

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 04/03/2025
NAME OF PROVIDER OR SUPPLIER Ambrosio Guillen Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871</p> <p>Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, which included the state survey agency, in accordance with State law through established procedures for 1 of 3 residents (Residents #10) reviewed for misappropriation of property.</p> <p>The facility failed to report to the State Survey Agency when Resident #10 reported to the facility that his wallet that had his SS card, ID, approximately \$180, and a check book was missing on 3/28/25.</p> <p>This failure could place residents at risk of vulnerability for unauthorized financial transactions, potential identity theft, and emotional distress.</p> <p>Findings include:</p> <p>1. Record review of Resident #10's face sheet, dated 4/1/25, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. He was documented as his own RP.</p> <p>Record review of Resident #10's history and physical, dated 8/5/24, revealed diagnoses which included: DM: A condition that causes high blood sugar levels; HLD: High levels of fats (like cholesterol) in the blood; HTN: High blood pressure; GERD:A condition where stomach acid frequently flows back into the tube connecting the mouth and stomach, causing heartburn and other symptoms.</p> <p>Record review of Resident #10's quarterly MDS assessment, dated 1/1/25, revealed a BIMS score of 15, which indicated his cognition was intact.</p> <p>Record review of progress note, dated 3/21/25, written by LVN B, revealed: [Resident #10] the CNA reported that spouse (Resident #11) had misplaced his wallet with his ID and social security card. Searched their room and unable to locate items. Missing items paper filled out and left under social workers door. RN supervisor aware.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #10's grievance, dated 3/21/25, revealed missing items which included the ID and Social Security card, which were marked as lost that morning. The items were later found with a note that read: SW found in residents (Resident #10's) second drawer of dresser, and was signed by the Social Worker (SW), Administrator, and OSR. The second page of the grievance, dated 3/28/25, documented additional missing items reported by Resident #10, including a brown soft leather wallet, checkbook, ID, healthcare card, Social Security card, Medicare card, and approximately \$180, all in \$20 bills. These items were marked as not found and the form was signed by the SW, Administrator, and OSR. Additional information read: Resident reports to social worker, his spouse misplaced his wallet. Social worker searched the room for his items, could not locate. Social worker and CNA A also searched the 500 Hall unit. Resident's rooms for missing items, could not locate. Social worker searched laundry, lost and found. Aide advised the missing item was not found in linen or laundry today. Social worker updated him and advised administrator to above. Social worker requested staff to keep eye open for missing item. Wallet has not been located. Resident aware staff will continue to keep an eye out for resident's wallet. Resident did advise there has been no activity on cards, one transaction in his bank and did alert and closed accounts.</p> <p>2. Record review of Resident #11's face sheet, dated 4/1/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. She was documented as her own responsible party (RP).</p> <p>Record review of Resident #11's history and physical, dated 3/18/25, revealed a diagnosis which included unspecified dementia, which is a condition that affects memory, thinking, and behavior. It causes confusion, forgetfulness, and difficulty in communication or daily functioning, and it worsens over time.</p> <p>Record review of Resident #11's admission MDS assessment, dated 3/24/25, revealed a BIMS score of 3, which indicated her cognition was severely impaired.</p> <p>Record review of Resident #11's care plan, dated 3/21/25, revealed a focus area for wanders aimlessly about the facility with interventions that included: observe whereabouts frequently when out of bed, redirect as needed, observe appropriate footwear.</p> <p>Record review of Resident #11's progress note, dated 3/24/25, written by the Social Worker, revealed: SW advised resident will be moving to memory care unit. SW met with [Resident #10] and agreed to room change.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/1/25 at 10:39 AM, the Social Worker stated Resident #10's grievance was reported by staff on 3/21/25, although no description of the wallet was included in the initial report. The SW stated the wallet contained an ID, a Social Security card, and a checkbook. The SW stated when she followed up with Resident #10, he was reportedly in the bathroom at the time. The SW stated she asked Resident #11 (his wife), who was his roommate at the time, for permission to search for the wallet in which it was consented to and found in the drawer on Resident #10's side and informed him through the door. The SW stated she later followed up with Resident #10 (3/28/25) after staff continued to report the wallet as missing and obtained a proper description. The SW stated she and CNA A searched the 500 hall with resident's permission, but did not locate the wallet. She stated she followed up with laundry and the med carts where it had not been located. The SW stated she reported this to Resident #10 and he was understanding of the situation. The SW stated Resident #10 had been monitoring his bank account and had already closed the account and begun replacing his cards. The SW reported the matter to the Administrator and Onsite Representative, the VA representative, provided the final signature for the grievance. The SW stated the risk of the wallet not been located was a concern that someone could potentially use the lost items. The SW stated they had been following up daily with Resident #10 for any activity on his account, but none was reported. The SW stated she also searched Resident #11 room (she had been moved to memory care) and found nothing. As of today, the wallet and checkbook had still not been found.</p> <p>During an interview on 4/1/25 at 10:45 AM, The Administrator stated according to the provider letter , any allegation involving a missing item must be reported to State Operations. He reported Resident #10's wallet was reported missing a second time on 3/28/25, which contained identification, a Social Security card, money, and a checkbook. The Administrator stated medication carts and the laundry area were checked, but nothing had been found. He stated since there was no alleged perpetrator identified by Resident #10, the incident did not meet the criteria for misappropriation of property. He referenced the provider letter, which indicated deliberate misplacement must be present to consider it misappropriation and reiterated the resident did not accuse anyone of taking the wallet.</p> <p>During an interview on 4/1/25 at 1:23 PM, CNA A stated the Social Worker approached her and asked for assistance in locating Resident #10's missing wallet on 3/28/25. CNA A reported, prior to Resident #11, Resident #10's wife, being placed with him, he had not reported any missing items. CNA A stated she received a report which indicated Resident #11 had been taking Resident #10's belongings and placing them in different locations. CNA A stated Resident #11 was subsequently moved to the memory care unit. CNA A stated when she followed up with Resident #11 regarding the wallet, she did not recall taking it. CNA A reported even Resident #10 asked Resident #11 where she had left the wallet, and the wife responded she did not know. CNA A recalled Resident #10 describing the wallet as being able to open 180 degrees and long enough to fit a checkbook. CNA A stated she assisted the SW in searching all the rooms in the 500 hall, with the resident's permission, and the wallet was not located. CNA A reported the SW also followed up with the laundry department, but the wallet was not found.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/1/25 at 1:46 PM, Resident #10 stated his wallet had been missing since last Friday (3/28/25). Resident #10 stated he suspected Resident #11, whom he identified as his wife, may have taken it without his consent, as she had recently become his roommate and had a history of wandering behavior, particularly at night. Resident #10 stated he recalled his shoes had been found in another resident's room on the day of Resident #11's arrival, which reinforced his concern. Resident #10 stated his wallet contained the following items: Identification Card, Social Security card, Medicare card, VA card, shot record, MasterCard, debit card, checkbook, and approximately \$180 in \$20 bills. Resident #10 stated he did not give Resident #11 permission to take the wallet and is uncertain if she is even aware that she took it. Resident #10 stated he had been monitoring his bank accounts daily and reported no abnormal activity. Resident #10 stated he canceled both his MasterCard and debit card two days ago after confirming a check written to his daughter had cleared. Resident #10 stated he experienced significant stress due to concerns about unauthorized use of his financial information. Resident #10 stated the facility informed him all resident rooms in the hallway, laundry areas, and other common locations were searched, but the wallet had not been found. Resident #10 stated he was offered assistance in replacing his identification documents but was currently struggling with the process due to having no identification in his possession.</p> <p>During an interview on 4/1/25 at 2:35 PM, Resident #11 was alert and oriented to person only and did not answer questions asked.</p> <p>During a follow up interview on 4/1/25 at 3:41 PM, the Administrator stated the situation which involved Resident #10's missing wallet was complex due to Resident #11, whom Resident #10 identified as his wife, having a low BIMS score and not being cognitively intact or capable of meaningful communication. The Administrator stated, because of this, Resident #11 was not considered interviewable and may not have fully understood or recalled her actions. The Administrator stated, based on how the allegation was presented, specifically the wallet was described as misplaced rather than definitively taken, it did not meet the threshold for misappropriation in his judgment. The Administrator stated if Resident #10 had clearly reported Resident #11 took his belongings and refused to return them, it would have warranted a report to State Operations. The Administrator stated the available information reflected uncertainty and shared living arrangements, which complicated the interpretation of the situation. The Administrator also stated Resident #10 and Resident #11 shared a room and possibly shared belongings, adding another layer of difficulty in determining intent or ownership boundaries .</p> <p>Record review of the facility's Abuse, Neglect, and Exploitation, dated 2024, read in part Definition: Misappropriation of Resident Property (Page 1) Defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Policy Expectations on Investigation and Reporting (Page 4-5) V. Investigation of Alleged Abuse, Neglect, and Exploitation An immediate investigation is required when there is suspicion or a report of: Abuse, Neglect, Exploitation, Misappropriation of resident property. VII. Reporting / Response (Page 4-5) Written procedures must include: Reporting of all alleged violations to the Administrator, State agency, Adult Protective Services, and other required agencies.</p>		