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	11/18/2024

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 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 were maintained on each resident that were complete and accurately documented for 2 (Resident #3 and Resident #12) of 14 residents reviewed for administration. -The facility failed to document in Resident #3's MAR/TAR medical records, a behavioral incident that was being tracked on the MAR/TAR. - The facility failed to document in Resident #12's MAR/TAR medical records, a behavioral incident that was being tracked on the MAR/TAR. These failures could place residents at risk of not receiving needed services or errors in treatment based on incorrect information. Findings included: Resident #3: Review of Resident #3's Admission Record dated 11/18/2024, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Review of Resident #3's H&P dated 02/09/2024, revealed diagnoses of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), mood affective disorder (mental health condition that involves extreme shifts in a person's emotional state), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). Review of Resident #3's quarterly MDS assessment dated [DATE], revealed resident had a BIMS score of 04 indicating severe cognitive impairment. Section E - Behavior indicated that resident had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed toward others. (continued on next page)

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

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	676060	A. Building B. Wing	11/18/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's progress notes dated 11/04/2024, revealed that on 11/04/2024 at 8:20 p.m., Resident #3 pulled on roommates blanket and slapped the roommate on the abdomen saying, get out of my house. CNAs immediately separated the residents. No injuries sustained. Review of Resident #3's care plan dated 11/18/2024, revealed target area of behavior of resident exhibiting mood/behavior problems and having physical contact with peer. Part of the intervention reads Observe and document behavior as needed. Review of Resident #3's MAR/TAR for November 2024, revealed a specific behavior tracking for target behavior of irritability/aggression towards others every shift. Document specific behavior observed. Review of 11/04/2024 revealed no behaviors identified during the evening shift. Resident #12 Review of Resident #12's Admission Record dated 11/18/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Review of Resident #12's H&P dated 02/05/2024, revealed diagnoses of delusional disorders (serious mental illness that causes people to have trouble distinguishing reality from imagination), impulse disorders (mental health condition that makes it difficult to control actions or reactions), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Review of Resident #12's quarterly MDS assessment dated [DATE], revealed resident had a BIMS score of 10 indicating moderate cognitive impairment. Section E - Behavior indicated had not had any physical, verbal, or other behavioral symptoms during the MDS look back of seven days. Review of Resident #12's progress notes dated 09/20/2024, revealed on 09/20/2024 at 7:48 a.m., Resident #12 hit another resident on the leg using his walker. Residents were immediately separated. No injuries sustained. Review of Resident #12's care plan dated 11/18/2024, revealed target area of behavior Resident #12 exhibits hitting another resident with his walker on 09/20/2024. Part of the intervention reads Monitor and document target behaviors. Review of Resident #12's MAR/TAR for September 2024, revealed a specific behavior tracking for target behavior of anger, aggressive behavior related to delusional disorders and other impulse disorders. Review of 09/20/2024 revealed no behaviors during the morning shift. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/2024 at 11:22 a.m., the DON said the purpose of the MAR/TAR was to provide medication and treatment to residents. The DON said there are some behaviors that are monitored on the MAR/TAR related to the medications taken for the behaviors. The DON said nursing staff were responsible for ensuring records are entered and Unit Managers and DON were responsible for accuracy of documentation. The DON said MAR/TAR was used to make decisions regarding resident care planning. The DON said there was a risk of residents not getting appropriate treatment or others who review the MAR/TARs not getting accurate information. The DON said the incidents with Resident #3 and Resident #12 should have been documented accurately in the MAR/TAR. The DON said for the incidents involving Resident #3 and Resident #12, could have been problematic if the MAR/TAR records were the only documentation to capture the incidents. The DON said the incidents were reported and documented in risk management documentation and both incidents were investigated, and care plans reviewed and revised as needed. Review of Medical Record Documentation policy dated October 2021, reads in part that 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 factual, objective, and resident centered.