tracheostomy status (surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), expressive aphasia.Record review of Resident #68's quarterly MDS dated [DATE] revealed a BIMS of 15, indicating resident #68 was cognitively intact.Record review of Resident #68's care plan included resident had Communication problem related to expressive aphasia and interventions included leaving the call light within the resident's reach.In an observation on 02/09/26 at 09:01 a.m., with Resident #68 revealed resident was unable to reach call pad. Staff found it hanging on side of bed by the headboard and provided Resident #68 with the call pad.During an interview on 02/11/26 at 10:55 a.m., CNA E stated the purpose of call lights were for residents to communicate their requests or needs to staff. She stated the call lights were to be left within the residents' reach. CNA E stated all staff were responsible for ensuring call lights were within a resident's reach. She stated CNAs made rounds every 2 hours on residents and ensured their call light was within reach. She stated nurses were responsible for monitoring residents and confirming call lights were within residents' reach every shift. CNA E stated the risks for residents not having their call light within reach included the possibility of falling or becoming injured from attempting to grab the call light.In an interview on 02/11/26 at 11:11 AM with CNA F, she stated the purpose for call lights was for residents to notify or request assistance from staff. She stated that CNAs and all staff were responsible for ensuring the call light was within the residents' reach throughout their shift. She stated that any staff that entered the room was responsible for providing the call light within the resident's reach. She stated nurses were responsible for following up and monitoring their residents, including call lights. She stated the risks of residents not having their call light within reach included needs and care would be delayed.In an interview on 02/11/26 at 12:07 PM with LVN D, he stated call lights were to stay within a resident's reach, and it served the purpose for residents to communicate their needs to the nursing facility staff. He stated all staff were responsible for ensuring call lights were provided within a resident's reach. He stated all staff round on the residents, including nursing staff, which was frequent rounds throughout all shifts daily. LVN D stated the risks for residents having call lights out of reach included delayed care since residents would not be able to communicate their needs. In an interview on 02/11/26 at 2:21 PM with the DON, he stated the call bell was for residents to communicate their needs to staff. The DON stated all facility staff providing care were responsible for ensuring call lights were left within residents' reach before leaving them. He stated nursing staff round on residents throughout their shift, and supervisors from different departments were assigned different rooms to round on residents daily which included confirmation of call lights being in residents' reach. He stated the risk of residents not having their call light within reach included residents being unable to communicate their needs to staff.In an interview on 02/11/26 at 4:29 PM with the Administrator, she stated call lights were for residents to call staff for assistance when needed. She stated call lights were to remain within the reach of the resident. She stated that all staff providing resident care were responsible for ensuring call lights were within residents' reach. She stated the different Department Supervisors were assigned different resident (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms, which they rounded on and followed up on any concerns including confirming call lights were provided within a residents' reach. She stated the risk for residents now having the call light within reach included staff inability to meet the residents' needs.On 02/11/26 at 9 AM, the DON stated there was no Call Light policy.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement written policies and procedures to prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of residents' property for 1 out of 8 residents (Residents #15) reviewed for abuse and neglect. The facility failed to implement their abuse policy when they failed to report, unknown charges made to Resident #15's bank card in the amount of 700 dollars while the resident resided at the facility. This failure could place residents at risk for exploitation, misappropriation, abuse, and neglect by not immediately following the facility policies and procedures of recognizing, reporting, investigating, allegations of exploitation, misappropriation, abuse and neglect.Findings included:Record review of Resident # 15's admission record dated 02/11/2026 revealed a 70 y/o female admitted on [DATE]Record review of Resident #15's diagnosis information dated 02/11/2026 revealed a diagnosis of bipolar disorder(chronic mental health condition causing shift in moods, energy and activity levels).Record review of Resident #15's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.Record review of Resident #15's care plan revised 09/28/2025 revealed Resident #15 had a mood problem related to bipolar disorder interventions included assisting resident to identify strengths, positive coping skills.Record review of Resident #15's resident grievance form dated 1/30/26, revealed that grievance was received on 01/30/26 generated by Resident #15. Per grievance form residents voiced concern was not having a card to purchase cigarettes and also regarded unclarity with the unknown amazon purchases. Pertinent findings included the facility along with Resident#15 contacted her bank together and that her card would be replaced for one last time as there had been a history card hackings. The online store was contacted as well and representative informed that money would be reimbursed. Corrective actions to be taken were to monitor resident and assuring her needs were being met and notifying the resident when her new bank card arrived. Incident was resolved on 1/30/2026.In an interview on 02/11/2026 at 10:22a.m., the Business Office manager stated the resident came to her office asking for assistance with checking her bank account, they both noticed that there had been charges made to her card with purchases from an online store She helped the resident call amazon, representative verified that the account had been compromised and opened a case. The representative stated that credit would be returned. She stated that she and resident contacted the bank branch via telephone as the bank is not local. She stated that the bank representative informed the resident that the card would be replaced. She stated that the facility did not manage the residents' funds and that Resident #15 would occasionally ask her to hold on to her bank card because she did not want to keep it in her room. She stated that she did inform Resident #15 that she did not hold on to bank cards, but she would make the exception. She stated that Resident #15 would ask her to store it for her and then come to ask her for it to buy cigarettes. She stated that as soon as she found out that there had been charges to the residents' card, she reported it to the Administrator. She stated that per the online store representative, the charges were made by an unidentifiable source and did not show a mailing address.In an interview on 02/11/2026 at 11:31 a.m., Resident #15 stated the facility would store her debit card in the business manager's office because she felt it was safer than keeping it on her, she stated the business office manger told her that she did not usually store resients bank cards, but she was able to leave it in there in a filing cabinet with a key. She stated she managed her own money. She stated she asked the business office manager to help her check her bank account and it was noted that several charges were made to the online store in the amount of -700 dollars. She stated she contacted and the representative informed her the card had been hacked, she stated not believing that because she did not use it frequently. She stated that she only used it for cigarettes and it was kept at the business office the rest of the time. She stated that the online store refunded her the money but not the overdraft fee and she was still paying that. She stated that she had contacted her (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bank and that they informed her that this would be the last card she would be getting due to there being many repeated instances like this in the past. She stated she spoke to the administrator and was told that she would contact the bank however she did not. She stated that she believed that the facility used her card and lied about the charges. she stated that she voiced this to the administrator but the administrator had told her to keep it quiet and to not make a big deal and that her staff would never do something like that.During an interview on 02/11/2026 at 2:38 p.m., The DON revealed if an allegation was made by a resident stating misappropriation of property or exploitation then it would be reported to the state survey agency, but if was just a complaint, then a grievance form would be done and the facility would work on correcting it. He stated that he and the administrator were responsible in reviewing allegations before reporting to the State Agency.During an interview on 02/11/2026 at 3:32 p.m., The Administrator revealed the Business office manager reported to her that she and Resident #15 identified charges made to her bank card. She stated when she spoke to Resident #15, the Resident had told her this had happened to her multiple times in the past. She stated that she asked Resident #15 if she believed if someone from the facility had used her card and Resident #15 stated she did not. The administrator stated she offered to call the police department to file a police report and the resident declined. She stated that she did not report the incident to the local State Survey Agency due to a history of the resident's bank accounts being compromised and the resident did not make the allegation against facility staff. She stated if the resident had made an allegation against facility staff, then it would have been reportable. She stated that since there was no allegation made, a grievance form was completed and followed up to help follow up on concerns. She stated it was her responsibility to report any allegations of abuse, neglect, and exploitation to the local State Survey Agency. She stated if allegations were not reported, residents could be at risk of ongoing abuse, neglect or exploitation.Review of facility policy titled Abuse/ Neglect revise on 5/9/2017 read in part .Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and or adult protective services . Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment, of residents, misappropriation resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report all allegations to HHSC

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure alleged violations involving neglect or mistreatment, including misappropriation were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 8residents (Resident #15) reviewed for reporting.The facility failed to report to the State Survey Agency when Resident #15 and Business Office Manager identified unknown charges in the amount of $700 charged to her debit card while she was a resident at the facility.this failure could place all residents at risk for misappropriation and neglect by not immediately reporting allegations of misappropriation to the proper authorities at the facility, other officials, and State Survey AgencyFindings include:Record review of Resident # 15's admission record dated 02/11/2026 revealed a 70 y/o female admitted on [DATE]Record review of Resident #15's diagnosis information dated 02/11/2026 revealed a diagnosis of bipolar disorder(chronic mental health condition causing shift in moods, energy and activity levels).Record review of Resident #15's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition.Record review of Resident #15's care plan revised 09/28/2025 revealed Resident #15 had a mood problem related to bipolar disorder interventions included assisting resident to identify strengths, positive coping skills.Record review of Resident #15's resident grievance form dated 1/30/26, revealed that grievance was received on 01/30/26 generated by Resident #15. Per grievance form residents voiced concern was not having a card to purchase cigarettes and also regarded unclarity with the unknown amazon purchases. Pertinent findings included the facility along with Resident#15 contacted her bank together and that her card would be replaced for one last time as there had been a history card hackings. The online store was contacted as well and representative informed that money would be reimbursed. Corrective actions to be taken were to monitor resident and assuring her needs were being met and notifying the resident when her new bank card arrived. Incident was resolved on 1/30/2026.In an interview on 02/11/2026 at 10:22a.m., the Business Office manager stated the resident came to her office asking for assistance with checking her bank account, they both noticed that there had been charges made to her card with purchases from an online store She helped the resident call amazon, representative verified that the account had been compromised and opened a case. The representative stated that credit would be returned. She stated that she and resident contacted the bank branch via telephone as the bank is not local. She stated that the bank representative informed the resident that the card would be replaced. She stated that the facility did not manage the residents' funds and that Resident #15 would occasionally ask her to hold on to her bank card because she did not want to keep it in her room. She stated that she did inform Resident #15 that she did not hold on to bank cards, but she would make the exception. She stated that Resident #15 would ask her to store it for her and then come to ask her for it to buy cigarettes. She stated that as soon as she found out that there had been charges to the residents' card, she reported it to the Administrator. She stated that per the online store representative, the charges were made by an unidentifiable source and did not show a mailing address.In an interview on 02/11/2026 at 11:31 a.m., Resident #15 stated the facility would store her debit card in the business manager's office because she felt it was safer than keeping it on her, she stated the business office manger told her that she did not usually store resients bank cards, but she was able to leave it in there in a filing cabinet with a key. She stated she managed her own money. She stated she asked the business office manager to help her check her bank account and it was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted that several charges were made to the online store in the amount of -700 dollars. She stated she contacted and the representative informed her the card had been hacked, she stated not believing that because she did not use it frequently. She stated that she only used it for cigarettes and it was kept at the business office the rest of the time. She stated that the online store refunded her the money but not the overdraft fee and she was still paying that. She stated that she had contacted her bank and that they informed her that this would be the last card she would be getting due to there being many repeated instances like this in the past. She stated she spoke to the administrator and was told that she would contact the bank however she did not. She stated that she believed that the facility used her card and lied about the charges. she stated that she voiced this to the administrator but the administrator had told her to keep it quiet and to not make a big deal and that her staff would never do something like that.During an interview on 02/11/2026 at 2:38 p.m., The DON revealed if an allegation was made by a resident stating misappropriation of property or exploitation then it would be reported to the state survey agency, but if was just a complaint, then a grievance form would be done and the facility would work on correcting it. He stated that he and the administrator were responsible in reviewing allegations before reporting to the State Agency.During an interview on 02/11/2026 at 3:32 p.m., The Administrator revealed the Business office manager reported to her that she and Resident #15 identified charges made to her bank card. She stated when she spoke to Resident #15, the Resident had told her this had happened to her multiple times in the past. She stated that she asked Resident #15 if she believed if someone from the facility had used her card and Resident #15 stated she did not. The administrator stated she offered to call the police department to file a police report and the resident declined. She stated that she did not report the incident to the local State Survey Agency due to a history of the resident's bank accounts being compromised and the resident did not make the allegation against facility staff. She stated if the resident had made an allegation against facility staff, then it would have been reportable. She stated that since there was no allegation made, a grievance form was completed and followed up to help follow up on concerns. She stated it was her responsibility to report any allegations of abuse, neglect, and exploitation to the local State Survey Agency. She stated if allegations were not reported, residents could be at risk of ongoing abuse, neglect or exploitation.Review of facility policy titled Abuse/ Neglect revise on 5/9/2017 read in part .Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and or adult protective services . Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment, of residents, misappropriation resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report all allegations to HHSC

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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 interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Residents #10) reviewed for care plans.The facility failed to have a comprehensive person-centered care plan for Resident #10 to address prescribed active Medications for pain, Tramadol 50 MG Take 1 tablet by mouth every 8 hours as needed pain, and Anxiety, Alprazolam 0.5 MG Take 1 tablet by mouth at bedtime.This failure could place residents at risk of not receiving care and services to meet individualized medical and nursing needs.Record review of Resident #10's face sheet dated 02/11/26 revealed a [AGE] year-old female with admission date 04/09/2025.Record review of Resident #10's health and physical progress note dated 02/10/26 revealed a medical history of: Bell's Palsy (a condition that temporarily paralyzes facial muscles),generalized muscle weakness, hepatic encephalopathy (condition causing your liver to not filter the toxins in the body causing buildup and causing confusion) and Bipolar disorder.Record review of Resident #10's Comprehensive MDS dated [DATE], revealed a BIMS of 15 indicating resident was cognitively intact.Record review of Resident #10's care plan,the care plan did not include active medications, 1. Tramadol 50 MG 1 Tablet by mouth every 8 hours as needed for pain, and 2. Alprazolam 0.5 MG Take 1 tablet by mouth at bedtime.Record review of Resident #10's Order Summary Report dated 02/11/26 revealed the following medciations orders: Tramadol 50 MG 1 Tablet by mouth every 8 hours as needed for pain order start date 05/12/25, and Alprazolam 0.5 MG Take 1 tablet by mouth at bedtime Order start date 11/12/25.During an interview on 02/11/26 at 12:11 p.m., LVN D stated care plans served as a list of the resident's needs and what interventions were expected from the nursing facility staff. He stated pain medication was to be included in a resident's care plan so staff could be aware to monitor and manage that resident's pain. He stated residents taking anxiety medication was to also be included in the resident's care plan. He stated this was for staff being made aware of the resident's conditions and treat them accordingly. He stated the risks of these medications not being included in a resident's care plan included unmanaged pain, and untreated anxiety. He stated nursing staff were responsible for the nursing portion of the care plan which included medications. He stated the ADONs were responsible for monitoring and verifying changes as needed.During an interview on 02/11/26 at 12:19 p.m., LVN I stated the purpose of care plans was for staff to be aware of how to take care of the residents. She stated pain medication was to be included in the care plan, including name of the medication resident was taking, so staff could monitor pain, medication effectiveness, and side effects. She stated anxiety medications were to also be included in resident's care plans so staff could monitor medication effectiveness, or symptoms or medication side effects such as insomnia (), or drowsiness, for example. She stated nursing staff were responsible for acute changes in residents care, and the MDS nurses were responsible for monitoring the care plan on a quarterly basis. She stated the risks of these medications not being included in the care plan included staff not being able to monitor their residents effectively, relating to the medications, and possible injury from medication side effects.During an interview on 02/11/26 at 2:33 p.m., the DON stated care plans were personalized to residents' care and needs. He stated nurses initiated the baseline careplan and the MDS nurses reviewed it and made the Comprehensive care plan. He stated care plans were evaluated daily and MDS monitored quarterly. The DON stated medications for pain and anxiety were to be added to a resident's care plan so staff could monitor for side effects.During an interview on 02/11/26 at 4:22 p.m., the Administrator stated the care plan was to serve as the baseline for the resident's care and needs. She stated it was for the nursing facility to meet the resident's needs. She (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it was a communication tool for the nursing facility staff to be aware of the resident's needs. She stated nursing staff were responsible for the initial care plan, and MDS nurses composed the comprehensive and evaluated quarterly. She stated the risks of anxiety and pain medication not being included in the care plan were unmanaged pain and residents experiencing behaviors related to anxiety or the medication not being monitored.Record review of the facility's Nursing Policy & Procedure Manual, titled Comprehensive Care Plan, undated, read in part: The Facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a residnet's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one of eight residents (Resident #58) reviewed for ADL care.The facility failed to ensure Resident #58's fingernails was clean and free from debris on 02/09/26. This failure could place residents who required assistance with ADL's at risk for unmet care needs.Findings included:Record review of Resident # 58's admission record dated 02/11/2026 revealed a [AGE] year old male admitted on [DATE] and readmitted on [DATE].Record review of Resident #58's History and Physical dated 01/13/2026, revealed a medical history of atrial fibrillation (heart condition where the top chambers of the heart quiver instead of beat causing irregular heartbeats).Record review of Resident # 58's five day MDS dated [DATE], revealed a BIMS score of 13 indicating intact cognition. Section GG indicated residents functional limitation in range of motion for upper extremity to include shoulder elbow wrist and hand was coded at a 2 meaning impairment to both sides.Record review of Resident # 58's care plan dated revealed Resident #58 had an ADL self-care deficit performance deficit intervention included, assisting with personal hygiene as required, hair, shaving, oral care as needed. During an observation and interview on 02/09/2026 at 11:37a.m., Resident #58's was observed with long nails with dark debri under nails on hands bilaterally. He stated his nails had not been cut and it would be nice if someone were to cut his nails. He stated staff had not offered to cut them.During an interview on 02/11/2026 at 11:03 a.m., CNA F stated that residents' fingernails were checked when residents were showered. She stated residents with long dirty fingernails could scratch themselves, potentially breaking the skin and leading to an infection. She stated it was the responsibility of the CNAs to ensure that fingernails were trimmed and clean. She stated that the facility provided ADL Inservice to include nail trimming. She could not recall the last Inservice.During an interview on 02/11/2026 at 11:40 a.m., LVN D stated residents' fingernails were checked upon rounds made by nurses, CNAs and department heads. He stated it was everyone's duty to observe and report long fingernails to the nurse. He stated that residents with long dirty fingernails were at risk of scratching and breaking the skin, leading to infection. He stated bacteria could be introduced by touching eyes, mouth, and nose. He stated that the facility did frequent in-services regarding ADLs. He could not recall the last in-service.During an interview on 02/11/2026 at 2:38 p.m., the DON stated residents' nails were checked on an as needed basis. He stated the CNAs and the nurses were responsible for ensuring residents' nails were clean and trimmed. He stated that the CNAs were to report when nails were long to the nurses so the nurses could assess and trim the nails. He stated that the facility conducted champion rounds, meaning every morning the department heads made rounds to each room and observed the overall grooming of the residents to include nail hygiene. He stated that residents with long dirty fingernails were at risk for infection because they could scratch themselves and break the skin. He stated that the last ADL Inservice was conducted last month.During an interview on 02/11/2026 at 3:32 p.m., the Administrator stated that residents' fingernails were trimmed on an as needed basis. She stated that some residents wanted to have their fingernails trimmed and some did not. She said residents were asked if they would like their nails trimmed, if they did not, the staff were to encourage them to wash their hands and they were to document every time the resident refused to have nails cut. She stated it was the responsibility of the nurses and CNAs to ensure fingernails were trimmed. She stated that champion rounds were done to identify residents with long fingernails. She stated that residents with long dirty fingernails were at risk of an infection. She stated she initiated an Inservice on 02/10/2026 regarding long fingernails.Review of facility policy and procedure titled Nail Care undated read in part . Nail care will be performed regularly and safely, the resident be free from abnormal nail conditions, and the resident will be free from infection .