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	07/26/2024

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 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** 45217 Based on observation, interviews and record reviews, the facility failed to provide appropriate treatment and services to prevent urinary tract infections for one resident (Resident #3) of three residents reviewed for catheter care. -Resident #3's catheter drainage collection bag was lying on the floor. This deficient practice could affect residents with catheters and could result in cross contamination of germs and could result in a urinary tract infection (an infection in any part of the urinary system). The findings included: Review of Resident #3's Admission Record dated 07/25/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3's diagnoses included: obstructive and reflux uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), and benign prostatic hyperplasia with lower urinary tract symptoms (needing to urinate frequently, a weak urine stream, and leaking or dribbling of urine). Review of Resident #3's quarterly MDS dated [DATE], revealed resident was rarely/never understood. Section H Bladder and Bowel indicated the resident had an indwelling catheter. Review of Resident #3's care plan dated 07/25/2024, reflected in part, (Resident #3) has Suprapubic Catheter: Obstructive and reflux uropathy. Pulling on his suprapubic. Part of the intervention steps reflected, Foley bag off the floor. Observation and interview on 07/25/2024 at 9:10 a.m., revealed the HHS Investigator walked by an open door of room [ROOM NUMBER] and observed Resident #3 lying on a bed with the Foley drainage bag on the floor next to the bed. Resident #3 was observed to be asleep at the time. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/2024 at 9:13 a.m., LVN F entered Resident #3's bedroom and observed the drainage bag on the floor. LVN F said the drainage collection bag should have been attached to the bedframe below Resident #3's bladder level. LVN F said the CNAs had just changed Resident #3 about 15-20 minutes ago and didn't reattach the drainage bag back onto the frame of the bed. LVN F said the risk of the bag being on the floor was infection control and a possible spill. LVN F said she did not know why the CNAs did not attach the drainage bag and said she would immediately address it with the CNAs. LVN F said Resident #3 did not have a urinary tract infection. During an interview on 07/25/2024 at 9:20 a.m., ADON D said that staff put Resident #3's bed in the lowest position and when hanging the drainage bag, it may fall to the floor. The ADON D said there was a way to place the drainage bag that allowed the bed to be in lowest position without risk of bag falling to the floor and that was by clipping the drainage bag to the fitted sheet which allows gravity drainage. ADON D said it was the nurse's and CNAs responsibility to make sure the drainage bag was off the floor. The ADON D said that he would address the issue with staff. The ADON D said the risk of the bag being on the floor was infection. The ADON D said Resident #3 had not had a urinary tract infection. During an interview on 07/25/2024 at 10:30 a.m., the DON said it was common practice to keep the drainage bag off the floor. The DON said the purpose of keeping the bag off the floor was to prevent any infection or bacteria as standard precaution. The DON said nursing staff including CNAs in the hall were responsible to ensure the bag is off the floor and below bladder level of the resident. Review of facility Catheter Care policy dated 06/2024, reflected in part. It is the policy of the facility to ensure residents with indwelling catheters receive appropriate catheter care suing proper technique while maintaining the resident's privacy and dignity Responsible staff include licensed and certified staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 1 (Resident #3) of 4 residents observed for oxygen management. Resident #3 was on oxygen and did not have oxygen signs posted outside his bedroom. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health; and place them at risk of an unsafe environment which could lead to accidents and injuries. Findings included: Review of Resident #3's Admission Record dated 07/25/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3's diagnoses included: acute upper respiratory infection (contagious infection of upper respiratory tract), and obstructive sleep apnea (intermittent airflow blockage during sleep). Review of Resident #3's quarterly MDS dated [DATE], revealed the resident was rarely/never understood. Review of Resident #3's Order Summary Report dated 07/25/2024, reflected in part and order with a start date of 07/24/2024, for oxygen at 2-3 liters per nasal cannula PRN for signs or symptoms of shortness of breath/comfort. Review of Resident #3's care plan dated 07/25/2024, reflected in part, (Resident #3) is receiving oxygen related to low oxygen saturation. Part of the intervention steps reflected, Place a No Smoking sign on resident's door while oxygen is in use. During an observation on 07/25/2024 at 9:15 a.m., revealed Resident #3 was lying on a bed and had on a nasal cannula with the oxygen concentrator running at 3 LPM. Outside of the bedroom entrance door revealed there was not a sign indicating oxygen in use/no smoking. During an interview on 07/25/2024 at 9:20 a.m., ADON D said there should have been an Oxygen in Use sign on the door to show that oxygen is being used in the room. The ADON D said it was his and the floor nurse's responsibility to put up the signs. The ADON D said he does not know why a sign was not on the door of the resident who was using oxygen. The ADON D said the purpose of the sign was to let others know that oxygen was being used inside the room. The ADON D said the risk was minimal as the facility is a smoke free facility. Review of facility provided Oxygen Therapy policy dated 10/2012, reflected in part, Purpose: to administer oxygen per physician's order. Part of the Procedure steps included, Place Oxygen in Use signs outside of resident's room.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45217 Based on, interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 (Resident #3) of 8 residents reviewed for medical records. -The facility failed to ensure a physician's order for PRN oxygen for Resident #3 was documented. This failure could lead to errors in treatment based on incorrect information. Findings included: Review of Resident #3's Admission Record dated 07/25/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3's diagnoses included: acute upper respiratory infection (contagious infection of upper respiratory tract), and obstructive sleep apnea (intermittent airflow blockage during sleep). Review of Resident #3's quarterly MDS dated [DATE], revealed resident was rarely/never understood. Review of Resident 3's progress notes dated 7/14/2024 at 5:35 a.m., written by LVN H reflected in part, chest x-ray completed at approximately 0430 pending results. Re-assessed resident 86%@ RA (room air. Started resident on oxygen @ 2L via nasal cannula and 02 went up to 90% then dropped between 88-86%. Notified RN Supervisor and increased oxygen to 3 L via nasal cannula. 02 at the time 92% @ 3Ls. Updated NP on the status of resident. Review of Resident #3's progress notes dated 7/16/2024 at 12:42 a.m., written by LVN I, reflected in part, Resident is on continuous oxygen at 3 LPM via nasal cannula, no shortness of breath noted. Review of Resident #3's Order Summary Report dated 07/25/2024, reflected in part and order with a start date of 07/24/2024, for oxygen at 2-3 liters per nasal cannula PRN for signs or symptoms of shortness of breath/comfort. There were no orders found from 07/14/2024 to 07/23/2024 for PRN oxygen use. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/26/2024 at 10:10 a.m., the DON said she reviewed the current and discontinued physician's orders and was unable to find a PRN order for oxygen for the date of 07/14/2024 as indicated on the progress notes. The DON said there should have been an order when received. The DON said she spoke with Nurse Practitioner (NP) who informed the DON that oxygen was ordered on 7/14/2024 for Resident #3, and that an order should have been written but was not. The DON said the process was the NP gave the orders and nurse who got the orders needed to enter the orders into the physician's orders system. The DON said she spoke with LVN H and was informed that they were busy stabilizing Resident #3 and forgot to put in the PRN O2 order into the system on 7/14/24. The DON said the good thing was that the O2 was kept on Resident #3 continuously until a new order was entered on 7/24/2024. The DON said if there was not an order there was a risk that other staff might not know if the patient needed oxygen or not. The DON said in this event the resident had continuous oxygen at all times. The DON said this was a failure on the part of nursing staff to document the physician order for oxygen. The DON said there was no negative outcome to the resident. During an interview on 07/26/2024 at 10:34 a.m., the NP said she was notified of Resident #3's O2 dropping below 90%. The NP said on 07/14/2024, she gave a verbal phone order for PRN oxygen via nasal cannula to maintain saturations above 90%. The NP said the nurses were responsible to document the orders and ensure it was entered into the system. The NP said she did not know if the order was entered on 07/14/2024. Review of facility policy titled Medical Record Documentation dated 10/2021, reflected in part, The medical record shall contain a representation of the experiences of the resident and include information to provide a picture of the resident's status through complete documentation. Documentation shall be completed at the time of service, but no later than the shift in which the observation or care service occurred. Documentation shall be accurate, relevant, and complete containing sufficient details about the resident's care and responses to care.