

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 11/20/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately to the State Survey Agency, for 1 of 4 residents (Resident #1) reviewed for abuse/neglect. The nursing facility failed to report Resident #1's allegation of abuse, alleging LVN B squeezed her left-hand, on 10/01/25 to the state survey agency within 2 hours of learning of the allegation. This failure could place residents at risk for abuse and neglect and result in increased risk of abuse and neglect not being reported within 24 hours to the State Agency to ensure appropriate investigation and corrective actions were taken. Findings include Record review of Resident #1's face-sheet dated 10/27/25 revealed she was an [AGE] year-old female with admission date 10/06/23. Record review of Resident #1's history and physical dated 10/10/25 revealed the resident's following medical history: Venous Insufficiency (a condition where the veins in your legs do not efficiently return blood to the heart, leading to blood pooling in the legs), Generalized Anxiety disorder (disorder causing excessive worrying about everyday life), Delusional disorders (mental illness characterized by one or more persistent delusions that last a at least month), Muscle wasting and atrophy (loss or thinning of muscle tissue leading to decrease in muscle mass and strength), muscle weakness, and Heart Failure (condition where the heart cannot pump blood efficiently enough to meet the body's need for blood). The document noted the Resident #1's Chief Complaint was aggression and foul urine odor; it noted Resident #1 was seen for aggression and refusal of labs. History and Physical noted [Resident #1] had been trying to hit staff and verbally aggressive towards staff and refusing medications at times and refusing care. She had been yelling 'people want to hurt her at times and put poison in food.' Patient also with foul smelling urine and being treated empirical with Cefdinir [antibiotic] as she is refusing labs and UA [urine analysis]. She was also started on Risperidone yesterday due to delusional disorder and is on Valproic Acid [an anticonvulsant drug used to treat seizures, bipolar disorder, and migraine headaches]; she follows up with psych team. The History and Physical medication list revealed Resident #1 was not on anticoagulants. Record review of Resident #1's Annual MDS dated [DATE] revealed no BIMS score. The Annual MDS noted resident was unable to participate or complete the Brief Interview for Mental Status (BIMS). Record review of Resident #1's care plan dated with revision date 07/14/25 revealed the resident was at risk for skin tears or discoloration related to her thin, fragile skin which included staff intervention if the resident was agitated staff were to provide patient safety and leave resident alone for a while and come back. The care plan also included Resident #1 exhibited mood/behavior problems of physical contact with staff with the last revision date 10/03/25. The staff interventions included approaching the resident warmly and positively at all times, consult with family as needed, notify the MD as needed, and they were to provide for safety of the resident during times of combativeness. Record review of Resident #1's incident report dated 10/01/25 prepared by LVN B revealed the following: IDT (Interdisciplinary team) reviewed circumstances surrounding resident skin integrity issue. DON went to look at resident's skin, three bruises noted to left hand, two approximately 2cm by 2cm with light purple and yellow discoloration, one 1cm by 3cm dark purple in color. Resident #1 was asked if she knew how bruise occurred. Resident shook her head no. Resident stated she had mild pain to hand. ROM [Range of Motion] WNL [Within Normal Limits], no swelling noted. Resident #1 reported that the night nurse from the previous shift tried to take away resident's medications, which were hers since she had paid for them, so the medications belonged to her. Resident #1 noted with mild confusion. Psychiatric NP notified about behavior from night shift and confusion this am. Lab work and UA order obtained, order for anxiety medication also obtained. Order for aricare ointment for bruise ordered from NP, which was an ointment used to temporarily treat pain and bruises. Facility does not suspect abuse, neglect, or exploitation. Incident Report, under Incident Description, Nursing Description: Noticed bruising to her left hand after the resident with aggressive behavior was throwing punches towards staff as she hit the table and side rail several times. Resident Description: Resident voicing staff was taking advantage of resident. The document reflected, the resident refused care for her bruising, and she was not taken to the hospital. Incident Report noted under Injuries Observed at Time of Incident Abrasion, back of left hand. Record review of Resident #1's progress notes dated 10/01/25 at 10:58 AM documented by LVN A revealed: Several bruises noted to resident's left hand this morning. Bruises to front of hand and on side of hand. Resident voiced pain to hand. Resident stated her hand was 'squeezed' early this morning when she did not want to give back the nurse a</p>		