STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675768	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Villa Nursing Center	2729 Porter Ave El Paso, TX 79930

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for two residents (Residents #5, and #8) of seven residents reviewed for care plans.The facility failed to have a comprehensive person-centered care plan for Resident #5 to address residents' blood thinner medication prescription, Eliquis. The facility failed to have a comprehensive person-centered care plan for Resident #8 to address residents' diabetes diagnosis. These failures could affect residents and put them at risk for not receiving care and services to meet their needs.Findings Include:Resident #5 Record review of Resident # 5's admission record dated 12/04/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #5's history and physical dated 09/17/2025 revealed diagnosis of atherosclerotic heart disease of native coronary artery without angina pectoris (hearts blood vessels are getting clogged with plaque, not causing chest pain). Record review of Resident #5's annual MDS dated [DATE] revealed a BIMS of 04 indicating severe cognitive impairment. Section N- Medications accounted for anticoagulant medication. Record review of Resident #5's medication administration record for December 2025 revealed Eliquis Oral Tablet2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for BLE arterial occlusion (a blockage in an artery on both lower extremities.) -Start Date- 02/29/2024. Record review of Resident #5's order summary report dated 12/04/2025 revealed Eliquis Oral Tablet2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for BLE arterial occlusion (a blockage in an artery on both lower extremities) -Start Date- 02/29/2024.Record review of Resident #5's care plan revised on 09/03/2024 revealed the care plan did not address the resident's blood thinner medication prescription. Resident #8 Record review of Resident #8's admission record dated 12/04/2025 revealed a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #8's history and physical dated 12/06/2024 revealed a diagnosis of diabetes mellites type II. Record review of Resident #8's quarterly MDS dated [DATE] revealed a BIMS of 15 indicating intact cognitive function. Record review of Resident #8's care plan revised on 09/08/2025 revealed the care plan did not address the resident's diagnosis of diabetes. In an interview on 12/04/2025 at 11:05a.m., with the DON revealed that the purpose of a care plan was to detail how to take care of a resident and what their needs were. She stated that MDS nurse was the one who was responsible for creating the care plans and for revising them quarterly. She stated that not having certain medications and diagnosis in the care plan could affect resident care by the staff not being aware of certain care that the resident needs. She stated she could not remember the last Inservice that was done regarding care plans. She stated that the MDS nurse received training upon hire, and she believes that the MDS coordinator would be the one to oversee that she was completing them. In an interview on 12/04/2025 at 1:22 p.m., with Administrator revealed that the purpose of a care plan was to detail the needs of the resident and (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to let staff know how to care for the resident. He stated that the diabetes diagnosis along with medications such as anticoagulants should have been care planned because it was pertinent to the care of the resident. He stated that the MDS nurse was responsible for ensuring that the care plans were updated with all pertinent information. She updates them quarterly and as needed. He stated that there had not been any in-services done pertaining to care plans. He stated that she was trained on how to complete the MDS upon hire and she was trained by MDS coordinator. In an interview on 12/04/2025 at 1:34 P.M. with MDS nurse revealed that the care plan was an outline on what care the patient needed. She stated that a diagnosis of diabetes should be in the care plan, and medications such as blood thinners should be included in the care plan, because of the risk of bleeding that could cause harm to the resident. She stated that she revised the care plans every 3 months and as needed and that she was responsible for updating the care plans with pertinent information. She stated that floor nurses were also responsible for letting her know any updates. She stated that there has not been any Inservice regarding care plans. Review of facility policy titled Resident Assessment and Care Planning- Care Plans revised 08/2011 read in part The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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; and failed to have an established system in place for accurate reconciliation of all controlled drugs for 1 (East wing) of 2 medication carts that had residents with orders for controlled substances.The facility failed to ensure Licensed staff signed the form after counting and verifying that all controlled substances in the East Wing medication cart had been accounted for with the on-coming and off-going nurses on 12/03/25.This failure could place residents at risk for not receiving the intended therapeutic response of prescribed medications and drug diversion of controlled substances. Record review and interview with LVN D of the facility's Controlled Substance Shift Change Audit Record on the East Wing's Medication Cart, dated 12/03/25, observed at 11:23 AM revealed one signature notated for shift change at 2:00 PM. LVN D stated she signed it at the 2:00 PM shift change but could not explain why it was signed ahead of time.In an interview on 12/04/25 at 11:19 AM with the DON, she stated that nurses were responsible for doing the narcotic count and signing during the change of shift. She stated nurses were only to sign during the change of shift when the count was completed, and the risk for signing ahead of time would include drug diversion which can lead to the resident not having access to their medications. The DON was unable to recall the last in-service regarding the narcotic count per policy. She stated she was responsible for monitoring the count sheet, which she did up to twice weekly.In an interview on 12/04/25 at 1:18 PM with RN A, she stated the narcotic count sheet was for nurses to ensure accuracy of medications counted during shift change. She stated that the DON was responsible for auditing the narcotic sheet as often as possible. She stated that the nurse signing the count sheet ahead of time could cause the residents to not have their medications available to them because the nurses completing the narcotic count were not counting or signing off correctly. She stated another risk was drug diversion. She was unable to recall the last in service.Record review of the facility's policy Medication Storage: Controlled Medication Storage, dated 2007, read in part: At each shift change or when keys are rendered, a physical inventory of all Schedule II controlled medications is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure drugs and biologicals were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions for one (medication aide's medication cart) of two medications carts reviewed.The Medication Aide B failed to ensure to update label Resident #31's medication Sertraline 100 MG on 12/03/25 with the current dosage instructions to Give 1 tablet by mouth one time a day, to give 25 MG tablet for total dose of 125 MG.This failure could place residents at risk for not receiving the intended therapeutic response of prescribed medications.Record review of Resident #31's face sheet dated 12/03/25, revealed a [AGE] year-old male with an admission date 02/18/2022.Record review of Resident #31's history and physical, dated 09/10/25, revealed a medical history of Anxiety (a mental health condition characterized by excessive fear and worry that can interfere with everyday life), and Major Depressive Disorder (mental health condition characterized by a constant feeling of sadness or loss of interest in activities enjoyed by the person affected).Record review of Resident #31's quarterly MDS dated [DATE] revealed a BIMS score of 4, indicating severe cognitive impairment.Record review of Resident #31's Care Plan revealed the resident used the antidepressant Sertraline related to depression and anxiety. The interventions included for nursing staff to administer Sertraline as ordered by the physician.Record review of Resident #31's Order Summary Report dated 12/03/25, revealed a physician order of Sertraline 100 MG Give 1 tablet by mouth one time a day, to give 25 MG tablet for total dose of 125 MG. Record review of Resident #31's MAR for 12/2025, dated 12/03/25, confirmed resident had received 125 MG per current physician order.In an observation on 12/03/25 at 09:29 AM at the [NAME] Wing's Medication Aide B's Medication cart, Resident #31's medication, Sertraline 100 MG was observed with instructions, to give one tablet by mouth one time a day with 50 mg tablet for total dose of 150 MG. In an interview on 12/04/25 at 11:11 AM with Medication Aide B, she stated medication aides and nursing staff were responsible for updating the medications instructions as observed on the Electronic Medication Administration Record (EMAR). Medication Aide B stated that she was trained to first notify the floor nurse when the blister packet's administration instructions, and the instructions of the resident's EMAR do not match. She stated the nurse was to then reconcile the medications. She stated she was trained to add the label which notated for staff to refer to the EMAR instructions, as the EMAR reflected the most current physician orders. She stated she would audit her medication cart one to two times a week, and she believed the nurses also audit medication carts but was not sure how often. She stated that the orders of the EMAR were always followed to ensure residents get the correct medication. She stated she failed to update the medication instructions label this past Monday 12/01/25, because she got distracted with other job duties. She stated she was unable to recall the last in-service regarding medication labeling.In an interview on 12/04/2025 at 11:24 AM with the DON, she stated the medication aides were responsible for updating medication blister packets to reflect the EMAR administration instructions. She stated there was a red sticker that noted for staff administering medications to refer to the resident's EMAR, to ensure correct dosage per the physician's order. She stated that the risks of not updating medication administration instructions included overdosing or underdosing the residents. She stated medication aides audit their medication carts weekly, and the nurse audits once every couple of weeks. She was unable to provide a timeframe. The DON was unable to recall the last in-service. She stated she was responsible for ensuring medications were updated.Record review of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy titled Storage of Medication, dated 2007, read in part: Medication storage conditions are monitored on a regular basis as a random quality assurance check. As problems are identified, recommendations are made for corrective action to be taken.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 1 of 6 facility staff (LVN C) reviewed for trainings consistent with their expected roles, in that; -The facility failed to provide LVN C with training consistent with their expected roles. This failure could place residents at risk of accidents with potential harm due to staff not having up to date training. Findings included: Review of LVN C's personal record revealed annual training by the facility that did not include evidence of training consistent with their expected roles to include Compliance and Ethics, Abuse, Neglect and Exploitation, and Restraint Reduction.In an Interview and Record Review on 12/04/2025 at 2:30 pm with HR personnel revealed that LVN C's last annual trainings for compliance and ethics, restraint reduction, abuse, neglect and exploitation were last completed in September 2018. She stated that LVN C was a nightshift nurse. She stated that even if staff are nightshift, all staff to include nurses and CNAs were still required to fulfil the annual trainings. She stated to refer to LVN C's direct supervisor for further information on why this was not completed. She stated that usually, all the staff complete the annual trainings together at one time. In an interview on 12/04/2025 at 2:40 pm with DON revealed that LVN C was a nightshift nurse and this was most likely the reason that the trainings were not done. She stated that trainings for night shift nurses were left for them to read and sign. She stated that she was responsible for ensuring that the nursing staff were completing the annual trainings by reviewing who has signed the sheets and who had yet to. She stated that it was important for staff to be up to date on trainings, and depending on what the training was, it could have an effect on the residents' care. In an interview on 12/04/2025 at 2:47 pm with Administrator revealed that he was responsible for ensuring that the staff were up to date with annual trainings. He stated that all staff were required to complete annual trainings regardless the shift they work, but that nightshift nurses were a little harder to get a hold of. He stated that staff not being up to date on trainings such as restraint reduction and abuse and neglect could lead to the staff not knowing how to properly proceed in an event of needing to restrain or identifying abuse and neglect. Review of facility policy titled Staff Development Program revised December 2009 read in part . All personnel must participate in initial orientation and regularly scheduled in-service training classes.