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	05/31/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on observations, interviews, and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 16 residents (Resident #8 and Resident #16) reviewed for accuracy of assessments. The facility failed to ensure Resident #8's MDS accurately reflected his g-tube status. The facility failed to ensure Resident #16's MDS accurately reflected his behaviors. These failures could place residents at risk for not receiving care and services to meet their physical needs and promote feelings of well-being and quality of life. Findings included: Record review of Resident #8's face sheet dated 05/29/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnosis of altered mental status (change to your average mental function). Record review of Resident #8's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, indicating he was cognitively intact. The assessment did not account for enteral feeding. Record review of Resident #8's care plan revealed focus area for requires feeding related to dysphagia with goal will maintain adequate nutritional and hydration status. Record review of Resident #16's face sheet dated 05/31/24 revealed a [AGE] year-old male who was admitted on [DATE] with diagnoses of Parkinson's disease (type of brain disorder that causes problems with memory, thinking, and behavior) with dyskinesia (involuntary, erratic movements of different body parts, such as the face, arms, legs, or trunk), and anxiety (a feeling of dread, fear, or apprehension, often with no clear justification). Record review of Resident #16's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating h he was cognitively intact. His behavior of false accusations was not accounted for under the behavior section of assessment. Record review of Resident #16's care plan revealed a focus area for behavior expresses repeated criticism of staff. (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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NAME OF PROVIDER OR SUPPLIER Ambrosio Guillen Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 9650 Kenworthy St El Paso, TX 79924	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/31/24 at 9:16 am, the Unit Manager stated Resident #8 did have a g-tube in place since admission. The Unit Manager referenced Resident #8's electronic records and stated his MDS was inaccurate due to enteral feeding section being marked no. The Unit Manager stated the facility was aware of Resident #16's behaviors. The Unit Manager stated staff were to always provide care with 2 people to avoid any false accusations and/or have witnesses always present. The Unit Manager referenced Resident #16's electronic record and stated his MDS assessment was accurate due to the behaviors section being marked as no. The Unit Manager stated MDS Nurses were responsible of reviewing MDS assessments quarterly, annually, and yearly . During an interview on 05/31/24 at 11:24 am, the MDS Nurse stated she was responsible for Resident #8 and Resident #16's MDS assessments. The MDS Nurse stated she was familiar with both of their conditions. The MDS Nurse stated Resident #8 did have a g-tube in place and it should have been accounted for on his most recent MDS assessment. The MDS Nurse stated she was aware of Resident #16's behaviors towards staff and his most recent MDS assessment should have included these behaviors. The MDS Nurse stated the only risk was that the State Office would not know of Resident #16's behavior and/or Resident #8's g-tube status. The MDS Nurse stated it was missed. Record review of the Resident Assessment policy dated 02/2015 read in part it is the policy of this facility in the long-term care facility resident assessment instrument user's manual 3.0 completion of assessments. Purpose: to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan and to assist the staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing facility to track changes in the resident's status.

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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 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** 43871 Based on interviews and record review the facility failed to implement care interventions in accordance with each resident's written plan of care for 1 of 16 residents (Resident #8) whose care was reviewed. The facility failed to implement behavior focused area and interventions for Resident #8's pulling on drainage. This failure could affect residents monitoring that could result in injury. Findings included: Record review of Resident #8's face sheet dated 05/29/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of altered mental status (change to your average mental function). Record review of Resident #8's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, indicating he was cognitively intact. Record review of Resident #8's care plan did not address behavior of pulling accordion drain. Record review of Resident #8's progress notes dated 04/21/24 read in part returned from being out on pass with [RP], reported resident was pulling on accordion drain, upon assessment was intact dressing was slightly removed, reinforced, draining with no difficulty. Record review of Resident #8's progress note dated 04/28/24 read in part resident noted disconnecting g tube from abdomen multiple times this shift, informed [RP] when he arrived,. Record review of Resident #8's physician order dated 05/28/24 revealed refer to surgeon post accordion drain removal and wound care nurse to assess right flank area due to removal of accordion drain. Record review of Resident #8's local hospital record dated 05/27/24 revealed diagnosis of accidental removal of percutaneous cholecystostomy tube with discharge instructions to follow up with PCP within 2-4 days. Record review of Resident #8's progress note dated 05/24/24 revealed resident came to this facility at 1830 (6:30 pm) via ambulance AAOx1 name only. DC accordion drain bag to right flank. During an interview on 5/29/24 at 11:28 am, Resident #8 was hard of hearing and had difficulty answering questions. Resident #8's RP was at bedside and stated Resident #8 was sent out to the hospital Monday (05/27/24) because he's drainage was dislodged and was removed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/24 at 1:46 pm, LVN A stated she was notified by CNA' s that Resident #8's drainage had been dislodged. LVN A stated she went to see Resident #8 and there was no blood noted and some pain voice. LVN A stated she notified the MD who gave orders to be transferred to the hospital for further evaluation. LVN A stated Resident #8 had tendency of pulling on the drainage and required a lot of redirecting. She stated he was moved to a room closer to the nurse's station to have him closer to round on. LVN A stated staff were aware of the behavior and would round on him frequently and his family visited everyday which helped in keeping eyes on him . During an interview on 05/31/24 at 9:16 am, CNA B stated she had worked with Resident #8 and was familiar with his care. CNA B stated Resident #8 had a history of pulling on the drainage bag, he required a lot of redirection, and he would comply. CNA B stated Resident #8's family visited every day and was very helpful with notifying them of the behavior and would redirect him as well. CNA B stated after the family left, they would put Resident #8 in the common area so more staff could keep an eye on him as they passed by . During an interview on 05/31/24 at 10:37 am, the Unit Manager stated he was aware of Resident #8's behavior of pulling the drainage. The Unit Manager stated the nurses and CNAs would round on him frequently and a lock was placed to prevent from dislodging. The Unit Manager stated Resident #8 was almost moved to a room closer to the nurse's station to keep a closer eye on him. The Unit Manager stated Resident #8's family was aware of behavior and would visit every day to assist as much as they could. The Unit Manager stated the MDS nurses were responsible of overseeing the care plans and to ensure they were updated as needed. The Unit Manager stated Resident #8's history of pulling on the drainage was a behavior that should had been reflected on his care plan for monitoring. The Unit Manager stated there was no risk for pulling on behavior not being implemented because the staff had interventions in place to prevent Resident #8 from pulling on his drainage. The Unit Manager stated MDS nurses were aware of Resident #8's behavior because it had been a topic of discussion during their daily morning meetings. During an interview on 05/31/24 at 11:24 am, the MDS Nurse stated she was responsible for Resident #8's care plan and was familiar with his care. The MDS Nurse stated she was not aware of Resident #8's history of pulling on his drainage. The MDS Nurse stated she was part of the daily mornings and she had not heard the part of Resident #8 pulling on his drainage. The MDS Nurse stated she would reference progress notes and ask staff about resident's condition/behavior when completing the quarterly, annually, and/or change in condition MDS assessments. The MDS Nurse referenced Resident #8's electronic records and stated there was documentation regarding him pulling on the drainage. The MDS Nurse stated Resident #8's behavior should have been implemented in his care plan for staff to be aware and monitor the behavior . Record review of Care Plan policy dated June 2019 read in part to develop a comprehensive resident/person centered care plan. The resident's comprehensive care plan has been designed to: A. identify care needs that include resident's strengths, history, and preferences. D. include individualized approaches to meet resident's goals.