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	04/09/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 14 residents (Resident #63, Resident #65, and Resident #148) reviewed for ADL care.- The facility failed on 04/2026 to ensure Resident #63's, Resident #65's and Resident #148's fingernails were clean and trimmed.This failure could place residents who required assistance with ADLs at risk for unmet care needs.Findings include: Resident #63 Record review of Resident #63's admission Sheet dated 04/08/26 revealed a [AGE] year-old male with admission date 07/31/2020. Record review of Resident #63's Health and Physical dated 03/13/26 revealed a medical history of Congestive Heart Failure (the heart becomes unable to pump efficiently to meet the body's needs), and Muscle Weakness. Record review of Resident #63's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating Resident #63 were cognitively intact. Under Section GG-Functional Abilities, it was noted Resident #63 was dependent with personal hygiene, meaning the helper does all the effort and the resident does none of the effort, to complete the task. Record review of Resident #63's Care Plan with revision date 10/01/25 revealed Resident #63 was ADL (Activities of Daily Living) self-care performance deficit. Staff interventions stated Resident #63 was totally dependent on 2 staff assistance with personal hygiene. In an observation on 04/07/26 at 9:29 AM, Resident #63 was observed with long nails measuring quarter of an inch past the finger tips on both hands. Resident #63 stated he would like to have them trimmed, and he had not had his nails trimmed in 1 month. Resident #65 Record review of Resident #65's admission Sheet dated 04/09/26 revealed a [AGE] year-old male with admission date 02/07/2022. Record review of Resident #65's Health and Physical dated 02/03/26 revealed a medical history of Cerebral Infarction (Stroke), and Type II Diabetes Mellitus (a chronic condition affecting the body's ability to make insulin and control blood sugar levels). (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
	676060	A. Building B. Wing	04/09/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #65's Comprehensive MDS dated [DATE] revealed a BIMS score of 14, indicating the resident was cognitively intact. Under Section GG- Functional Abilities, it was noted that Resident #65 required substantial/maximal assistance with personal hygiene. This meant the helper does more than half the effort to complete the task. Record review of Resident #63's Care plan with revision date 10/20/25 revealed Resident #63 had an ADL self-care performance deficit. Staff interventions noted Resident #63 was dependent on 2 staff to assist with personal hygiene. In an observation on 04/07/26 at 2:06 PM, Resident #65 was observed with long nails approximately a quarter of an inch long, past his fingertips, to his left hand. He was observed with a left-hand contracture (meaning the skin of the palm of the hand thickens causing the fingers to curl). He stated he would like to have his nails trimmed and was unable to recall last time his nails were trimmed. Resident #148 Record review of Resident #148's admission record revealed an [AGE] year-old male with an admission date on 10/17/2024. Record review of Resident #148's Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 15 with the significance being the resident was cognitively intact. Under section GG for functional abilities of self-care the resident was coded for being substantial/maximal assistance required for personal hygiene. Under Section I active diagnoses, the resident was coded for Diabetes mellitus (chronic metabolic disorder characterized by high blood sugar resulting from inadequate insulin production) and cerebrovascular disease (includes conditions that affect blood flow to the brain, such as stroke). Record review of the Resident #148's care plan dated 04/09/2026 had a focus area for ADL self-care performance with intervention of 1 person assist for personal hygiene. During an interview and observation on 04/08/2026 at 8:33 AM with Resident #148, he stated he wanted his nails cut but had to wait a long time for service because only the nurse could cut his nails due to his diabetes diagnosis. He stated he had asked last week but did not have his request fulfilled. He stated that his contracted right-hand nails were longer. Observation of Resident #148's right hand nails revealed to be 1 inch longer left hand nails. During an interview on 04/09/2026 at 11:10 AM CNA D stated her responsibilities were to assist residents with adjustments, transfers, incontinent changes, change clothes, hygiene, nail trimming, and brushing teeth/hair. She stated that if a resident was diabetic the nurse needed to cut the resident's nails but CNAs could use the nail file for residents who were diabetic. She stated if a resident notified her that they wanted their nails trimmed but were diabetic she would notify the nurse promptly to have the services provided. She stated she would follow-up with the resident to see if it was completed. She stated that long nails affected the resident because they could not get the services they needed. She stated that a resident with limited range of motion needed assistance for nail trimming. She stated she did not remember the last in-service she received for nail cutting or nail filing. During an interview on 04/09/2026 at 11:38 AM LVN G she stated the Nurse and CNA could provide nail trimming services to residents. She stated that the nurse needed to observe or provide it if there (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	04/09/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a skin integrity issue. She stated that the CNAs could not trim or file nails if a resident was diabetic. She stated that any nurse RN or LVN could cut the nails and needed to further monitor for infections or bleeding that could be exacerbated by the diabetic diagnosis. She stated that a CNA needed to notify her immediately if a resident wanted their nails cut and the nurse would follow up immediately as well. She stated there was only one resident she was aware of who could be resistant for ADL care and added the other residents in her hall were receptive of the services. She stated that a resident with long fingernails could scratch themselves, cause infection, and could be left without the services they were asking for. She stated that nail care was routinely conducted on Sundays for residents with diabetic diagnosis and as needed. She stated the nurse was responsible for ensuring the residents' nails were trimmed. She stated the last in-service she received for ADLs and nail cutting March 2026. During an interview on 04/09/2026 at 2:41 PM the DON she stated that nail care could be provided by CNAs and nurses. She stated that if a resident was diabetic then the nurses needed to complete it. She stated that the CNA should notify the nurse as soon as feasible if a resident with diabetes wanted their nails trimmed. She stated that it was a hygiene issue. She stated there was a concern for compromising skin integrity and infection for long nails. She stated that the CNAs observed residents' nails on Sunday as a scheduled routine and for those that were diabetic the nurse would provide that care. She stated that the nurse was responsible for ensuring nail care was provided to the resident. She stated the last in-service/training staff received in November 2025 for ADL assistance. Record review of the facility's Nail Care (Fingernails/Toenails) Policy, revised on 09/02/25, revealed in part: Purpose: Nail care will be provided to resident, with diabetic residents referred to the licensed nurse or podiatrist.

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	04/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage. -The facility failed on 04/07/2026 to ensure leftover food was properly covered and sealed in the walk-in refrigerator.-The facility failed on 04/07/2026 to ensure dietary staff maintained proper hygiene, as evidenced by a torn hairnet that allowed hair exposure during meal handling.-The facility failed on 04/07/2026 to ensure dietary staff practiced hand hygiene and glove changes per the facility policy after their hands became contaminated. These failures had the potential to place all residents who received meals from the kitchen at risk for foodborne illness due to improper food storage and handling practices. Findings included: In an observation and interview on 04/07/2026 at 8:36 a.m. with the Dietary Director, revealed a zip top bag containing boiled eggs was observed open and not properly sealedinside the walk-in refrigerator; the bag had a date of 04/06/2026. Adjacent to the refrigerator door, revealed on a metal rack, a plastic container holding fruit salad was also observed unsealed; the plastic wrapping covering the container had a visible opening at one corner, leaving the contents exposed. The Dietary Director stated that both the zip top bag containing boiled eggs and the plastic container with fruit salad had not been properly sealed. The Dietary Director stated that storing food in an unsealed condition inside the refrigerator increased the risk of contamination, including potential exposure to insects and other environmental factors such as frost bite. The Dietary Director stated that such practices could result in food spoilage and, if served to residents, posed a risk of gastrointestinal illness, including symptoms such as diarrhea and vomiting. In a follow-up interview on 04/09/2026 at 4:29 PM, the Dietary Director stated that the proper prevention for cross contamination included staff wearing gloves, utilizing hairnets, and practicing hand hygiene. The Dietary Director stated that staff needed to change their gloves whenever they touched something that wasn't food or in the serving process. The Dietary Director stated that staff needed to practice hand hygiene and change their gloves if they were to touch the door handle and before resuming meal service. The Dietary Director stated it was cross contamination that could potentially make the resident sick. During an observation and interview on 04/07/2026 at 11:38 a.m., LVN A was observed inside the kitchen handling meal trays that were scheduled for distribution to residents during lunch service. LVN A was noted to be wearing a torn hairnet, which left his hair exposed on the right side of his head. The Dietary Director stated that all personnel entering the kitchen were required to wear appropriate hair restraints, including hairnets and beard guards when applicable. The Dietary Director stated that the use of a torn hairnet compromised infection control standards, as it increased the likelihood of hair falling into food, potentially contaminating meal trays. The Dietary Director stated that if contaminated food were consumed by residents, it could result in gastrointestinal illness, including symptoms such as diarrhea and vomiting, and could also present a choking hazard. During an interview on 04/07/2026 at 11:59 a.m. with LVN A, he stated he was responsible for verifying meal tickets on residents' trays to ensure accuracy of diet orders and consistency requirements. LVN A stated he had been informed by the Dietary Manager that his hairnet was torn and that his hair was exposed. LVN A stated that wearing a torn hairnet inside the kitchen environment was not acceptable, as it increased the risk of hair falling into residents' meals, which could lead to contamination. LVN A stated that such contamination could potentially cause residents to become ill with gastrointestinal symptoms and could also pose a choking risk. During an observation on 04/07/2026 at 11:53 AM in the memory unit dining room during meal service, the Dietary staff was observed exiting and reentering into the kitchen three times while wearing serving gloves. Dietary Staff did not practice hand hygiene before reentering the meal serving area. The Dietary staff was observed grabbing bread rolls with gloves contaminated by door handle and touching surfaces outside of the food service area for approximately 20 residents who were (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	04/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	served in the memory unit side. During an interview on 04/09/2026 at 10:00 a.m. with the ADD, she stated that leftover food posed a risk when not properly sealed, as exposure could allow insects to come into contact with items such as the boiled eggs or other stored foods, leading to contamination. The ADD stated there was also a risk of cross-contamination when food remained open. The ADD stated that if residents consumed contaminated food, it could result in gastrointestinal illness, including diarrhea or vomiting, which could further lead to dehydration and exacerbate existing health conditions. Regarding hair restraints, ADD stated that all individuals entering the kitchen were required to wear hairnets and beard guards as applicable. She explained that hairnets served as a preventive measure to minimize the risk of hair falling into food, which could otherwise result in contamination and potentially cause residents to become ill. During an interview on 04/09/2026 at 10:27 a.m. with the Administrator, he stated that all staff entering the kitchen were expected to wear appropriate hair restraints, including hairnets and beard guards, when necessary, to maintain infection control standards. The Administrator stated that the purpose of these measures was to prevent hair from entering food and compromising cleanliness and safety within the kitchen environment. The Administrator stated that failure to utilize PPE could lead to contamination and increase the risk of residents developing gastrointestinal symptoms. The Administrator stated that while all staff shared responsibility for adhering to these practices, the Dietary Manager was responsible for ensuring compliance. Regarding left over food, the Administrator stated that all food items were required to be properly sealed and stored to prevent spoilage, maintain quality, and avoid contamination. He stated that if exposed or improperly stored food were served, it could result in illness or reduced palatability for residents. In a follow-up interview on 04/09/2026 at 4:35 PM he stated the facility used hand hygiene and glove changing as needed during meal service. The Administrator stated that when staff touched something that wasn't food like a door handle hand hygiene needed to be adhered to. The Administrator stated that they needed to remove gloves, practice hand hygiene, and reapply gloves when touching an unclean surface. The Administrator stated that Dietary Manager and Assistant Dietary Manager were responsible for overseeing the dietary staff and ensuring hand hygiene protocol was followed. The Administrator stated that the food could be contaminated, spread germs, and the resident could feel ill or sick from eating cross-contaminated foods. During an interview on 04/09/2026 at 10:42 a.m. with the DON, she stated that hairnets were considered part of infection control practices and were used to prevent cross-contamination during food preparation. The DON stated that if hair were to fall into food, it could compromise the integrity of the meal and potentially result in residents experiencing gastrointestinal illness, including symptoms such as vomiting or diarrhea. The DON stated that leftover food was required to be adequately covered and stored to prevent bacterial growth and spoilage. She indicated that failure to properly store food could lead to contamination and increase the likelihood of residents developing infections or becoming ill after consumption. During an interview on 04/09/2026 at 11:41 a.m. with the Cook, she stated that hairnets were utilized to maintain hygiene and reduce the risk of contamination during food preparation. She explained that if hair were to fall into prepared meals, it could contaminate the food and present both a choking hazard and a risk of illness for residents. The [NAME] stated that leftover food needed to be cooled to appropriate temperatures, properly sealed, labeled, and dated to ensure safety and quality. The cook stated that failure to store food correctly could result in spoilage or bacterial growth, and if such food were served to residents, it could lead to gastrointestinal illness and other health complications. During an interview on 04/09/2026 at 12:31 PM the Dietary Staff stated that hairnets needed to be worn all the time in the kitchen. He stated beard guards need to be worn, and nursing staff needed to wear a hair net whenever they entered the kitchen. He stated that there were hairnets by the entry that staff could use and apply at any time before entering the kitchen. He stated he would tell the staff member to exit and reapply the hairnet before entering. He stated that there was potential for loose hair to get in the cooking/serving area which would contaminate the food. He stated that it was all Dietary departments' responsibility to prevent cross contamination but the (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	04/09/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dietary director's responsibility to ensure it was completed. He stated the last in-service was in February 2026. He stated he was grabbing the bread rolls with a gloved hand. He stated he did not practice hand hygiene or change gloves and continued serving bread after all exits and reentries into the meal serving area. He stated he went into the room to access the warmer for food and plates. He stated he should have removed gloves, practiced hand hygiene and applied new gloves before resuming work. He stated this needed to be done to prevent cross contamination. He stated that the residents were affected if it was not adhered to. He stated that last time he received hand hygiene training was in February 2026. He stated the process of washing hands was to wash hands for 20 seconds front and back and exposed wrist and turn off the faucet with the paper towel. Record review of the facility's policies and procedures titled Policy and Procedure Manual, Chapter 3: Food Production and Food Safety, dated 2023, revealed in part: 12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days or discarded as per the 2022 Federal Food Code. (Also see policy on Use of Leftovers later in this chapter.) Check state regulations as some states may allow shorter time frames for the use of leftovers. f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded. Record review of the facility's policies and procedures titled Policy and Procedure Manual, Chapter 4: Employee Hygiene for Food Safety, revealed in part: Policy: All food and nutrition services employees will practice good personal hygiene and safe food handling procedures. Procedure: 1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. Record review of the facility's policy and procedure titled policy and procedure manual bare hand contact with food and use of plastic gloves revealed in part: Single use gloves or other barriers will be used when handling food directly with hands to assure that bacteria are not transferred from the food handles hands to the food product being served .Single use gloves shall be used for only one task such as working with ready to eat food or with raw animal food, used for no other purpose and discarded when damaged, or soiled, or when interruptions occur in the operations Hands are to be washed when entering the kitchen before putting on the single use gloves Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed and hands must be washed

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	04/09/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat the resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 3 residents (Resident #127) reviewed for dignity. -The facility failed on 04/07/2026 to ensure Resident #127's Foley catheter bag had a privacy bag. The deficient practice could affect residents by contributing to poor self-esteem, dignity issues, and diminished quality of life.The findings include:Record review of Resident #127's face sheet dated 04/09/2026 revealed a [AGE] year-old male with an original admission date of 12/05/2025. Record review of Resident #127's physical and health dated 03/07/2025 revealed the resident was diagnosed with Alzheimer's dementia (irreversible neurodegenerative disease characterized by cognitive decline, memory loss, and behavioral changes), overactive bladder (uncontrollable urges to urinate and high frequency of urinating), benign prostatic hyperplasia without lower urinary tract symptoms (an incidentally found enlarged prostate that is not causing functional bladder issues or distress). Plan of care under physical and health revealed Resident #127 was to follow up with urologist and provide foley care. Record review of Resident #127's MDS dated [DATE] revealed under section C, a BIMS score of 3 the significance meaning he had severe cognitive impairment. Record review of Resident #127's care plan dated 12/18/2025 revealed the resident had a focus area related to disorientation from dementia. Interventions in place included to provide choices for the resident and assist with decision making.Record review of Resident #127's March 2026 MAR/TAR revealed the resident had an indwelling catheter with instruction to keep the Foley bag below the bladder and utilize a privacy bag in place.During an observation and interview attempt on 04/07/2026 at 3:01 PM, Resident #127 was observed in the common area watching TV while seated in his wheelchair and a clear Foley catheter bag exposed underneath his wheelchair without a privacy cover in place. Follow up observation completed at 4:07 PM, revealed the resident was still in the common area watching TV with his Foley catheter bag still exposed. Resident #127 was unable to participate in an interview due to dementia diagnosis and continuous confusion. In a follow up observation on 04/08/2026 at 9:42 AM revealed the Resident #127's clear Foley catheter bag was placed in a privacy bag suspended under his wheelchair. In an interview on 04/09/2026 at 11:20 AM CNA D stated that the privacy bag was used to hold the residents' Foley catheter bag when the resident was in their wheelchair. She stated that the purpose of the privacy bag was so that other residents could not see the urine output or color since Foley catheter bags were transparent. She stated that CNAs and nurses were responsible for ensuring residents had their Foley catheter bag in the privacy bag. She stated that residents in the memory care unit needed to have their Foley catheter bags covered as well. She stated it affected the resident by exposing the color and amount of urine the resident was releasing and was a dignity issue. She stated she could not remember the last training she received for dignity or resident rights. In an interview on 04/09/2026 at 1:18 PM LVN C stated that Foley catheter care included ensuring the catheter line was not backed up, kinked, off the floor, and a privacy bag was being utilized. She stated the privacy bags were white on the back and had a blue flap on the front. She stated that she did not know if there was another version of privacy bags the facility used for Foley catheter bags. She stated that the Foley catheter bag would receive a satchel with fabric strips for Foley catheter bags without hooks. She stated that the privacy flap on the Foley catheter bag provided privacy to the residents who had an indwelling catheter in place. She stated the Foley b catheter ag needed to be covered for the privacy of the resident. She stated the color and the amount of urine could be exposed to other residents. She stated that a resident would be affected by not having their privacy and dignity respected. She stated the last in-service for privacy and dignity was a couple weeks ago, and (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	04/09/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added all employees were responsible for upholding the resident's privacy and dignity. In an interview on 04/09/2026 at 1:18 PM LVN F stated that residents were provided the privacy bag once the facility was made aware of the different Foley catheter bag or indwelling catheter in place. She stated the privacy bag could be provided by the nurses, nursing supervisors, DON, or Unit managers. She stated that it needed to be provided immediately. She stated that it affected a resident by compromising their privacy. She stated the color of the urine could be exposed if they did not have a privacy bag. She stated that she observed residents' Foley catheter bags for privacy whenever they were in the common area. She stated the last in-service for privacy, dignity, and resident rights was two weeks prior. In an interview on 04/09/2026 at 2:48 PM the DON stated that the flap on the Foley catheter bag provided privacy to the residents' urine output. She stated if a resident had a clear Foley catheter bag the facility usually switched it to the white with blue flap Foley catheter bag version when they come back from the hospital. She stated that the facility had a privacy bag in place for residents that did not have the foley bag with the privacy flap. She stated the dignity of a resident was compromised and the residents' right to privacy if their Foley catheter bag did not have privacy cover. She stated all staff were responsible for upholding residents' dignity and any nurse could change out the Foley catheter bag to the white with blue flap Foley catheter bag and added anyone could provide the privacy satchel. In an observation and interview on 04/09/2026 at approximately 3:15 PM, revealed LVN F observed the Foley catheter bag of Resident #127 in his private restroom and confirmed the Foley catheter bag inside the privacy satchel was clear and not the facility's standard issued white with blue privacy flap. In an interview on 04/09/2026 at 4:11 PM the Administrator stated he wanted to defer comments on the Foley catheter bag to his DON due to his limited knowledge on the topic. Record review of the facility's policy titled Resident's Rights dated 10/2022 revealed in part, Purpose: To ensure the facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility 3. Planning and implementing care: b. the right to participate in the development and implementation of his or her person-centered plan of care 5. Respect and dignity: the resident has a right to be treated with respect and dignity including 8. Privacy and confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment Record review of the facility's in-service titled Resident's Rights dated 03/23/2026 revealed CNA D and LVN C were educated and acknowledged about providing privacy for the residents and residents rights.

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	04/09/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident resided and received services in the facility with reasonable accommodation of resident needs and preferences for 1 of 8 residents reviewed for accommodation of needs. The facility failed to ensure resident call lights were within reach for Resident # 15 on 04/07/2026.This failure placed residents at risk of having their needs unmet when they were unable to contact staff.Findings included:Record review of Resident #15's admission record dated 04/09/2026 revealed and original admission date of 09/19/2025 and a readmission date of 09/25/2025.Record review of Resident #15's history and physical dated 03/03/2026 revealed a diagnosis of multiple sclerosis (a disease that causes breakdown of the protective covering of nerves).Record review of Resident #15's comprehensive MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive function. Section GG indicated Resident #15 was dependent with toileting and hygiene. It also indicated resident was dependent for bed mobilityRecord review of Resident #15's care plan revised on 03/23/2026 revealed Resident #15 was at risk for injury/ falls related to impaired mobility, general weakness related to multiple sclerosis. Intervention included keeping the call light within reach when in bed.An observation and interview on 04/07/2026 at 10:19 a.m., revealed Resident #15 was lying in bed, and the call light was behind the chair to the right of her bed. She stated that she did not know how the call bell got there, but that she could not reach it. she stated that she does use the call light to ask the staff for help.In an interview on 04/09/2026 at 1:53 p.m., with CNA B revealed that the purpose of a call light was for the residents to be able to call for assistance. She stated that it was usually clipped to their sheets where the resident could reach it. She stated that it was necessary to be kept within reach so that the resident could call for assistance when needed. She stated that if the call light was not within reach the resident could be at risk for needs not being met. She stated that it was the responsibility of the nurses and the CNAs to ensure that call lights were within reach.In an interview on 04/09/2026 at 2:05 PM with LVN C revealed that the purpose of a call light was so the residents could let staff know when they needed assistance. She stated that the call light should always be kept within reach to ensure residents get their needs met in a timely manner. She stated that if the call light was not within reach, the resident was at risk for falls. She stated that all staff were responsible for ensuring call lights were within reach at all times.In an interview on 04/09/2026 at 3:41 PM with the DON revealed that the purpose of the call light was for residents to be able to call staff for assistance. She stated that it was to be kept within reach to ensure residents had accessibility to ask for help. She stated that a risk of the call light not being readily accessible would be the residents' needs not being met. She stated that it was the responsibility of all staff to ensure call lights were within reach.In an interview on 04/09/2026 at 4:16 PM with the Administrator revealed that the purpose of the call light was for residents to signal for help, therefore it was to be kept within reach. The risk of the call light not being within reach was that the residents would not get the assistance needed. He stated that all staff were responsible for ensuring that the call light was within reach. Review of the facility policy titled Call Light System generated on 10/2019 revealed in part Staff will receive education related to the mechanism of the call light system and call light availability/ placement for the resident.

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	04/09/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 2 of 6 residents (Resident #14 and Resident #24) reviewed for dementia care.-The facility failed to have a comprehensive person-centered care plan for Resident #14 by not including a diagnosis and focus area for dementia and dialysis diagnosis.-The facility failed to have a comprehensive person-centered care plan for Resident #24 that was completed within the previous 3 months.These failures could affect residents and put them at risk of not receiving care and services to meet their needs.Findings include: Resident #14 Record review of Resident #14's admission record dated 04/08/26 revealed an admission date 10/06/2020. Resident #14's Primary Diagnosis was noted as Unspecified Dementia, mild. Record review of Resident #14's Quarterly MDS dated [DATE] revealed Resident #14 was unable to participate in a BIMS. Under Section I, Resident #14 was noted to have Non-Alzheimer's Dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities). Record review of Resident #14's Health and Physical dated 03/23/26 revealed a medical history of dementia under date of service 02/10/26. Record review of Resident #14's care plan last revised 03/17/2026, revealed Dementia was not included. Resident #24 Record review of Resident #24's admission record dated 04/09/2026 revealed an [AGE] year-old male with an original admission date on 04/05/2021 and readmission on [DATE]. Record review of Resident #24's annual MDS dated [DATE] revealed the resident had a BIMS score of 09 with the significance being the resident had mild cognitive impairment. Under section I the resident had an active diagnosis for dementia (irreversible neurodegenerative disease characterized by cognitive decline, memory loss, and behavioral changes), depression (serious mental health disorder characterized by persistent sadness, loss of interest in activities, and reduced energy) and other symptoms and signs with cognitive functions and awareness (referring to non-specific issues like memory lapses, confusion, poor concentration, and altered awareness). Record review of Resident #24's Physical and Health dated 04/02/2026 revealed the resident had been complaining about his POA guardian not giving him enough money. Record review of Resident #24's published care plan dated 07/2025 with a target completion date of 10/23/2025 revealed the resident had a focus area for being at risk for increased confusion and disorientation related to diagnosis of dementia with specific behavior listed as, asking staff to take him to border city in neighboring country resident is bribing staff to take him to border city with (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	04/09/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything they want including money. Additionally, the resident had a focus area to address diagnosis of major depressive disorder with intervention to observe for change in mental status. During an interview and observation on 04/07/2026 at 2:05 PM revealed Resident #24 was continuously fixated on his money, family member, and spouse in Mexico. Resident #24 was observed expressing signs of restlessness, difficulty regulating emotions, and frustration. Follow-up interviews and observations completed on 04/08/2026 at 9:57 AM and 04/09/2026 at 11:17 AM revealed Resident #24 was still fixated on recent stressors. During an over the phone interview on 04/08/2026 at 12:09 PM with Resident #24's guardian, he stated he had not participated in a care plan for Resident #24 within the 4 months of guardianship and had not been contacted by the facility to schedule a future care plan meeting. During an interview on 04/09/2026 at 11:47 AM LVN G stated that care plans needed to be updated when there was a change in condition, dietary changes, and change in behaviors. She stated whenever a significant finding or event occurred the care plan needed to be updated immediately. She stated that a care plan that was last completed October 2025 was not up to date. She identified the care plan team was comprised of the DON, Social Worker, Administrator, and nursing supervisors. She stated she has a floor nurse did not directly participate in the care plan meetings. During an interview on 04/09/2026 at 2:03 PM the Social Worker stated the IDT was comprised of nursing (MDS), the activities department, and dietary department. He stated that the care plan needed to be updated quarterly, on admission, and change of condition. He stated that the facility had a corporate facilitator who would be providing a care plan meeting within the coming weeks. He stated that Resident #24's care plan needed to be updated since July of 2025, since the target completion was scheduled for October 2025. He stated that a resident who was missing a dialysis diagnosis needed to be care planned. He stated that care concerns could arise, and appropriate care could not be provided if the care plan was not updated or accurate. He added that care might not be continued because there were other issues that were not being updated. During an interview on 04/09/2026 at 2:56 PM the DON stated that MDS developed the care plan and there were 2 individuals who managed the care plans for all the residents within the facility. She stated that care plans were updated when there was a fall, standards of care (gastro tubes [a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications when oral intake is not possible], Foley catheter [a flexible, indwelling tube inserted through the urethra into the bladder to drain urine], transmission based precautions) once a week as needed. She added that care plans and MDSs were routinely completed quarterly, when a significant change occurred, on admission, discharge, and readmission. She stated that a resident's care plan not being updated since July (2025) would not meet the expectations of the facility. She stated that if a resident's care plan was missing a dementia diagnosis, then the facility could not create a plan of care. She stated the facility would not be able to address the behaviors and implications of dementia. She stated the care plan would signify to the care team what their needs were for the dialysis diagnosis. She stated that MDS was responsible for ensuring care plans were accurate, comprehensive, and updated. She identified social services, dietary, and the activities departments were individuals who participated in the development of care plan. She stated there could be potential missing pieces for comprehensive care of the residents and a potential failure to meet their needs. She stated the Administrator had documentation for training with MDS for care plans. She stated she suspected it had been completed in January 2026. (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	04/09/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Care Plans (Comprehensive) Policy dated 06/2019, revealed in part: Purpose: To develop an interdisciplinary resident centered comprehensive care plan to meet the individual needs of each resident. Under Policy Explanation and Compliance Guidelines, it continued: 1. An interdisciplinary team develops and maintains a comprehensive care plan for each resident. 2. The comprehensive care plan has been designed to: a. Identify care needs that include resident's strengths, history, and preferences; b. Incorporate risk factors. 3. The resident's comprehensive care plan is developed within seven (7) days after the completion of the MDS assessment. New residents will have a comprehensive care plan within seven (7) days after the completion of the MDS assessment, not to exceed twenty-one (21) days from the date of admission. a. Care plans are revised as changes are indicated.

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	04/09/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to review and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 6 residents (Resident #24) reviewed for care plan accuracy. -The facility failed to have a comprehensive person-centered care plan for Resident #24 that was completed within the previous 3 months.These failures could affect residents and put them at risk of not receiving care and services to meet their needs.Findings include:Resident #24Record review of Resident #24's admission record dated 04/09/2026 revealed an [AGE] year-old male with an original admission date on 04/05/2021 and readmission on [DATE]. Record review of Resident #24's annual MDS dated [DATE] revealed the resident had a BIMS score of 09 with the significance being the resident had mild cognitive impairment. Under section I the resident had an active diagnosis for dementia (irreversible neurodegenerative disease characterized by cognitive decline, memory loss, and behavioral changes), depression (serious mental health disorder characterized by persistent sadness, loss of interest in activities, and reduced energy) and other symptoms and signs with cognitive functions and awareness (referring to non-specific issues like memory lapses, confusion, poor concentration, and altered awareness). Record review of Resident #24's Physical and Health dated 04/02/2026 revealed the resident had been complaining about his POA guardian not giving him enough money. Record review of Resident #24's published care plan dated 07/2025 with a target completion date of 10/23/2025 revealed the resident had a focus area for being at risk for increased confusion and disorientation related to diagnosis of dementia with specific behavior listed as, asking staff to take him to border city in neighboring country resident is bribing staff to take him to border city with anything they want including money. Additionally, the resident had a focus area to address diagnosis of major depressive disorder with intervention to observe for change in mental status. During an interview and observation on 04/07/2026 at 2:05 PM revealed Resident #24 was continuously fixated on his money, family member, and spouse in Mexico. Resident #24 was observed expressing signs of restlessness, difficulty regulating emotions, and frustration. Follow-up interviews and observations completed on 04/08/2026 at 9:57 AM and 04/09/2026 at 11:17 AM revealed Resident #24 was still fixated on recent stressors. During an over the phone interview on 04/08/2026 at 12:09 PM with Resident #24's guardian, he stated he had not participated in a care plan for Resident #24 within the 4 months of guardianship and had not been contacted by the facility to schedule a future care plan meeting. During an interview on 04/09/2026 at 11:47 AM LVN G stated that care plans needed to be updated when there was a change in condition, dietary changes, and change in behaviors. She stated whenever a significant finding or event occurred the care plan needed to be updated immediately. She stated that a care plan that was last completed October 2025 was not up to date. She identified the care plan team was comprised of the DON, Social Worker, Administrator, and nursing supervisors. She stated she has a floor nurse did not directly participate in the care plan meetings. During an interview on 04/09/2026 at 2:03 PM the Social Worker stated the IDT was comprised of nursing (MDS), the activities department, and dietary department. He stated that the care plan needed to be updated quarterly, on admission, and change of condition. He stated that the facility had a corporate facilitator who would be providing a care plan meeting within the coming weeks. He stated that Resident #24's care plan needed to be updated since July of 2025, since the target completion was scheduled for October 2025. He stated that care concerns could arise, and appropriate care could not be provided if the care plan was not updated or accurate. He added that care might not be continued because there were other issues that were not being updated. During an interview on 04/09/2026 at 2:56 PM the DON stated that MDS developed the care plan and there were 2 individuals who managed the care plans for all the residents within the facility. She stated that care plans were updated when there was (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	04/09/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a fall, standards of care (gastro tubes [a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications when oral intake is not possible], Foley catheter [a flexible, indwelling tube inserted through the urethra into the bladder to drain urine], transmission based precautions) once a week as needed. She added that care plans and MDSs were routinely completed quarterly, when a significant change occurred, on admission, discharge, and readmission. She stated that a resident's care plan not being updated since July (2025) would not meet the expectations of the facility. She stated that MDS was responsible for ensuring care plans were accurate, comprehensive, and updated. She identified social services, dietary, and the activities departments were individuals who participated in the development of care plan. She stated there could be potential missing pieces for comprehensive care of the residents and a potential failure to meet their needs. She stated the Administrator had documentation for training with MDS for care plans. She stated she suspected it had been completed in January 2026. Record review of the facility's Care Plans (Comprehensive) Policy dated 06/2019, revealed in part: Purpose: To develop an interdisciplinary resident centered comprehensive care plan to meet the individual needs of each resident. Under Policy Explanation and Compliance Guidelines, it continued: 1. An interdisciplinary team develops and maintains a comprehensive care plan for each resident. 2. The comprehensive care plan has been designed to: a. Identify care needs that include resident's strengths, history, and preferences; b. Incorporate risk factors. 3. The resident's comprehensive care plan is developed within seven (7) days after the completion of the MDS assessment. New residents will have a comprehensive care plan within seven (7) days after the completion of the MDS assessment, not to exceed twenty-one (21) days from the date of admission. a. Care plans are revised as changes are indicated.

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	04/09/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; and failed to have an established system in place for accurate reconciliation for 1 (East wing) of 2 medication carts that had residents with orders for controlled substances.The facility failed to ensure LVN C signed the form after counting and verifying that all controlled substances in the medication cart had been accounted for with the Controlled Medication Accountability Record on 04/09/26.The facility failed to ensure Resident #157's Lidocaine Patch was removed per Physician's Order.This failure could place residents at risk for not receiving the intended therapeutic response of prescribed medications and drug diversion of controlled substances.Findings include:Record review of Resident #157's admission date 04/09/26 revealed an [AGE] year-old male resident with admission date 09/16/25.Record review of Resident #157's Health and Physical dated 03/31/26 revealed a medical history of Rheumatoid Arthritis (chronic condition of inflammation of the joints causing stiffness and pain).Record review of Resident #157's Quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating Resident #157 was cognitively intact. Record review of Resident #157's care plan last revised 01/22/26, revealed the resident was at risk for alteration of comfort/pain related to arthritis. The staff interventions included to administer medications as ordered.Record review of Resident #157's medication order revealed: Lidocaine External Patch 4% Apply to Affected area topically in the morning for pain and remove per schedule with start date 01/20/26.Record review of Resident #157's Medication Administration Record for April 2026, dated 04/09/26, revealed the medication order: Lidocaine External Patch 4% Apply to Affected area topically in the morning for pain and remove per schedule with start date 01/20/26, with Administration Time at 08:00 AM, and Removal at 08:00 PM. The Lidocaine External Patch 4% was marked as removed on 04/08/26 at 08:00 PM by LVN J.An observation was made on 04/09/26 at 08:30 AM of LVN H removing the Lidocaine Patch from Resident #157's right shoulder that was dated 04/08/26. LVN C then administered a new Lidocaine patch dated 04/09/26 to Resident #157's right shoulder. Resident #157 was assessed for pain by LVN H, which Resident #157 denied. The skin of the right shoulder was observed to be free of redness or inflammation.In an review and interview on 04/09/26 at 11:20 AM of the Controlled Medication Accountability Record with LVN C, it revealed she failed to sign the record when she started her shift. She stated nurses were supposed to sign the Controlled Medication Accountability Record at the beginning of the shift, but she did not because she usually did it in the middle of her shift. She stated she did that in case she received more medications that needed to be accounted for during her shift.In an interview on 04/09/26 at 11:20 AM with LVN H, he stated Resident #157's Lidocaine patch was to be removed at night per the physician's order. He stated the nurse that signed off on the Medication Administration Record was responsible for removing the patch per physician's order. He stated the potential risk of not following the physician's order, such as not removing the lidocaine patch, including possible skin irritation for a resident.In a follow up interview on 04/09/26 at 2:20 PM with LVN C, she stated nurses that were incoming onto the shift were responsible for signing the Controlled Medication Accountability Record. She stated the purpose for signing when coming onto the shift was to confirm the count and accuracy of the narcotic medications. She stated the potential risk of not signing per policy included residents not obtaining their medications. She stated nursing supervisors did random checks of the narcotic books daily. LVN C stated the nurse on shift administering or removing the medication was responsible for following the physician's orders. She stated the DON monitored nurses' medication administration compliance once a week. She stated the potential risk for residents having a topical medication longer than the physician's order included skin (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	04/09/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	irritation.In an interview on 04/09/26 at 2:37 PM with LVN E, she stated the nurses coming onto shift were responsible for signing the Controlled Medication Accountability Record after they finished counting the narcotic medications at the beginning of the shift. She stated nurses were to sign their name and date after confirming medication count. She stated the nursing supervisors reviewed and monitored the narcotic book and logs every shift. She stated the potential risk of nurses not signing the Controlled Medication Accountability Record included residents having limited medication availability for residents which could depend on the medications of the residents.In an interview on 04/09/26 at 3:38 PM with the DON, she stated nurses were responsible for following physician orders. She stated if nurses were to report any concerns regarding medications including a topical medication patch not being removed per physician order. She stated there was no monitoring system in place, but Supervisors were notified of any concerns and the Supervisors or self as the DON, would follow up. She stated she did not believe there was potential risk to the resident since the Lidocaine Patch was removed within 24 hours. The DON stated the pharmacy nurse completed a comprehensive review of the facility's medication carts monthly including the narcotic books. She stated the potential risk of not signing the narcotic books per policy included drug diversion.Record review of the facility's policy Medication Administration with revision date 07/01/26, revealed in part: Purpose: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

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	04/09/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility failed to label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts (300-hall) viewed for pharmacy services.The facility failed to ensure the 300-hall medication cart was clean and free from dried drippings, pieces of paper and a loose tablet.This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects.The findings include:In an observation on 04/09/26 at 11:05 AM of the medication cart located in the 300-hall with LVN I, revealed the second drawer contained blister packet medications with pieces of paper from the blister packets and a loose tablet medication on the bottom of the drawer. It also revealed a dried deep-yellow dripping on the first drawer of the right side when facing the medication cart.In an interview on 04/09/25 at 2:17 PM with LVN C, she stated the nurse or medication aide that had the cart that shift was responsible for cleanliness of the cart. She stated nursing staff were to clean and maintain the cart every shift. She stated potential risk of loose tablets and dried drippings in a medication cart included residents' medications being exposed to unknown substances causing unknown reactions.In an interview on 04/09/26 at 3:38 PM with the DON, she stated the pharmacy nurse completed a comprehensive review of the facility's medication carts monthly. She stated the pharmacy nurse reviewed medications and the cart for cleanliness. She stated the purpose of cleaning the medication cart and keeping it free from dried drippings, loose tablets, and small loose pieces of paper was for hygiene purposes and was an infection control issue.Record review of the facility's policy Medication Administration with revision date 07/01/26, revealed in part: Purpose: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Under Procedure, it read in part: Keep medication cart clean, organized, and stocked with adequate supplies.