STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676060	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambrosio Guillen Texas State Veterans Home	9650 Kenworthy St El Paso, TX 79924

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 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** 43871 Based on observation, interview and record review the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 7 (Resident #1) residents reviewed for abuse. The facility failed to immediately suspend CNA B after CNA A reported suspected roughness when CNA B was providing care to Resident #1. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of Resident #1's face sheet dated 4/23/24 revealed an [AGE] year-old female who was admitted to the facility 08/07/2020 with diagnoses of dementia, Alzheimer's, acute pain due to trauma, and anxiety. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed her cognitive level was severely impaired and had behavior symptoms like verbal/vocal symptoms like screaming, disruptive sounds. Record review of Resident #1's care plan revealed exhibit continuous low, feeble expressive sounds during ADL care with interventions of staff explain the care that would be providing, do not rush, reinforce positive behavior, provide safe environment. Record review of Resident #1's progress note dated 03/07/24 written by RN C at 12:34 pm revealed, head to toe assessment was done, no skin issues, open areas or irritated noted. Record review of Resident #1's progress note dated 03/07/24 written by LVN D at 4:22 pm revealed POA was called and notified of alleged allegations and POA voiced [Resident #1} cries when being woken up that's her normal behavior, I hope this misunderstanding gets resolved POA was notified of body audit being completed and no skin issues noted, no distress noted to [Resident #1]. POA voiced no concerns. Record review of CNA B's time sheet dated 03/07/24 revealed she worked from 6:15 am- 2:13 pm. (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: 676060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA A's written statement dated 03/07/24 revealed in part To administrator, I am reporting a abuse. This morning [CNA B] was in the room of Resident #1. When I go in the room, I saw [CNA B] grab [Resident #1 from her arms and pull her very strong towards her. During an interview and observation on 04/16/24 at 9:52 am, Resident #1 was in the lobby area watching television, no reaction when approached and greeted by the surveyor and did not answer any questions. Resident #1 did not show signs of distress. During an interview on 04/16/24 at 11:13 am, the DON stated Unit Manager had reported that CNA A had made an allegation of CNA B was rough , she had forcefully sat her down on her wheelchair, when providing care to Resident #1 on 03/07/24. The DON stated he made the self-report to HHSC, PD was notified, and MD was notified. The DON stated him, and the Administrator gathered statements from staff who worked that day. The DON stated he did not remember the time the allegation was made. The DON stated CNA B was suspended and was not sure at what time. The DON stated the Administrator was the one who suspended CNA B and he was the lead investigator of the allegation made. During an interview on 4/23/24 at 8:45 am, the Administrator stated CNA A had reported to him that she was concerned CNA B had rushed ADL care for Resident #1 and had not provided proper care on 03/07/24 at around lunch time. The Administrator stated him, and the DON went to the memory unit and started interviewing staff on the floor that day at around lunch time and no concerns were identified. The Administrator stated they requested written statements from CNA A, CNA B and potential witnesses and no concerns were identified. The Administrator stated at the end of shift CNA A had provided a second statement in which she included allegations of verbal aggression from CNA B and roughness towards Resident #1. The Administrator stated he then called CNA B and notified her of suspension pending investigation, she had finished her shift at that point. The Administrator stated he had conducted an investigation and results were unsubstantiated due to CNA A inconsistency in statements, history of problems with CNA A, no other witnesses with similar concerns related to CNA B, and Resident #1 was noted with no injuries. During an interview on 4/23/24 at 11:22 am, CNA B stated she had worked the day of the allegation was made (03/07/24) and was assigned to Resident #1. CNA B stated Resident #1 had history of making crying like noises when she was provided any type of care. CNA B stated she was made aware of the allegations that were made against her on 03/07/24 at around lunch time (being verbally aggressive and being rough during care) which was at around 11:40 am. CNA B stated she was approached by the DON and Administrator who had questioned her interaction with Resident #1. CNA B stated she was asked if she had been verbally and/or rough when providing care, due to CNA A making an allegation against her, and she had stated no . CNA B stated she was asked to write a statement and continued to work until her shift was over. CNA B stated she was not placed in a different hallway when asked about Resident #1 and was eventually suspended after her shift was over. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/24 at 8:47 am, RN C stated she had worked the day the allegation was made on 03/07/24. RN C stated every time the staff received a complaint of any type of suspected roughness, they were required to conduct a head-to-toe assessment and required to report to DON and Administrator immediately. RN C stated she had not witnessed CNA B being rough with Resident #1 and/or any other resident the day in question. RN C stated she was approached by LVN D who reported they needed to conduct a head-to-toe assessment on Resident #1 due to some allegations of roughness reported around lunch time approximately 12:00 pm. RN C stated she conducted Resident #1's head to toe assessment on 03/07/24 and no findings were noted related to physical and/or emotional distress. RN C stated she was asked to write a statement regarding her observations on 03/07/24 by the DON and the Administrator at around lunch time, approximately 11:30 am. During an interview on 4/24/24 at 9:21 am, LVN D stated she worked the day the allegation was made on 03/07/24 and was the charge nurse assigned to Resident #1. LVN D stated she was questioned about CNA B's interaction with Resident #1 at around 11:30 am on 03/07/24. LVN D stated she had not witnessed CNA B be rough and/or verbally aggressive with Resident #1 and/or any other residents. LVN D stated usually when a staff was named as an alleged perpetrator the facility immediately suspended the staff. LVN D stated she was not sure why CNA B was allowed to finish her shift on 03/07/24. LVN D stated RN C had completed Resident #1's head to toe assessment and no findings were identified. LVN D stated there had not been a change in Resident #1 demeanor post allegation. Record review of the Abuse Investigation policy dated October 2022 read in part an immediate investigation is warranted when abuse is suspected or reported, and a thorough investigation result will be documented. If an alleged person is identified, obtain a written statement from this individual and suspend pending results of the investigation. The policy does not address timeframe of alleged perpetrator to be suspended.