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	02/03/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately notify and consult with the resident's physician when a significant change in a residents physical, mental, or psychosocial status (that was a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 3 residents reviewed for change in condition.The facility failed to immediately inform the NP/MD on 12/10/25 of Resident #1's new diagnosis of osteomyelitis (bone infection).This failure could place residents at risk of serious decrease in health related to delayed treatment. Findings include:Record review of Resident #1's admission Record dated 02/03/26, revealed an [AGE] year-old male with an admission date of 02/27/25 to the facility and a discharge date of 01/25/2026.Record review of Resident #1's discharge MDS dated [DATE], revealed, no BIMS score. Section C- Cognitive Patterns revealed Resident #1's Cognitive Skills for Daily Decision Making coded at a 2 meaning resident was moderately impaired- decisions poor; cues/supervision required.Record review of Resident #1 's local hospital history and physical dated 02/12/25, revealed, a medical history of open wound of foot, open wound of left great toe and diabetes mellitus with hyperglycemia (elevated blood sugar). Per assessment plan, Resident was referred to local hospital on 12.12.25 due to concern of osteomyelitis in the left foot. MRI imaging was consistent with left-sided calcaneal osteomyelitis (infection of the heel bone), possible left 5th toe osteomyelitis.Record review of Resident #1's progress note dated 12/9/2025 revealed Resident #1 had a podiatrist appointment at 1:00 pm.Record review of a progress note dated 12/10/2025, revealed no information regarding Resident #1's podiatrists' progress note detailing osteomyelitis diagnosis or notification to nurse practitioner of diagnosis.Progress note dated 12/12/2025 revealed Resident was sent out to hospital for further evaluation regarding osteomyelitis due to veterans affairs infectious disease doctor scheduling appointment taking long to schedule resident. Record review of a podiatrist progress noted not dated revealed erosion of left 5th toe indicated osteomyelitis, will consult infectious disease today as toe is stable.Record review of hospital notes revealed resident was admitted on [DATE] for management of a urinary tract infection and left open wound concerning for osteomyelitis. Plan was for resident to be started on antibiotic therapy before being discharged back to nursing facility. Hospital records noted calcaneal osteomyelitis(bone infection of the heel) of the left foot.Record review of Resident #1's care plan with a target date of 01/26/26, revealed, Resident #1 Required IV therapy related to osteomyelitis. Interventions included administering IV fluid per order, Auscultating lung sounds as indicated, check site routinely for signs and symptoms of infection, and notifying physician of signs and symptoms of infection at site and or complications. In an interview on 02/03/2026 at 11:20 a.m., LVN A revealed that when a resident attends an outside appointment, and brings back a progress note, the nurses was responsible for relaying any new orders and or diagnosis to the nurse practitioner or medical doctor. She stated that once they were (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified, then a progress note was input in the system. She stated that the importance of reporting any new orders or diagnosis to the nurse practitioner would be continuity of care so that the team was aware of what was going on with the resident. She stated that it was the responsibility of the nurse receiving the resident back from the appointment and whoever reviewed the progress note to inform the nurse practitioner immediately as soon as the changes were noted. She stated that the risk to the resident would be a delay in care and miscommunication. She stated that she could not recall the last Inservice over notifying the nurse practitioner.In an interview on 02/03/2026 at 11:40 a.m., the Nurse Practitioner revealed that she was not notified of Resident #1's diagnosis of osteomyelitis by the nurses, she was notified by the residents family member on 12/12/2026, she stated that it was nice to know when there was changes to residents diagnosis or any new orders from outside doctors. She stated that there was always a risk for residents when the nurse practitioner was not notified in a timely manner that could result in a delay of care.In an interview on 02/03/2026 at 12:00 p.m., LVN B revealed that he was not aware of Resident #1's diagnosis of osteomyelitis, he stated that he was informed on 12/12/25 by Resident #1's POA. He stated that when a resident came back from an outside appointment, the nurses was to review any new orders/changes, and they were to notify the nurse practitioner immediately as soon as they were aware of changes. He stated that it was the receiving nurse's responsibility to report any changes to the nurse practitioner. He stated the importance of this was for continuity of care of the residents and so all the nurses caring for the resident could be informed. He stated that the risk to the resident would be a delay in care if changes wase not relayed to the nurse practitioner. He stated that the last Inservice over reporting changes to the nurse practitioner was about a month ago. In an interview on 02/03/2026 at 12:58 p.m., the DON revealed that staff was to report any new orders or change in condition/new diagnosis immediately to the nurse practitioner and document a progress note. She stated that since Resident #1's podiatrist progress note did not contain any orders, and it stated that the podiatrist was referring Resident #1 to the infectious disease doctor, and that the condition was stable, therefore there was nothing to act on at that time. She stated that the nurse practitioner did not need to be notified immediately of the osteomyelitis diagnosis in this case as it was stable. She stated that it was acceptable for the nurses to notify the nurse practitioner the following day. She stated that if the staff failed to notify the nurse practitioner of any new orders, then that would cause a delay in care, but not in this case as there was no new orders. She stated that the nurse receiving the report was responsible for notifying the nurse practitioner. She stated that the last Inservice over notification and documentation was held periodically with the last one being in November 2025.In an interview on 02/03/2026 at 4:00 p.m., the Administrator revealed that whenever a resident was brought back from an outside appointment with a progress note detailing any new orders or changes to diagnosis the staff was to notify the nursing supervisor, and nurse practitioner immediately. He stated that the risk of not notifying the nurse practitioner of these changes would cause an opportunity for miscommunication and care could be delayed and or missed; incorrect information could be given. He stated that the receiving nurse was responsible for notifying the nurse practitioner. He could not recall the last in-service held regarding notification to nurse practitioner.Review of facility policy titled Change in Resident Condition Notification revised February 2020 read in part . In the following situations: residents attending physician or designee and resident representative will be notified by the licensed nurse Situations which would require a change in medication or treatment regimen: (examples not limited to) need for restraints, exacerbation of known condition, onset of new condition, abnormal lab values, behavior, weight loss, appointments, elopement, skin issues, elimination changes, vital (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sign changes and physical functioning.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure that the assessment accurately reflected the resident's status for 1 (Resident #1) of 5 residents reviewed for accuracy of MDS assessment, in that: Resident #1's Discharge MDS dated [DATE] did not accurately reflect the residents' diagnosis of Osteomyelitis (infection of the bone).This failure could place residents at risk of not receiving necessary care . Findings included:Record review of Resident #1's admission Record dated 02/03/26, revealed an [AGE] year-old male with an admission date of 02/27/25 to the facility and a discharge date of 01/25/2026.Record review of Resident #1's local hospital history and physical dated 02/12/25, revealed, a medical history of open wound of foot, open wound of left great toe and diabetes mellitus with hyperglycemia (elevated blood sugar). Per assessment plan, Resident was referred to local hospital on 12.12.25 due to concern of osteomyelitis in the left foot. MRI imaging was consistent with left-sided calcaneal osteomyelitis (infection of the heel bone), possible left 5th toe osteomyelitis.Record review of hospital notes revealed resident was admitted on [DATE] for management of a urinary tract infection and left open wound concerning for osteomyelitis. Plan was for resident to be started on antibiotic therapy before being discharged back to nursing facility. Hospital records noted calcaneal osteomyelitis(bone infection of the heel) of the left foot.Record review of Resident #1's discharge MDS dated [DATE], revealed, no BIMS score. Section C- Cognitive Patterns revealed Resident #1's Cognitive Skills for Daily Decision Making coded at a 2 meaning Resident was moderately impaired- decisions poor; cues/supervision required. MDS did not include osteomyelitis diagnosis.Record review of Resident #1's care plan with a target date of 01/26/26, revealed, Resident #1 Required IV therapy related to osteomyelitis. Interventions included administering IV fluid per order, Auscultating lung sounds as indicated, check site routinely for signs and symptoms of infection, and notifying physician of signs and symptoms of infection at site and or complications. In an interview on 02/03/2026 at 2:40 p.m., the MDS LVN revealed that the MDS assessment paints a picture of the residents' care that was being provided at the facility while a resident. He stated that all active diagnoses should have been included. He stated that the floor nurses was responsible for updating the MDS assessment upon initiation of a new diagnosis. He stated that he only reviewed the MDS quarterly. He stated that if the MDS was missing a diagnosis, this did not pose a risk to resident care; rather it was a reimbursement issue affecting the facility. He stated that he had not received any in-services over accurate MDS completion.In an interview on 02/03/2026 at 4:00 p.m., the Administrator revealed that the MDS was an assessment of the resident's functional cognitive state. He mainly looks at the BIMS score. He stated that he was not sure if the resident's diagnosis had to be included in the MDS assessment. He stated that if medical diagnosis were not included, it would not be showing the resident's full clinical picture. He stated that the floor nurses and MDS nurses was responsible for ensuring the MDS assessment was completed accurately. He stated that he could not recall the last IInservice provided.Review of facility policy titled Resident Assessment revised April 2025 read in part . A comprehensive assessment will be completed when a significant change is determined based upon the criteria outlined in the RAI manual .

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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	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** 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 1 of 1 (Resident #1) resident reviewed for accuracy and completeness of medical records.-The facility failed to document notification to NP/MD of osteomyelitis for Resident #1 on 12/10/25.These failures could place residents at risk of not receiving needed services.Findings included: Record review of Resident #1's admission Record dated 02/03/26, revealed an [AGE] year-old male with an admission date of 02/27/25 to the facility and a discharge date of 01/25/2026. Record review of Resident #1 's local hospital history and physical dated 02/12/25, revealed, a medical history of open wound of foot, open wound of left great toe and diabetes mellitus with hyperglycemia (elevated blood sugar). Per assessment plan, Resident was referred to local hospital on 12.12.25 due to concern of osteomyelitis in the left foot. MRI imaging was consistent with left-sided calcaneal osteomyelitis (infection of the heel bone), possible left 5th toe osteomyelitis. Record review of hospital notes revealed resident was admitted on [DATE] for management of a urinary tract infection and left open wound concerning for osteomyelitis. Plan was for resident to be started on antibiotic therapy before being discharged back to nursing facility. Hospital records noted calcaneal osteomyelitis(bone infection of the heel) of the left foot. Record review of Resident #1's discharge MDS dated [DATE], revealed, no BIMS score. Section C- Cognitive Patterns revealed Resident #1's Cognitive Skills for Daily Decision Making coded at a 2 meaning resident was moderately impaired- decisions poor; cues/supervision required.Record review of Resident #1's progress note dated 12/9/2025 revealed Resident #1 had a podiatrist appointment at 1:00 p.m.Record review of Resident #1's progress notes dated 12/10/2025 revealed no information regarding podiatrists' progress note detailing osteomyelitis diagnosis or notification to nurse practitioner of diagnosis.Progress note dated 12/12/2025 revealed Resident was sent out to hospital for further evaluation regarding osteomyelitis due to veterans affairs infectious disease doctor scheduling appointment taking long to schedule resident.Record review of a podiatrist progress noted not dated revealed erosion of left 5th toe indicated osteomyelitis, will consult infectious disease today as toe is stable.Record review of Resident #1's care plan cancellation date 01/27/26, revealed, Resident #1 Required IV therapy related to osteomyelitis. Interventions included administering IV fluid per order, Auscultating lung sounds as indicated, check site routinely for signs and symptoms of infection, and notifying physician of signs and symptoms of infection at site and or complications. In an interview on 02/03/2026 at 11:20 a.m., LVN A revealed that when a resident attended an outside appointment, and brings back a progress note, the nurses were responsible for relaying any new orders and or diagnosis to the nurse practitioner or medical doctor. She stated that once they were notified, then a progress note was input in the system. She stated that the importance of reporting any new orders or diagnosis to the nurse practitioner would be continuity of care so that the team was aware of what was going on with the resident. She stated that documenting a progress note after notifying the nurse practitioner was also important because that way everyone was aware of what each nurse did with the resident. She stated that it was the responsibility of the nurse receiving the resident back from the appointment and whoever reviewed the progress note to inform the nurse practitioner immediately as soon as the changes were noted and to document it. She stated that the risk to the resident would be a delay in care and miscommunication. She stated that she could not recall the last Inservice over notifying nurse practitioner and that the documentation in-services were done monthly.In an interview on 02/03/2026 at 12:00 p.m., LVN B revealed that he was not aware of (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's diagnosis of osteomyelitis, He stated that he was informed on 12/12/25 by Resident #1's POA. He stated that when a resident came back from an outside appointment, the nurses were to review any new orders/changes, and they were to notify the nurse practitioner immediately as soon as they were aware of changes. He stated that it was the receiving nurse's responsibility to report any changes to the nurse practitioner and to document that it was reported. He stated that he did not always document a progress note when residents came back from an appointment if there were no new orders to report. He stated that the importance of reporting and documenting was for continuity of care of the residents and so all the nurses caring for the resident could be informed. He stated that the risk to the resident would be a delay in care if changes were not relayed to the nurse practitioner. He stated that the last Inservice over reporting changes to the nurse practitioner was about a month ago and documentation in-service was this morning 02/03/2026. In an interview on 02/03/2026 at 12:58 p.m., the DON revealed that staff was to report any new orders or change in condition/new diagnosis immediately to nurse practitioner and document a progress note. She stated that since Resident #1s podiatrist progress note did not contain any orders, and it stated that the podiatrist was referring Resident #1 to infectious disease doctor and that the condition was stable, therefore there was nothing to act on at that time. She stated that nurse practitioner did not need to be notified immediately of osteomyelitis diagnosis in this case as it was stable. She stated that it was acceptable for the nurses to notify the nurse practitioner the following day. She stated that if the staff failed to notify the nurse practitioner of any new orders, then that would cause a delay in care, but not in this case as there were no new orders. She stated that the nurse receiving the report was responsible for notifying the nurse practitioner. She stated that the last Inservice over notification and documentation were held periodically with the last one being in [DATE].In an interview on 02/03/2026 at 4:00 p.m., the Administrator revealed that whenever a resident was brought back from an outside appointment with a progress note detailing any new orders or changes to diagnosis the staff was to notify nursing supervisor, and nurse practitioner immediately and document a progress note. He stated that the risk of not notifying the nurse practitioner of these changes would cause an opportunity for miscommunication and care could be delayed and or missed; incorrect information could be given. He stated that the receiving nurse was responsible for notifying the nurse practitioner and documenting the progress note. He stated that the clinical team including the DON and corporate compliance team also oversee documentation. The DON oversees documentation daily and the corporate compliance team oversees documentation once a week. He could not recall the last in-service held regarding notification to nurse practitioner.Review of the facility policy and procedure titled Medical Record Documentation dated October 2021 read in part Licensed staff and interdisciplinary team members shall document observation and services provided in the resident's medical record in accordance with state law .