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	09/15/2025

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 - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation for 2 of 10 employees (CNA A and CNA B) reviewed for annual employee misconduct registry and nurse aide registry screenings, in that: The facility had failed to complete annual employee misconduct registry and annual nurse aide registry screenings for CNA A and CNA B. This failure could place residents at risk for abuse, neglect, exploitation, and misappropriation of property. The findings included:-Record review of facility's policy undated on Abuse, Neglect and Exploitation revealed, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The components of the facility abuse prohibition plan include Screening-Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Screening may be conducted by the facility itself, third-party agency or academic institution. The facility will maintain documentation of proof that the screening occurred. -An interview and record review on 09/12/25 at 3:59 p.m., with the HR Resource Assistant, revealed CNA A was hired on 03/26/24 and the last EMR/NAR screening was completed on 03/20/2024. She said, We do not have any other EMR/NAR screening in the CNA's employee file to show that the annual EMR/NAR screening was completed according to facility policy. She said EMR/NR screening should be completed upon hire and annually. -An interview and record review on 09/12/25 at 4:04 p.m., with the HR Resource Assistant, revealed CNA B was hired on 05/01/18 and the last EMR/NAR screening was completed on 01/31/24. She said, We do not have any other EMR/NAR screening in the CNA's employee file to show that the annual EMR/NAR screening was completed according to facility policy. -During an interview and record review on 09/15/25 at 9:59 a.m., with the HR Business Partner, confirmed annual EMR/NAR screenings had not been completed on CNA A and CNA B. She said, EMR/NAR checks should be completed upon hire and annually according to facility policy.-During an interview on 09/15/25 at 11:30 a.m., with the Administrator in the presence of HR Business Partner revealed, EMR/NAR checks should be completed upon hire and annually according to facility's policy and best practice.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676060	A. Building B. Wing	09/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	09/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents environment remained as free of accidents and hazards as possible, and each resident received adequate supervision to prevent accidents for 2 (Resident #2 and Resident #12) of 5 residents reviewed for quality of care.1. The facility failed to ensure the call light was within reach, assist bars were in place, and the bedside table was positioned away from Resident #2 on 8/28/25.2. The facility failed to ensure an PT/OT evaluation was completed for Resident #12, who required an assessment for assist bars to support bed mobility.These failures could place residents at risk for falls, injuries, loss of independence, and unmet care needs, which may result in a decline in overall health, safety, and quality of life. Findings included: 1. Record review of Resident #2's face sheet dated 9/11/25 revealed [AGE] year-old male was admitted to the facility on [DATE]. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed his cognition was severely impaired. For rolling left and right Resident #2 required substantial/ maximal assistance. Record review of Resident #2's history and physical dated 10/1/24 revealed a diagnosis of right sided hemiparesis (weakness on the right side of the body) seizure (sudden surge of electrical activity in the brain that can cause shaking, staring spells, confusion, or loss of awareness for a short period), vascular dementia (memory loss and difficulty thinking caused by poor blood flow in the brain, often after strokes or mini-strokes), hemorrhagic stroke (type of stroke that happens when a blood vessel in the brain bursts, causing bleeding and damage to brain cells), BPH (enlarged prostate gland (not cancer) that can make urination slow, frequent, or difficult, usually in older men). Record review of Resident #2's care plan dated 5/1/25 revealed a focus area of ADL self-care performance deficit related to Hemiplegia and risk for falls and interventions that included the resident requires (maximal assistance) by x1 staff to turn and reposition in bed every 2 hours and as necessary and assist Resident with ambulation and transfers, utilizing therapy recommendations. At risk for injury/falls r/t Traumatic hemorrhage, fall prior to admission with interventions that included Call light within reach when in bed and provide assistive devices for mobility as indicated. Record review of Resident #2's side rail assessment dated [DATE] revealed consideration due to medical needs and mobility/transfer assistance; benefits included assist resident with movement while in bed, assists with positioning/turning side to side in bed, provides with feeling of comfort and security in bed, defines bed parameters; no risks were identified; siderail were recommended at the time for medical reason; resident and resident RP were marked notified and discussed the risks and benefits from using siderails. Record review of Resident #2's electronic medical records for August and September 2025 revealed no side rail assessment was completed.Record review of Resident #2 video picture dated 8/28/25 at 4:22 pm, call light does not appear within reach, and bedside table was arm's length from the bed, and side rails were not in place. Record review of Resident #2's progress note dated 8/28/25 written by LVN Unit Manager F read in part 1625 hours Nurse was notify by CNA that resident was on the floor at principal for pain on left hip, hospice, to inform that resident situation, and has previous hip surgery. RN supervisor perform head to toe assessment, resident complain of pain on left hip, ambulance was the same place, ok sent him to hospital, call 911 at 1630, and leave facility at 1700 to [local hospital] main campus notify ADON DON, RN, we continue as protocol of this facility.Record review of Resident #2's progress note dated 8/28/25 written by DON Was notify by floor nurse that resident was on the floor, resident was on his left side scooting around, resident was partially off the floor matt. Resident alert and oriented times 1 left hip, unable to move extremity, resident unable to fully extend upper extremity and noticed abrasions to shin area. Resident unable to fully extend the upper extremity, normal baseline noticed. Called [family member] to notify of incident, [family member] stated he will call hospice. Floor nurse called hospice and got okay to send him to hospital for further treatment. Record review of Resident #2's local EMS care report dated 8/28/25 revealed cause of injury was fall from bed and height of fall was 2 feet tall. The narrative read in part he was normal baseline, GCS of 13, history of dementia, distal pulses (heartbeat felt farthest from the heart) present, and lung sounds clear. The patient sustained a bedside fall, no LOC, no blood thinners, but was found to be trauma hypotensive with systolic of 105. He denied any pain. Record review of Resident #2's local hospital note dated 8/28/25 revealed a [AGE] year-old male with a history of vascular dementia, prior hemorrhagic stroke with right-sided weakness, seizures, and BPH, was admitted to the hospital on [DATE] after an unwitnessed fall from bed at the nursing facility. On arrival, he was confused but hemodynamically stable with a GCS of

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	09/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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	09/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient nursing staff possess the competencies and skill sets necessary to provide nursing services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being for 1 of 1 staff member (RN C) reviewed for nursing services. 1. The facility failed to ensure RN C followed the facility's policy on blood sugar checks for Resident #6 by delegating the task to Certified Nurse Aide.2. The facility failed to ensure RN C administered injections according to the facility's policy and procedures to Resident #7.These failures could place residents at risk of being cared for not receiving nursing services by adequately trained and licensed staff, which could result in injury and infection. Findings included:Resident #6 -Review of Resident #6's admission Record, dated 09/10/25, revealed resident was admitted to the nursing facility on 06/06/25. -Review of History & Physical dated on 06/11/25 for Resident #6 revealed, [AGE] year-old male with history of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), delusional disorder (is a type if mental health condition in which a person can't tell what's real from what's imagined), type 2 DM (a condition where the body has trouble using insulin, a hormone that helps cells use glucose for energy. This leads to high blood sugar levels because the body doesn't respond well to insulin). -Review of Resident #6's Annual Minimum Data Set (MDS) assessment dated [DATE], revealed short-term/long-term memory problems. Unclear speech. Active Diagnoses: Diabetes Mellitus. Section N - Medications: N0300. Injections. Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days - 7. N0415. High-Risk Drug Classes: Use and Indication: J. Hypoglycemic (including insulin). -Review of Care Plan of Resident #6's Care Plan dated 06/07/25 revealed, at risk for hyper/hypoglycemia related to diagnosis of diabetes mellitus. Interventions/Tasks: Observe percentages of food eaten and report food not eaten. Observe for s/s of hyper/hypoglycemia (i.e. Sweating, tremor, pallor, nervousness, headache, double vision, confusion, lack of coordination etc.), FSBS as ordered by physician. Rotate injection sites. Medication as ordered. FSBS as ordered by physician. -Review of Physician Order Summary for Resident #6 dated 09/11/25 revealed, Insulin Aspart Injection Solution 100 unit/ml inject as per sliding scale: if 0-160 = 0 if BS less than 70 initiate hypoglycemic protocol and notify MD/NP; 161-200 = 4; 201 - 250 = 8; 251 - 300 = 12; 301 - 350 = 16; 351 - 400 = 20; 400+ notify MD/NP for further orders, subcutaneously before meals related to Type 2 Diabetes Mellitus.-Review of Medication Administration Record (MAR) for Resident #6 dated July 2025 revealed, Humalog Injection Solution 100 unit/ml (Insulin Lispro) Inject as per sliding scale: If 0-160 = 0. 161-200 = 4 units. 201 - 250 = 8 units.251 - 300 = 12 units.301 - 350 = 16 units.351 - 400 = 20 units.400+ notify MD/NP for further orders, subcutaneously before meals related to Type 2 Diabetes Mellitus. BS at 7:30 AM; BS at 11:30 AM, BS at 5:00 PM. -Review of Resident #6's Medication Administration Record (MAR) dated July 2025 revealed, RN C had administered Humalog Injection Solution 100 unit/ml (Insulin Lispro) Inject as per sliding scale, on 07/19/25 at 11:30 AM for Blood Sugar Level of 238, administered 8 units of insulin Lispro subcutaneously before meals; 5:00 PM for Blood Sugar Level of 337 administered 16 units subcutaneously before meals. -Review of In-Service Training Sign-in Sheet provided by the DON on 09/15/25 revealed the Staff Development Coordinator had in-serviced Certified Nurse Aides on 09/12/25 at 12:00 noon, Topic: CNAs are NOT authorized to check blood sugars in this facility. Failure to comply with the above will result in disciplinary action. -Review of Review of copy of Text Message provided by DON on 09/15/25 revealed, Text Message was sent to Licensed Staff and Certified Nurse Aides on 09/12/25 at 4:47 pm, by Staff Development Coordinator to 148 recipients. Details of Message documented, ATTN: ALL NURSING STAFF-CNAS are NEVER to check sugars in this facility. Failure to comply will result in disciplinary action. If you are receiving this message, PLEASE contact Staff Development Coordinator from 0800-1700 Monday-Friday and/or RN Supervisor after hours and weekend.-Review of Review of Note to File provided by DON on 09/15/25 revealed, Subject: RN C. Author was left blank. Other participants and witnesses were left blank. Date/time event took place 07/19/25. Date/time note was written 09/10/25. On 07/21/25 Unit Manger F and RN ADON E, had a phone conversation with RN C regarding an incident in which he delegated to a CNA to check blood sugar for him on 07/19/25. RN C was educated on how within long term care nursing assistants and medication aids are not allowed to check blood sugar and that it is strictly the charge nurse responsibility to perform that check. RN C verbalized an understanding with no

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	09/15/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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	09/15/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents are free of any significant medication errors for 1 (Resident #6) of 2 residents reviewed for pharmaceutical services.-The facility failed to administer insulin to Resident #6 according to physician orders.-The facility failed to ensure LVN D administered insulin to Resident #6 according to Manufacturer's Specifications. This deficient practice could place residents at risk of inadequate therapeutic outcomes, increased adverse side effects, and a decline in health.The findings include: -Review of Resident #6's admission Record, dated 09/10/25, revealed resident was admitted to the nursing facility on 06/06/25. -Review of History & Physical dated on 06/11/25 for Resident #6 revealed, [AGE] year-old male with history of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), delusional disorder (is a type if mental health condition in which a person can't tell what's real from what's imagined), type 2 DM (a condition where the body has trouble using insulin, a hormone that helps cells use glucose for energy. This leads to high blood sugar levels because the body doesn't respond well to insulin). -Review of Resident #6's Annual Minimum Data Set (MDS) dated [DATE], revealed short-term/long-term memory problems. Unclear speech. Active Diagnoses: Diabetes Mellitus. Section N - Medications: N0300. Injections. Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days - 7. N0415. High-Risk Drug Classes: Use and Indication: J. Hypoglycemic (including insulin). -Review of Care Plan of Resident #6's Care Plan dated 06/07/25 revealed, at risk for hyper/hypoglycemia related to diagnosis of diabetes mellitus. Interventions/Tasks: Observe percentages of food eaten and report food not eaten. Observe for s/s of hyper/hypoglycemia (ie. Sweating, tremor, pallor, nervousness, headache, double vision, confusion, lack of coordination etc.), FSBS as ordered by physician. Rotate injection sites. Medication as ordered. FSBS as ordered by physician. -Review of Physician Order Summary for Resident #6 dated 09/11/25 revealed, Insulin Aspart Injection Solution 100 unit/ml inject as per sliding scale: if 0-160 = 0 if BS less than 70 initiate hypoglycemic protocol and notify MD/NP; 161-200 = 4; 201 - 250 = 8; 251 - 300 = 12; 301 - 350 = 16; 351 - 400 = 20; 400+ notify MD/NP for further orders, subcutaneously before meals related to Type 2 Diabetes Mellitus. -Review of facility's mealtimes revealed Breakfast was served at 7:00 a.m., Lunch at 11:30 a.m., and Dinner at 5:00 p.m. -Review of Medication Administration Record dated September 2025 for Resident #6 revealed LVN D had not checked Resident #6's Blood Glucose on 09/09/25 at 5:00 PM before meals according to physician's order. -Review of Resident #6's Nursing Progress Note dated 09/09/25 at 6:47 p.m. written by LVN D, revealed Resident was in activities and went straight to the dining room. -Review of Note to File dated 09/09/25 at 6:30 PM written by RN ADON E, revealed LVN D was educated by LVN Unit Manager F on 09/09/25 regarding proper documentation and timely administration of insulin. LVN D was also educated on following orders for residents regarding assessment of blood glucose levels prior to mealtimes. LVN D verbalized an understanding at this time. -Review of Medication Error Report dated 09/09/25 at 6:45 PM, written by DON revealed, Incident Description: On 09/09/25 approximately 6:45 p.m., Resident #6 did not have his blood glucose checked prior to dinner and therefore did not receive any sliding scale coverage for his dinner. Immediate Action Taken: Upon discovery of incident, Unit Manager assessed resident. Morning BGL 181. The resident was covered with 4 units of short acting insulin and scheduled dose of long-acting insulin. The Resident did not exhibit any signs of hyper/hypoglycemia. NP notified - no new orders obtained. Notes: Resident #6 is an [AGE] year-old male admitted [DATE]. Resident diagnosis includes dementia and type 2 diabetes. DON identified medication error made night prior - resident was not administered sliding scale insulin because resident did not get his blood glucose read prior to dinner. NP notified of findings in morning and reported most recent BGL in am and that resident did not exhibit any signs of hypo or hyperglycemia. No new orders obtained from NP. Resident POA notified about incident. LVN D educated about proper procedure if resident blood glucose not checked prior to dinner - call NP that blood glucose was not checked prior to dinner and obtain orders for how to proceed. Nurse verbalized understanding. -Review of Resident #6's Nursing Progress Note dated 09/10/25 at 8:30 AM, written by LVN Unit Manager F revealed, Spoke with NP regarding blood sugar not being checked yesterday evening. His BS this morning was 181, given 4 units of Novolog for sliding scale coverage and 23 units of insulin Glargine scheduled. No new orders given. No s/s of hypo/hyperglycemia. Will continue to monitor. -Review of Medication