STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675874	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamun-Lusk-Sanchez Texas State Veterans Home	1809 N Hwy 87 Big Spring, TX 79720

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 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49279 Based on observation, interview, and record review, the facility failed to provide food that accommodated resident allergies, intolerances, or preferences for 3 of 12 residents (Resident #1, #2, #6) reviewed for meal preferences. 1. The facility failed to ensure there was no cheese or Resident #1's sandwich, a documented allergy, resulting in Resident #1 having anaphylaxis symptoms and receiving an epi-pen (epinephrine, a medication that can help decrease a body's allergic reaction) on 12/15/2024. 2. The facility gave Resident #2, Resident #6's meal tray, and Resident #2 consumed the incorrect tray on 12/17/2024. 3. The facility gave Resident #6, Resident #2's meal tray, and Resident #6 consumed the incorrect tray on 12/17/2024. An Immediate Jeopardy (IJ) was identified on 12/18/24 at 9:22 AM. The IJ template was provided to the facility on [DATE] at 9:22 AM. While the IJ was removed on 12/18/24 at 6:55PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of pattern because all staff had not been trained on 12/18/2024. This failure placed residents at risk for not having their dietary restrictions and allergy restrictions followed which can result in anaphylaxis. The findings include: (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: 675874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
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F 0806

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

During an interview on 12/17/2024 at 9:12 AM with the DON and ADM, the DON stated she had been notified of Resident #1's incident on 12/15/2024 a little after 2pm. The DON stated Resident #1 had come down the hall stating he had eaten cheese and he felt like his throat was getting tight. She stated RN A assessed him, notified the FNP on call and administered an epi-pen. The DON stated RN A monitored Resident #1 for about an hour, and she followed him outside to smoke. The DON stated Resident #1 was very upset and he made some threats, and he notified the police. The DON stated the facility took immediate action and began their investigation. The DON stated she spoke to the kitchen staff, and they had all stated there was no cheese on the plate. The ADM and DON stated Resident #1 brought out a 75% eaten sandwich with ham and cheese but they could not verify where the cheese had come from. The DON stated Resident #1's allergy is posted on his meal ticket and there had been multiple steps in place to prevent cheese from being on his plate. The DON stated there had been instances where there was cheese on his plate that the facility staff had caught. The DON stated CNA A had taken the lid off Resident #1's tray and saw sandwich with meat and bread but did not see cheese. She stated CNA A did not disassemble Resident #1's sandwich but when she removed Resident #3's lid, his sandwich had cheese on it. She stated CNA A did not believe to have switched the trays because she remembered seeing the cheese on Resident #3's plate. The DON stated Resident #1 had complained of cheese being on his tray even on days they did not serve cheese with the meals, and he had ordered pizza before. The DON and ADM stated they had begun a multi focal training and education with their staff. The DON stated they had Resident #1's picture and a colored picture of a no cheese sign to make it more visible, on the serving line in the kitchen. She stated the kitchen would have a sign off sheet that they have to physically sing off what comes out of the kitchen and the nurses on the floor will have to sing off on his tray saying it had been checked as well. The DON stated the FNP did not believe Resident #1 needed to be sent to the ER as he was monitored by RN A, and his symptoms had resolved.

Resident #1

Record review of Resident #1's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #1 had a medical history of type 2 diabetes, lumbago(lower back pain), schizophrenia (a serious mental health condition that affects how people think, feel and behave), bipolar disorder(a mental health condition that causes extreme mood swings), post-traumatic stress disorder(a mental health condition that's caused by an extremely stressful or terrifying event) , and [NAME] encephalopathy (a neurological disorder induced by thiamine, vitamin B1, deficiency). Resident #1 had a listed allergy of gabapentin metformin, cheese, and milk.

Record review of Resident #1's annual MDS dated [DATE], section C- Cognitive patterns revealed a BIMS score of 15 which indicated Resident #1 was cognitively intact.

Record review of Resident #1's care plan revealed a focus initiated on 6/13/2024, of Allergic to gabapentin, metformin, milk cheese. Interventions included administer medication or allergies as ordered by MD.

Record review of Resident #1's physician orders revealed EpiPen 2-Pak injection solution auto-injector 0. 3mg/0.3ml (Epinephrine (Anaphylaxis) (a severe, life-threatening allergic reaction that can happen seconds or minutes after exposure to an allergen).

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's a communication form dated 6/17/2024 revealed Resident #1's name, other (checked box): Allergies. Diet order: No cheese or Milk (Allergies). Message/comments: IF there is cheese or milk in any meal, please give substitute. Record review of Resident #1's progress note dated 10/08/2024 at 10:31AM revealed IDT held care plan with Resident #1. Resident will remain a DNR. Medications, weights, and diagnosis were discussed. Resident states that he no longer has faith in the facility because he keeps getting served cheese, resident states the next time he gets served cheese he is going to go to the nurse's station and eat it and for them to call 911. Resident was educated on not eating cheese as he is allergic to it. Resident was educated on the importance of taking his medication consecutively, pharmacy nurse did ask resident what medications he would like changed and resident stated he did not care because he was not going to take any of them. Resident states that he has applied to be moved to another facility. Resident is refusing to complete care plan and left the meeting. Record review of Resident #1's progress note dated 12/15/2024 13:20 by RN A, resident #1 came to nurses' station frantic after eating cheese, was served one piece of bread with ham ontop-cheese was not seen when given to resident. resident folded bread and had two bites when he realized there was a piece of cheese under the ham. Resident states feels like my throat is closing (noted to have a hoarse voice) staff member states he has anaphylaxis to cheese. EpiPen given to right thigh at 1322 (1:32pm) , heart rate increased from 80's up to 108. within a minute residents state throat isn't feeling tight. 1340 (1:40pm) resident states throat is just a little sore no longer feeling like throat is swelling. lung fields clear to auscultation. resident stayed with nurse until 1355 (1:55pm), went to his room without further incident- call light within reach- no further complaints of throat tightness, heart rate in 80's 1400 (2:00pm) resident outside to smoke tolerating without difficulty. no increased throat discomfort- tolerated smoking without incident contacted FNP for prn orders, she states no need to send to ER. Supervisor, DNS, RN on call aware of incident. Record review of Resident #1's progress note dated 12/15/2024 at 1511 (3:11pm) by RN A revealed BSPD officer arrived on scene to speak with resident-resident insistent on charging kitchen staff. Officer explained could not press charges and issue was a facility issue. officer states would give him a complaint number for his records. this nurse spoke with officer and resident- resident raised his voice towards the officer, this nurse was able to calm resident with light touch and speaking with him. 1530 (3:30pm) resident states I have to go to the store and get out of here before I kill someone 1545 (3:45pm) resident returned from the store. Record review of Resident #1's progress note dated 12/15/2024 at 1549 (3:49pm) by RN A revealed resident returned from front of facility stated, the ADM was here and now she's gone- this is bullshit asked resident if he was ready for his pain medications he stated, I'm not taking a fucking thing, not eating not taking anything from this fucking place. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's progress note dated 12/16/2024 at 12:19pm by the ADON revealed this writer went to talk to resident in his room to discuss the plan and his refusal to eat in dining room. inquired what happened over the weekend. resident stated, 'they gave me a fucking cheese' and showed me the sandwich, it has cheese in it. this writer apologized and sympathetic to resident, and stated the plan of action, resident raised his left arm and verbalized ' Stop! stop lying to yourself!' 'I have been given cheese for the last six months' 'Admin is not doing anything'. 'I am done, I am not going to eat here' this writer clarified if he wants to eat in the dining room or his room or is he going to eat outside the facility, resident verbalized 'No! I am not going to eat at all, I will starve myself to death'. writer tried to ask further but resident said, ' I am done' and left his room via scooter.' DNS made aware. Record review of Resident #1's progress note dated 12/16/2024 at 1305 (1:05pm) by the SW revealed Social worker was speaking to resident to see how he is feeling after eating cheese over the weekend. Resident stated that his throat still hurts and he is pissed When the resident was asked if he was depressed, resident that put his hand up and stated, I'm done talking. SW then left the room. Record review of Resident #1's progress note dated 12/16/2024 at 2346 (11:46pm) by LVN B revealed Resident rolled up on his scooter at supper time and looked at his tray and refused. This writer acknowledged that there was no cheese on the tray. He still declined the tray and stated that someone had purchased wings he was waiting on. Record review of Resident #1's progress note dated 12/17/2024 at 2155 (9:55pm) by the DON revealed Met with resident to discuss his verbalized fears of dying and being unsafe in the facility. Resident states that he feels safe in his room and at night but feels unsafe during mealtimes and when any food is served to him. He continues to believe that the kitchen staff is trying to kill him and does not feel safe eating the food here. When he was asked what would make him feel safe, he stated that moving to another facility would be the only thing. He states that he is willing to move anywhere else to get away from here. He denied three different times that he feels unsafe or like he is going to die right now or tonight. He stated that he will not be eating the food from here, but that we should continue to send him his trays. Record review of RN A's undated statement revealed the following On 12/15 about 1320 (1:20pm), veteran Resident #1 came to nursing station via electric wheelchair, with roommate right behind him. Resident #1 was yelling they put fucking cheese on my sandwich, and I didn't know. I didn't fucking know. I ate it! I didn't fucking know Resident grabbing at his throat saying I'm allergic to fucking cheese! My throat feels like it is getting tighter Residents face appears reddened, with noted shaking of hands. Instructed on slowing breathing, residents face getting red, noted to have tears. EpiPen injected to right thigh. Within minutes residents facial color returned to normal and no longer had complaints of throat tightness. Once resident had calmed, attempted to educate resident but was interrupted by him and he refused to listen to anything this writer had to say. I monitored him post incident and he did not have adverse reactions. I spoke with the cnas regarding the incident. The cna who served the meal stated she inspected the sandwich and did not see cheese. Document signed but RN A. Resident #3 (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's undated face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #3 had a medical history of peripheral vascular disease, chronic hepatitis, liver disease, and polyneuropathy (when multiple peripheral nerves become damaged). Record review of Resident #3's annual MDS dated [DATE], section C- Cognitive patterns revealed a BIMS score of 14 which indicated Resident #3 was cognitively intact. During an interview on 12/17/2024 at approximately 10:00AM, Resident #3 stated he was roommates with Resident #1 and was in the room on Sunday 12/15/2024, when Resident #1 ate cheese. Resident #3 stated Resident #1 had made a comment about his sandwich only having one slice of bread on the bottom. He stated they even joked about the other piece of bread having the cheese on it and so they must have taken it off. Resident #3 stated he saw Resident #1 rolled the sandwich up and took a bite of the sandwich. He stated soon after Resident #1 stated his throat was closing up and he was shaking and could not talk very well. He stated what he saw was bread on the bottom, cheese, and ham. Resident #3 stated he knew Resident #1 had received an injection to his leg and has not seen him eat much since the incident. Resident #3 stated at no point were the trays switched because he ate his entire meal and, his plate had a sandwich with two slices of bread, cheese, and ham. Resident #2 Record review of Resident #2's face sheet, dated 12/17/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnosis to include unspecified dementia with mood disturbance (impaired ability to remember with mood concerns), type 2 diabetes mellitus with diabetic polyneuropathy (inability to regulate blood sugar levels), anxiety disorder (mental health concern), chronic respiratory failure with hypoxia disturbance (lack of oxygen in the blood), and other allergy, initial encounter (an allergy to an uncommon substance). Additionally, the allergies listed were Atorvastatin (medication for cholesterol), calcium/polysorbate 80 (calcium supplement with a soluble stabilizer), iodine (mineral), and shellfish. Record review of Resident #2's Comprehensive Minimum Data Set, dated dated [DATE], revealed under Section C Brief Interview for Mental Status score revealed a score of 03, which indicated the resident's cognition was severely impaired. Record review of Resident #2's Care Plan, dated 12/14/24 revealed a focus area, initiated on 6/14/24, the resident's current diet was regular texture, thin/regular consistency with large protein portions. Further review revealed a focus area, initiated on 5/30/24, that the resident was allergic to Iodine, Atorvastatin, Calcium/Polysorbate 80, and shellfish. The goal was the resident would not have any adverse reactions to allergies. The interventions initiated on 5/30/24 were to ensure a list of allergies go with the resident to the physician, pharmacy, and hospital and to ensure dietary was notified of any food allergies when he was admitted . Additional interventions were that the resident was severely allergic to shellfish (prior anaphylactic reaction), keep EpiPen available for shellfish allergy, administer medication for allergies as ordered by the medical doctor, and to notify the doctor of unresolved allergy symptoms as needed. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #2's physician orders, dated 12/17/24, revealed a prescription for EpiPen 2-pak injection solution, auto-injector 0.3 MG/0.3ML (Epinephrine Anaphylaxis). Inject 1 application intramuscularly every 24 hours as needed for allergies. Physician orders further revealed, Resident #2 was on an RCS (Reduced concentrated sweets) diet with a regular texture, thin/regular consistency, provide large protein portions with meals. Record Review of Resident #2's Communication form with the dietary department, dated 5/30/24, revealed Resident #2 had a diet order of Regular and regular liquid. Additionally, the document indicated Resident #2 had an Iodine allergy and no shrimp. Resident #6 Record review of Resident #6's face sheet, dated 12/18/24, revealed a [AGE] year-old-male was admitted to the facility on [DATE] and readmitted on e 9/23/24 with diagnosis to include bipolar disorder (mental health concern), vascular dementia (impaired ability to remember), and type 2 diabetes mellitus without complications (inability to regulate blood sugar levels). Additionally, Resident #6 had no known allergies. Record review of Resident #6's Comprehensive Minimum Data Set, dated dated [DATE], revealed under Section C Brief Interview for Mental Status score revealed a score of 15, which indicated the resident's cognition was intact. Record review of Resident #6's Care Plan, dated 12/18/24 revealed a focus area, initiated on 3/22/24, the resident's current diet was regular texture, thin/regular consistency and that the resident was at risk for nutritional deficits and/or dehydrations risks related to therapeutic diet. During an interview on 12/17/24 at 12:22 PM, Resident #2 stated he had lived here for about 3 months. He stated the facility was clean. He stated food was alright but lacked flavor and the staff was polite. He stated he was a diabetic and he was highly allergic to shrimp and all crustaceans. He stated he found out he was allergic when he was in the navy. He stated he had been served shrimp at this facility three times, but he saw it and did not eat it. He stated he told staff, and they brought him something else to eat. He stated he listed his allergies on his admission paperwork. He stated he could get choked up and die if he eats shrimp or crustaceans. He stated he was offered snacks such as sandwiches between meals. He stated he had no concerns of abuse or neglect. He stated he had no additional concerns to report. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a dining observation on 12/17/24 at 1:03 PM in the memory care unit with the following: The food was brought to the memory care unit in an insulated rolling food warmer. There were two meals on each food tray. RN C was observed looking at each tray ticket, she picked up the plate cover to observe the food, then she put that tray on the counter where she prompted the CNA's that they were inspected and ready to be passed out. The CNAs were observed performing hand hygiene and then took the trays and passed them out to the residents. During the lunch observation the surveyor observed Resident #2 eating in the dining room and had eaten about 75% of his food, as the surveyor approached him it was observed that the tray ticket had the name of Resident #6 on it. The surveyor asked Resident #2 if the name on the tray ticket was his and he said it was not. The surveyor then stopped RN C as she passed out drinks and told her that Resident #2's tray ticket had another person's name on it. RN C apologized to Resident #2 for getting the wrong plate and took the plate. CNA C stated she handed Resident #2 the wrong tray. Resident #6 was observed eating his food in the dining room as well and staff took his tray. It was observed that he had eaten about 50% of the food on the plate and the tray ticket had Resident #2's name. During an interview on 12/17/24 at 1:16 PM, Resident #6 stated he had not noticed another person's name was on the tray ticket and was not happy that he was served someone else's food. Resident #6 stated this happened to him before. During an interview with CNA A on 12/17/2024 at 2:39pm, she stated on 12/15/2024 she had finished assisting residents in the dinning hall for lunch and began helping pass out trays. She stated she saw they were having grilled cheese sandwiches and noticed Resident #1's was different. She stated it was plain ham with a piece of bread underneath it. She stated she did not see any cheese at that point and did not want to pick up his food. She stated Resident #1s meal ticket was underneath the plate and had his allergies listed. She stated she took the plate to Resident #1's room and he had asked aren't we having alfredo? and she responded no. She stated she saw him pick up the sandwich and fold it in half but exited the room before he took a bite of it. She stated Resident #3's sandwich had cheese on it and two pieces of bread while Resident #1's only had one piece of bread and that is why she assumed there was no cheese on Resident #1's sandwich. She stated Resident #1 began having symptoms about 10 minutes later and received an EpiPen to his leg. She stated this has happened a lot of times where they put cheese on his tray and Resident #1 catches it and gets upset and yells at them to go fix it. She stated sometimes it is meals like ravioli which have cheese inside or mac and cheese. She stated the mac and cheese is usually caught before being served to Resident #1. She stated they have been in-serviced on his allergies, but she believes the issue comes from the kitchen. She stated the staff will let the kitchen know but it just gets brushed off and nothing happens. She stated she is not sure why there was sandwiches for that meal. On 12/18/2024 at 6:19pm CNA A stated Resident #1's meal ticket showed a smothered turkey patty not a sandwich. CNA A stated the meal and ticket did not match up, and the meals are usually verified by the nurse, but they had not been verified that day and she is not sure why. CNA A stated she witnessed Resident #1 pick up the sandwich and fold it before exiting the room. She stated at no point did she see Resident #1 tamper with the tray, and she did not see anyone else tamper with the tray cart (the rolling cart that holds the meals for transport). CNA A stated there had been about three other incidents where Resident #1 had cheese served on his tray but does not recall the dates or times. She stated she remembers Resident #1's sandwich was not grilled and had a missing piece of bread while Resident #3's was grilled and had two pieces of bread and she is sure the trays did not get switched. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Resident #1 on 12/17/2024 at 3:20 PM he stated, I have been here 6 months and told them I'm allergic to cheese. I told them one of these days I'm going to eat cheese and wind up dead. It feels like they are trying to kill me, and it is premeditated murder because they have known about it for months and it keeps happening. On Sunday they gave everyone ham and cheese. I got two pieces of ham and 1 piece of bread. I joked and said I bet the other bread had the cheese on it. I folded it up and took a bite. I knew something was wrong because my throat felt weird, so I went up to the nurse's station and they gave me an epi pen. The cheese was yellow, and it was below the ham when I took it apart. I have had epi pens twice in my life, both from eating cheese accidently. I don't know exactly why I'm allergic to cheese, I think it has something to do with the enzymes in it, but milk doesn't give me the same reaction. Milk makes my stomach upset and diarrhea. I think the facility just didn't believe me. I don't think they believed I was really allergic to cheese. I am still mad about it. After the epi pen, I did feel better, but my throat is sore. I have avoided eating cheese my whole life, I'm glad I did notice because what if I had passed out and stopped breathing and didn't tell anyone. I did call law enforcement because I felt like it was attempted murder. Everyone has been kissing my ass and being nice since the incident. I feel unsafe and disrespected, and I haven't eaten since then. I don't trust them. Yes, I have bought pizza before, but I usually order it for the other residents, and I'll get myself some wings or a burger. I have also ordered pizza without cheese; people are surprised when I tell them it's pizza without cheese . I did not leave the facility on Sunday prior to the incident. I have an ice box and my roommate does not and he stores his pimento cheese in my ice box but that's my fridge and I let him. During an interview on 12/17/24 at 4:31 PM, the Director of Dining Services stated she spoke with Resident #1 about what happened, and he told her that he would never eat the food here anymore. She stated she asked if she could buy him dinner and he agreed so she bought him chicken wings. She stated there were twos staff that were witnesses. She stated she had bought other residents' food before. She stated Resident #1 refused his food trays yesterday and did not eat. He asked for a steak, and he got wings. She stated he was kind during their conversation. She stated she was not aware of him being served cheese before. She stated she came three times a month from [NAME]. She stated once the food comes out of the kitchen, a licensed nurse checked the trays, and the CNAs passed out the trays. She stated the Dietary Manager provides training to staff. She stated the dietary staff, and the cook were responsible for ensuring trays were correct. She stated the cook places the food on the trays. She stated staff called the tray tickets out to the cook when plating the trays. She stated a potential negative outcome was that they could get a stomachache. (continued on next page)

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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 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/17/24 at 5:47 PM, with RN C she stated she was responsible to ensure residents were served the right texture in their diet during meals. She stated she looked at the tray tickets for their name, texture, and allergies and then she looked at the food to ensure the order was correct and allergies were correct. She stated then she passed the trays to the CNAs who were then responsible to pass trays to residents after she had checked them out. She stated the CNAs were supposed to ensure they give trays to the correct resident. She stated she was given an in-servicing on tray passing recently to herself and all her staff, yesterday and the day before. She stated she became aware that Resident #2 was served the wrong food tray when she passed out the drinks and saw that he had the wrong tray ticket. She stated normally they pass drinks before the food but today the drinks were late, so she passed the drinks after the food today. She stated Resident #2 and Resident #6 were served each other's meals by CNA C. She stated she was not aware if either of those two residents had any food allergies but they both ate regular diet texture. She stated Resident #2 had eaten about 20-30% of the food by the time she discovered it. She stated dietary staff were responsible to ensure the correct food was on the tray, she was responsible to double check it, and the CNAs were responsible to pass trays to the correct resident. She stated she expected staff to deliver trays to the correct residents. She stated a potential negative outcome was they could have an anaphylactic reaction or an allergy, or an obstruction from their throat swelling, or they could develop hives. She stated also if someone were to eat the incorrect diet texture, they could have difficulty swallowing the food or people that don't have teeth may not be able to eat the food. She stated she was responsible to ensure CNAs were providing care to residents according to their treatment plans. She stated she was not responsible to ensure the CNAs gave resident's the correct tray. She stated the CNAs also received training for this and she could not see everything going on in the facility. She stated after today's incident at lunch, she had a huddle meeting with the DON and the staff and reviewed the recent in-service. During an interview on 12/17/24 at 6:04 PM, CNA C stated she worked on the D-wing Memory Unit. She stated she was overstimulated today when passing the food trays during lunch because her pig tails on her hair were pulling. She stated she also felt rushed by RN C. She stated she accidentally served Resident #6 and Resident #2 each other's trays for lunch. She stated their plates were on the same tray and she switched them. She stated they both eat the same regular diet texture so luckily there was no allergy mix-up. She stated when she passed out food trays, first the nurse read every tray ticket and she compared it to the food on the plate to ensure it was correct. Then the nurse would let them know it was approved to serve to the residents. She stated she knew all the residents and did not need to ask their names to verify their identities. She stated she was aware Resident #2 had a shellfish allergy. She stated she was not aware of him being served shellfish or shrimp before. She stated a potential negative outcome could have been itching or the worst-case scenario was the resident could experience anaphylaxis or death, however it would depend on the severity of the allergy. She stated she was trained on abuse and neglect recently and received additional trainings once a month. She stated she received an in-service yesterday on tray tickets and passing out trays. She stated she went and told the DON that she mixed up the two resident's food trays today and was not given additional instructions. She stated she was made aware of the mix up when RN C told her. She stated Resident #2 had eaten about 75 % of the food on the plate and Resident #6 had eaten about 50% of his food. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Lamun-Lusk-Sanchez Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N Hwy 87 Big Spring, TX 79720	

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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 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with RN A on 12/17/2025 at 6:13pm, she stated on Sunday 12/15/2024, Resident #1 had come up to the nurses stating saying they fucking gave me cheese again, they are trying to kill me. She stated she asked Resident #1 to slow down and explain what had happened and he explained he had eaten some cheese that was served on his sandwich. She stated the CNA's (she didn't remember who) said they didn't see the cheese. She stated one of the CNA's told her he was allergic to cheese, and she asked if he was having symptoms. She stated Resident #1 told her his throat was closing up, he had tears in his eyes, was breathing fast and was clutching his throat. She stated she notified the FNP, grabbed the epi pen from the medication cart and administered the epi pen. She stated she did check his lungs prior to, and he had clear lung sounds but did not want to risk waiting because anaphylaxis symptoms can occur rapidly. She stated she had no idea how his sandwich ended up with cheese because she had been told the food was looked at. She stated that CNA who checked it remembers checking it because it only had the one slice of bread. She stated Resident #1 had told her this was not the first time they had put cheese on his meal, but she has not been present for those other times. She stated the kitchen checks his plate, the staff checks his plate, and he checks his plate so she is unsure how it could have been missed. During an interview with the FNP on 12/18/2024 at 9:45AM, she stated she had been called on 12/15/2024 about Resident #1 having eaten cheese and having an allergy to cheese. She stated the RN A told her his vitals were normal and he did not appear hypoxic (low levels of oxygen in body tissue), so she ordered a dose of epinephrine to be given. She stated she checked back about 15 minutes later and Resident #1's symptoms had resolved and was smoking, and she did not feel he needed to go to the ER. She stated the RN A's actions were appropriate and she had no concerns with the way the situation had been handled. She stated she is not sure how he was given cheese, but his dietary restrictions need to be followed to prevent this from occurring again. During an interview on 12/18/24 at 11:49AM, Resident #3 stated he had never seen Resident #1 eat cheese. He stated he had never seen Resident #1 store cheese in his refrigerator. He stated the pimento cheese in Resident #1's refrigerator belonged to him. He stated Resident #1 did not put cheese in his sandwich, he would never have done that because he was allergic to cheese. He stated on the day of the incident Resident #1 complained to him that he only had one bread, then he folded the sandwich in half and ate it. He stated Resident #1 did not tamper with the sandwich. During an interview on 12/18/24 at 12:00 PM, Resident #1 stated the facility provided him with apartment applications this morning, but the feeling was mutual. He stated he had been talking to them about wanting to move. He stated he ate a couple of bites of the dinner last night and threw it in the trash. He stated staff looked at his tray before giving it to him. Resident #1 granted permission to take photographs of [NAME][TRUNCATED]