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	01/14/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observation, interview, and record review, the facility failed to ensure residents who are incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #8) of 3 residents reviewed for catheter care. The facility failed to ensure Residents #8s catheter leg strap was in place to secure the catheter. This failure could place residents with foley catheters at risk of catheter pulling causing pain. Findings included: Record review of Resident #8's face sheet dated 1/14/25 revealed a [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses of retention of urine and neuromuscular dysfunction of bladder. Record review of Resident #8's significant change MDS assessment dated [DATE] revealed a BIMS score of 15, her cognition was intact and had and had indwelling catheter. Record review of Resident #8's physician order dated 10/16/24 revealed ensure catheter strap in place and holding, every shift change as needed. Record review of Resident #8's care plan dated 11/19/24 revealed a focus area for [Resident #8] has a Indwelling Catheter with goal of will remain free from catheter-related trauma through review date and interventions that included ensure tubing is anchored to the residents leg or linens so that tubing is not pulling on the urethra. In an observation and interview on 1/14/25 at 11:26 am, Resident # 8 was alert and oriented to place, time, and event. While in bed, it was observed that Resident # 8's urinary catheter was positioned below the bladder and hanging over the bed, with no leg strap secured. Resident # 8 stated that the catheter strap had not been in place for two days and that she had reported the issue, though she could not recall to whom or when. Resident # 8 stated that the lack of a secured strap caused discomfort when moving, as it allowed the catheter to shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/14/25 at 11:35 am, RN B stated that it was the responsibility of nursing aides and nurses to ensure urinary catheters were secured with leg straps and checked at least every two hours or as needed. RN B stated she had not received any communication indicating that Resident #8's catheter strap was not secured. RN B stated that she had spoken to Resident #8 that morning and asked how she was doing, but the resident had not mentioned the issue. RN B stated that during her check that morning, she only ensured the urinary catheter bag was off the floor and in a privacy bag, and she did not verify if the leg strap was in place. RN B stated that checking for the leg strap was part of her assessment, but she had forgotten to do so. RN B stated that the risk of not securing the leg strap included the catheter being tugged or pulled, potentially causing injury or trauma to the urethra. RN B stated she had received training on urinary catheter to include ensuring catheter strap was secured upon hire. In an interview on 1/14/25 at 11:49 am, CNA A stated that she had received training on urinary catheter care upon hire and at least twice a year. CNA A explained that it was the CNA's responsibility to ensure the leg strap was secured at all times, with checks performed at least every two hours or as needed. CNA A noted that Resident #8 was verbal and able to communicate her needs. CNA A clarified that she was not the CNA assigned to the resident but had assisted with perineal care. CNA A stated that the risk of an unsecured catheter included possible discomfort, as she had been told that catheter movement when not secured could cause residents some pain. In an interview on 1/14/25 at 3:00 pm, the DON stated that all staff, including CNAs, nurses, and nurse managers, were required to conduct rounds regularly. The DON stated nurse managers were expected to perform daily rounds, while CNAs and nurses were required to check on residents constantly and as needed throughout the day. The DON stated that nurses were expected to check catheter placement during their rounds, not just the privacy bags. The DON stated that nurses oversee the CNAs, while nurse managers oversee the nurses. The DON stated that failing to secure the catheter properly increases the risk of it being pulled out accidentally. In an interview on 1/14/25 at 4:01 pm, the Administrator referred the question to the DON. Record review of the facility's Cather Care policy dated 02/13/2007 read in part hold catheter tubing to one side and support against leg to avoid traction or unnecessary movement of the catheter while washing perineum.