STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676063	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alfredo Gonzalez Texas State Veterans Home	301 E Yuma Ave McAllen, TX 78503

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on observation, interviews, and record review the facility failed to have physician orders for the resident's immediate care at time of admission for 2 of 5 residents (Resident #4 and #5) reviewed for physician admission orders. 1.The facility failed to have physician orders in place for Resident #4's enhanced barrier precautions. 2.The facility failed to have physician orders in place for Resident #5's enhanced barrier precautions. This deficient practice could place residents with indwelling devices at risk of developing infections. The findings included: 1.Record review of Resident #4's face sheet, dated 10/30/24, revealed a [AGE] year old male with an initial admitted [DATE] with diagnoses which included: gastrostomy status (surgical opening into the stomach), dysphagia (difficulty swallowing) following cerebral infarction (ischemic stroke - disrupted blood flow to the brain to due problems with the blood vessels that supply it), type 2 diabetes mellitus without complications (high blood sugar), and essential (primary) hypertension (high blood pressure). Record review of Resident #4's quarterly minimum data set assessment (MDS), dated [DATE], revealed Resident #4 had a BIMS score of 13, indicating no cognitive impairment. Resident #4's MDS also reflected the use of a feeding tube while a resident. Record review of Resident #4's care plan with an initiated date of 07/10/24 revealed a focus of, I have a feeding tube, but it is not used for feedings. I am able to eat by mouth. My doctor wants for me to keep it in case due to my hx of dysphagia with an initiated date of 7/11/24 and a revision date of 07/22/24. Resident #4's interventions stated, Enhanced Barrier Precautions with an initiated date of 10/21/24. Record review of Resident #4's Order Summary Report reflected Resident #4 had an active order for, Eternal Feed Order every shift Flush Gastric Tube with 50 CC H2O for Patency with a start date of 07/22/24. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's physician's orders, on 10/30/24 at 4:30pm reflected there were no orders in place for enhanced barrier precautions. On 10/30/24 at 5:08pm Surveyor C asked ADON D about enhanced barrier orders for Resident #4, ADON D was unable identify any EBP orders on Resident #4's chart. Record review of Resident #4's physician orders on 10/30/24 at 5:23pm, revealed order for EBP (Enhances Barrier Precautions): Practice EBP as indicated. With a frequency of every shift and start date of 10/30/24 at 5:13pm. Observation of Resident #4's room on 10/26/24 at 7:17pm revealed a container of gowns located in the hallway outside of Resident #4's room and a box of gloves inside the room at the entrance with signage posted on the outside of his door stating enhanced barrier precautions. Instructions stated everyone must complete hand hygiene before entering and when leaving the room and stated providers and staff must also wear gloves and a gown for high contact resident care activities which included device care or use of a feeding tube. During an interview with Resident #4 on 10/26/24 at 7:17pm he stated that he had a PEG tube that staff worked on about every day. Resident #4 stated staff members seemed like they wore protective clothing that included a yellow gown and gloves. 2. Record review of Resident #5's face sheet, dated 10/30/24, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: gastrostomy status (presence of surgical opening to the stomach), type 2 diabetes mellitus with other specified complication (high levels of sugar in blood), dysphagia, oropharyngeal phase (difficulty swallowing), and rhabdomyolysis (condition that caused muscle breakdown). Record review of Resident #5's admission Minimum Data Set assessment, dated 09/26/24, reflected Resident #5 had a BIMS score of 00, indicating severe cognitive impairment. Resident #5's MDS also reflected the use of a feeding tube while a resident. Record review of Resident #5's care plan, initiated on 09/22/23 reflected Resident #5 had a focus of, I require a feeding tube r/t dysphagia, oropharyngeal phase: with an initiation date of 09/23/24 and a revision date on 10/02/24/24 and an intervention of Enhanced barrier precautions, every shift. with an initiation date of 09/23/24. Record review of Resident #5's physician's orders, on 10/30/24 at 4:30pm reflected there were no orders in place for enhanced barrier precautions. On 10/30/24 at 5:08pm Surveyor C asked ADON D about enhanced barrier orders for Resident #5, ADON D was unable identify any EBP orders on Resident #5's chart. Record review of Resident #5's physician orders on 10/30/24 at 5:24pm, revealed order for EBP (Enhances Barrier Precautions): Practice EBP as indicated. With a frequency of every shift and start date of 10/30/24 at 5:16pm. Observation of Resident #5's room on 10/26/24 at 6:15pm revealed a container of gowns outside of Resident #5's room and a box of gloves inside the room at the entrance with signage posted on the outside of his door stating enhanced barrier precautions. Instructions stated everyone must complete hand hygiene before entering and when leaving room and stated providers and staff must also wear gloves and a gown for high contact resident care activities which included device care or use of a feeding tube. Observation of Resident #5 on 10/26/24 at 6:15pm revealed he had a PEG tube in place. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with ADON D on 10/30/24 at 6:02pm she confirmed Residents #4 and #5 had invasive devices that would put them on EBPs. ADON D stated both residents should have orders for EBPs. ADON D stated when Surveyor C notified her of missing orders for EBP in Resident #4 and Resident #5's chart she reviewed the resident's charts herself and stated there were no orders at that time. ADON D stated she had since input orders for EBP. ADON D stated it was important to have EBP orders in place because it's an order and it was something that had to abide by. ADON D stated staff were aware who was on EBP precautions because of the signage and PPE cart. ADON D also stated staff had been told that anybody with pegs, foleys, stoma, or any opening that could attract some kind of infection would have EBP put in place. ADON D stated the admitting nurse would have been responsible for inputting EBP orders and stated she or the RN supervisor at that time would have been responsible for overseeing and reviewing the charts to ensure those orders were input. ADON D did not know why EBP orders for Residents #4 and #5 were not input and stated she did not even know who would have done it. When asked about the facility policy for inputting orders related to EBPs, ADON D stated she believed it was something that came from CMS and stated they had not followed that information because they did not have an order in place for EBP for Residents #4 and #5. ADON D stated that they did however have all PPE in place along with signage to indicate EBP was in place and stated EBPs were followed. ADON D stated both her and the facility staff had been trained over inputting orders via on the job training and stated they did not have a specific in-service on that. ADON D stated not inputting EBP orders could negatively impact residents because it could be that EBPs were not used and could cause an infection which was what EBPs were meant to prevent. During an interview with the DON on 10/30/24 at 6:25pm she stated Residents #4 and #5 should have EBPs orders in place. The DON stated she had not reviewed the resident's charts and was not able to confirm if the orders were in place prior to Surveyor C notifying ADON D. The DON stated they had input the orders for EBPs after Surveyor C notified them and stated the admitting nurse should put in the orders and those orders should be reviewed by ADON D. The DON stated she did not know why the EBPs orders were not input. The DON stated it was important to have EBP orders in place to make sure the aides, medication aides, and nurses knew they needed to use it. The DON stated staff knew who was on EBPs because they had signs and PPE bins outside of the rooms. The DON stated the facility policy stated EBP orders should have been in the chart. The DON stated in this situation the facility policy was not followed. The DON stated ADON D had previously been trained however it was an on-the-job type training and not a written in-service. The DON stated not inputting EBP orders could negatively impact residents because staff may not know to follow them. During an interview with the DON on 10/30/24 at 7:11pm she stated her regional had informed her that their policy did not state to have EBP orders and stated it was a CMS thing on information on what PPE to wear.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on observations, interviews, and record review the facility failed to follow their policy regarding storage of foods brought to the residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption of the food and beverages for 1 of 2 Residents (Resident #3) reviewed for personal food storage. The facility did not have completed documentation of temperature checks for Resident #3's personal refrigerator for the month of October. This failure could place residents with personal refrigerators at risk of food borne illness. The findings included: Record review of Resident #3's face sheet, dated 10/26/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: Parkinson's disease (chronic brain disorder that caused gradual decline in motor and non-motor functions) with dyskinesia (involuntary muscle movements), without mention of fluctuations, type 2 diabetes mellitus without complications (high levels of sugar in blood), and dysphagia, oropharyngeal phase (difficulty swallowing). Record review of Resident #3's quarterly Minimum Data Set assessment, dated 08/15/24, reflected Resident #3 had a BIMS score of 13, indicating intact cognition. Resident #3's MDS also reflected the use of a feeding tube while a resident. Record review of Resident #3's care plan, initiated on 11/09/23 reflected Resident #3 had a focus of, I have a personal refrigerator in my room as per RP's request, and resident isn't able to access it and only for family's use. with an initiation date of 12/22/23 and an intervention of, Ensure temperature log is updated daily and within acceptable range. Record review of Resident #3's order summary report, on 10/30/24 reflected there was a discontinued order for, pleasure feed diet with RP only to give veteran broth, jello, liquids, sprite, apple sauce etc. when she comes to visit resident. waiver in place. With an order date of 04/10/24 and an order status of discontinued. There was no specific discontinue date noted. Record review of Resident #3's nursing note dated 10/24/24 at 12:05pm reflected he had been sent out to the hospital on 10/24/24. Record review of Resident #3's nursing note dated 10/29/24 at 8:49pm reflected Resident #3 returned to the facility at 8:15pm. Observation of Resident #3's fridge on 10/29/24 at 10:50am revealed a document titled DAILY REFRIGERATOR TEMPERATURE LOG that was identified for the month of October. The only days with logged temperature checks were 10/01/24 - 10/03/24 and 10/20/24 and 10/21/24. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #3's fridge on 10/29/24 at 11:21am revealed items such as ice cream, sealed Jello's, sealed purred baby food, and closed Sprite sodas. During an interview the DON on 10/29/24 at 12:35pm she stated the fridge in Resident #3's room was not his personal fridge, it was his family members, and was used for her personal items. The DON stated Resident #3's family member had told her that she brought apple sauce for Resident #3, but the DON stated she had not seen it. The DON stated there were Sprites in the fridge, but she was not sure if they were for Resident #3 or his family member. The DON stated the night nurses who work Resident #3's hall were responsible for checking and logging the temperature of Resident #3's fridge daily at night. The DON stated there were some blanks on the temperature log for October 2024. The DON stated based on their facility policy for personal refrigerators the staff did not follow the policy. The DON stated staff had been trained over monitoring the temperature in the fridges and stated this took place within the last year by one of the RN supervisors. The DON stated not monitoring the temperatures could cause the food to be spoiled and residents eat it. During an interview with Resident #3's family member on 10/29/24 at 2:25pm she stated the fridge in Resident #3's room was used for his pleasure feeding items and stated she had taken things like Jello, Sprite, baby food, and ice cream to provide Resident #3 with the pleasure feedings. Resident #3's family member stated the items in the fridge were not hers and were for Resident #3. Record review of facility in-service dated 02/02/24 revealed multiple staff members had been trained over refrigerators. Verbiage on in-service included, Temperature Logs to be updated daily. Record review of the facility policy titled, Personal Refrigerators included a section titled, Monitoring that included verbiage that stated. 2. A team member will place a thermometer in the refrigerator and begin to record temps [SIC] to ensure the refrigerator is properly working and maintaining proper temperatures. 3. Document the temperature of internal refrigerator gauges.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on observations, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 2 of 5 Residents (Resident #3 and Resident #5) that were reviewed for infection control and transmission-based precautions policies and practices. 1. LVN A failed to don the appropriate PPE before he entered Resident #5's room and provided care to Resident #5's PEG tube. 2. LVN B failed to don the appropriate PPE before he entered Resident #3's room and provided care to Resident #3's midline. These failures could place residents at risk for infection through cross-contamination of pathogens and infectious diseases. The findings included: 1. Record review of Resident #5's face sheet, dated 10/30/24, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: gastrostomy status (presence of surgical opening to the stomach), type 2 diabetes mellitus with other specified complication (high levels of sugar in blood), dysphagia, oropharyngeal phase (difficulty swallowing), and rhabdomyolysis (condition that caused muscle breakdown). Record review of Resident #5's admission Minimum Data Set assessment, dated 09/26/24, reflected Resident #5 had a BIMS score of 00, indicating severe cognitive impairment. Resident #5's MDS also reflected the use of a feeding tube while a resident. Record review of Resident #5's care plan, initiated on 09/22/23 reflected Resident #5 had a focus of, I require a feeding tube r/t dysphagia, oropharyngeal phase: with an initiation date of 09/23/24 and a revision date on 10/02/24 and an intervention of Enhanced barrier precautions, every shift with an initiation date of 09/23/24. Record review of Resident #5's physician's orders, on 10/30/24 at 4:30pm reflected there were no orders in place for enhanced barrier precautions. On 10/30/24 at 5:08pm Surveyor C asked ADON D about enhanced barrier orders for Resident #5, ADON D was unable identify any EBP orders on Resident #5's chart. Record review of Resident #5's physician orders on 10/30/24 at 5:24pm, revealed an order for EBP (Enhances Barrier Precautions) : Practice EBP as indicated. With a frequency of every shift and start date of 10/30/24 at 5:16pm. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #5'S room on 10/26/24 at 6:15pm revealed a container of gowns outside of Resident #5's room and a box of gloves inside the room at the entrance with signage that was posted on the outside of his door stating enhanced barrier precautions. Instructions stated everyone must complete hand hygiene before entering and when leaving room and stated providers and staff must also wear gloves and a gown for high contact resident care activities which included device care or use of a feeding tube. Observation of Resident #5 on 10/26/24 at 6:15pm reflected his feeding pump tubing had been disconnected and was leaking. Surveyor C notified LVN A of Resident #5's observation on 10/26/24 at around 6:16pm. Observation and interview of LVN A on 10/26/24 at 6:20pm revealed he entered Resident #5's room without donning a gown and was only wearing gloves when LVN A was observed pausing Resident #5's feeding and using a syringe to flush Resident #5's PEG tube with water. LVN A stated because Resident #5 did not have any infections and his urine was contained, they only had to wear gloves and keep a distance. LVN A stated he had not recently worn gowns with Resident #5 and stated he had just been using gloves for residents who were on peg tubes or enhanced barrier precautions. LVN A stated he had not really had training over enhanced barrier precautions. LVN A was then shown the signage posted on Resident #5's door and then stated that he had received training upon hire. LVN A was unable to answer if he was aware that he needed to wear a gown during high contact activates with residents on enhanced barrier precautions before Surveyor C showed him the signage at Resident #5's door. During an interview with RN E on 10/29/24 at 1:45pm he stated he was the IPC nurse and stated Resident #5 was on EBP on 10/26/24. RN E stated LVN A had told him he washed his hands and put on gloves but did not put on a gown when working with Resident #5's PEG tube on 10/26/24. RN E stated a gown and gloves should be used with residents on EBP and stated LVN A had not worn the gown because he forgot. RN E stated LVN A was trained over EBP during orientation but had also been retrained on 10/26/24 after being notified by Surveyor C that LVN A had not followed EBP. RN E stated it was important to use the proper PPE because they don't want to give those residents anything or get anything from residents and pass it to others. RN E stated the facility had both gowns and gloves available. RN E stated the facility policy stated to wear gowns and gloves anytime they did direct patient care or came in contact with a tube or foley with residents on EBP. RN E stated in this situation staff had not followed the policy. RN E stated staff, and facility leadership ensured staff wore the appropriate PPE by having a physician order, placing signage on the doors, and educating staff on why and what PPE should be worn. RN E stated not wearing the appropriate PPE could negatively impact the residents because you may pass something from one resident to another or give them something that was on you. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview with LVN A on 10/30/24 at 12:23pm he stated he was not aware who the IPC nurse was at the facility. LVN A stated on 10/26/24 Resident #5 was on enhanced barrier precautions when he entered the room. LVN A stated he paused the feeding, flushed the feeding tube, and put the feeding back in place because it had dislodged. LVN A stated he did this while only wearing gloves. LVN A stated prior to 10/26/24 he had been trained but stated on 10/26/24 he was bombarded and might have missed a few steps. LVN A stated when residents were on enhanced barrier precautions, they needed to perform hand hygiene, and wear gloves and a gown. LVN A stated it was not that he had never worn the gown it was that he got nervous. LVN A stated it was important to wear the proper PPE when working with residents on enhanced barrier precautions to prevent from bringing anything into a patient or taking anything out to another that might cause more harm to a resident. LVN A stated he had gowns and gloves available to him at the facility. He stated after not wearing the appropriate PPE on 10/26/24, he had received a training over the appropriate PPE to be worn during high contact activities with residents on enchanted barrier precautions. LVN A was unable to recall who provided him with that training. LVN A stated he thought the facility policy stated it was mandatory to wear gowns and gloves during high contact with a resident on enhanced barrier precautions. LVN A stated he did not follow the facility policy on 10/26/24 when providing care to Resident #5. LVN A stated to ensure that staff wore the appropriate PPE staff had to be educated, updated, and reminded daily about the facility policy and that it was mandatory to wear with residents who needed that protection. LVN A stated not wearing the appropriate PPE could negatively impact the residents by causing them to develop infections, get worse or decline in health. Record review of the facilities orientation subject areas document reflected LVN A had completed, IPC, Isolation/Precautions, Bloodborne Pathogens training on 10/08/24. Record review of the facilities Inservice attendance sheet dated 10/26/24 included LVN A's signature. This in-service covered the topic of EBP. 2. Record review of Resident #3's face sheet, dated 10/26/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: Parkinson's disease (chronic brain disorder that caused gradual decline in motor and non-motor functions) with dyskinesia (involuntary muscle movements), without mention of fluctuations, type 2 diabetes mellitus without complications (high levels of sugar in blood), and dysphagia, oropharyngeal phase (difficulty swallowing). Record review of Resident #3's quarterly Minimum Data Set assessment, dated 08/15/24, reflected Resident #3 had a BIMS score of 13, indicating intact cognition. Resident #3's MDS also reflected the use of a feeding tube while a resident. Record review of Resident #3's care plan, initiated on 11/09/23 reflected Resident #3 had a focus of, UTI r/t: I have a Midline to left upper arm. Record review of Resident #3's order summary report reflected Resident #3 had orders for, EBP (Enhanced Barrier Precautions): Practice EBP as indicated. every shift. and to Monitor Midline for S/S of infection every shift. Both orders had an order status of active and an order start date of 10/30/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #3's room on 10/30/24 at 3:05pm revealed a container of gowns outside of Resident #3's room and a box of gloves and hand sanitizer stationed inside the room at the entrance with signage posted on the outside of Resident #3's door stating enhanced barrier precautions. Instructions stated everyone must complete hand hygiene before entering and when leaving room and stated providers and staff must also wear gloves and a gown for high contact resident care activities which included device care or use of a central line. Observation and interview of LVN B in Resident #3's room on 10/30/24 at 3:05pm revealed LVN B was working with Resident #3's midline while not wearing a gown and was only noted to be using gloves. LVN B stated Resident #3 was on contact precautions and stated he was only wearing gloves and should have worn a gown, LVN B stated he would stop providing care and go put on a gown. During an interview with LVN B on 10/30/24 at 3:24pm he stated he did not know who the IPC was for the facility. LVN B confirmed Resident #3 was on EBP on 10/30/24, and stated he was going to start Resident #3's IV to his midline and was trying to get the midline out from in between his armpit and chest. LVN B also stated before Surveyor C had walked into Resident #3's room he had just provided him his feeding via his PEG tube and stated he was only wearing gloves during this activity and was not wearing a gown. LVN B initially stated he was not used to wearing PPE with Resident #3 and stated he was not previously aware that he was on EBP. LVN B stated he did not know what EBP were. After Surveyor C explained to LVN B what EBPs were LVN B then stated he did know what they were and stated he had previously used the gown and gloves with Resident #3 because he had been on precautions. LVN B stated he had recently been in-serviced over EBP. LVN B stated he had to complete hand hygiene, wear gloves and a gown during high contact activities with residents on EBP. LVN B started he forgot to wear the gown with Resident #3. LVN B stated it was important to use the appropriate PPE to protect patients from bacteria. LVN B stated the facility had gowns and gloves available. LVN B stated he had not yet been reeducated after being observed by Surveyor C providing care to Resident #3. LVN B stated the facility policy stated PPE to include gloves and gowns needed to be used during high contact with a resident who was on EBP. LVN B stated in this situation he had not followed the facility policy. LVN B stated nursing staff and facility leadership ensured the appropriate PPE was being worn by rounding on staff and stated he would remind the aides to use gowns. LVN B stated not wearing the appropriate PPE could negatively impact residents by transferring microorganisms and possible infections. During an interview with the DON on 10/29/24 at 12:35pm she stated RN E was the infection preventionist for the facility. The DON stated Resident #5 was on EBP on 10/26/24. The DON stated LVN A had not spoken to her about what care he provided to Resident #5 or what PPE he was wearing on 10/26/24. The DON stated LVN A had been provided training over EBP during orientation and stated RN E provided LVN A with training on 10/26/24 after Surveyor C notified her of LVN A being observed not following EBP. The DON stated staff should have worn gowns and gloves during high contact activities with residents on EBP and did not know why LVN A had not worn a gown. The DON stated it was important to wear the appropriate PPE with residents to prevent any MDROs from being transmitted in case there was any. The DON stated the facility had gowns and gloves available. The DON stated the facility policy stated gowns and gloves should be used during high contact activities with residents on EBP. The DON stated LVN A had not followed the facility policy. The DON stated she ensured staff wore the appropriate PPE by doing rounds and seeing staff go in and out of the rooms and providing them with in-services. The DON stated not wearing the appropriate PPE could negatively impact residents because it could pass MDROs to residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676063	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alfredo Gonzalez Texas State Veterans Home	301 E Yuma Ave McAllen, TX 78503

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview with the DON on 10/30/24 at around 4:40pm she confirmed Resident #3 was on EBP on 10/30/24. The DON stated LVN B told her that he had forgotten to put on his PPE. The DON stated LVN B had been trained but was not sure of the specific date. The DON stated she did not know of LVN A or LVN B not using the appropriate PPE when working with other residents on EBP. The DON stated LVN B was currently being retrained on PPE to be worn with residents on EBP. The DON stated LVN B did not follow the facility policy. Record review of the facilities orientation subject areas document reflected LVN B had completed, IPC, Isolation/Precautions, Bloodborne Pathogens training on 09/03/24. Record review of the facilities Inservice attendance sheet dated 10/30/24 included LVN B's signature. This Inservice covered the topic of EBP. Record review of facility policy titled, Infection Prevention and Control Program with a revised date of April 2024, included a section titled, Clarification for the use of enhanced Barrier Precautions: included the following verbiage, EBP requires the use of gown and gloves during high-contact resident care activities. The policy further clarified high contact activities to include, Device care or use: Central line, urinary catheter, feeding tube.