

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Alfredo Gonzalez Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573</b></p> <p>Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for accuracy of records, in that:</p> <p>The facility failed to accurately document as the staff continued to log temperatures on the MAR for Resident #1's personal refrigerator from [DATE]-[DATE], although the refrigerator was taken home on [DATE] by Resident #1's family.</p> <p>This failure could affect residents whose records are maintained by the facility and could place them at risk for errors in care.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated [DATE] 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), encounter for attention to gastrostomy (feeding tube insertion), and dysphagia, oropharyngeal phase (difficulty swallowing).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 00, indicating severe cognitive impairment.</p> <p>Record review of Resident #1's care plan dated [DATE] and initiated on [DATE] reflected Resident #1 did not have the personal refrigerator care planned as he no longer had the refrigerator at the facility.</p> <p>Record review of Resident #1's order summary report for entire stay dated [DATE] reflected Resident #1 had an order for, Fridge temperature every night shift, fridge range ,d+[DATE]. Report any out-of-range temps to maintenance. Order had an order status of discontinued and an order start date of [DATE]. There was no specific discontinue date noted.</p> <p>Record review of Resident #1's progress notes dated [DATE] reflected at 12:30 PM, FM 2 here, took refrigerator home. Documented by: LVN C.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's MAR report dated [DATE] reflected the temperatures for the fridge were recorded from [DATE]-[DATE]. Temperatures were between ,d+[DATE]. The MAR noted Fridge temperature every night shift, fridge range ,d+[DATE]. Report any out-of-range temps to maintenance. Start date: [DATE] at 10:00 PM. Discontinue date: [DATE] at 11:17 AM.</p> <p>Interview with FM 1 on [DATE] at 11:00 AM revealed FM 1 said they took the personal refrigerator home on [DATE], but the staff documented temperature logs for the refrigerator until [DATE].</p> <p>Interview with LVN C on [DATE] at 10:00 AM revealed LVN C said she recalled the family took Resident #1's personal refrigerator home, but she did not remember which family member. LVN C said she did not recall the exact date, but she documented a progress note on the date and time when the family took the refrigerator home.</p> <p>Interview with the DON on at 12:35 PM revealed the DON said Resident #1's FM 2 took the refrigerator home. The DON said she did not remember what day FM 2 took it home, but there was a note on [DATE] that FM 2 took the refrigerator home. The DON said when FM 2 took the refrigerator, then they would have discontinued the order and no longer entered the temperatures in the MAR. The DON said the point of checking the refrigerator was to ensure the temperature was within the appropriate range of ,d+[DATE] and to ensure the contents of the refrigerator were not expired. The DON said she did not know how staff continued to document the temperatures without a refrigerator in the room for Resident #1 from [DATE]-[DATE]. The DON said she did not know why the order was not discontinued on [DATE]. The DON said there were no indications or concerns that staff did not check the personal refrigerators of other residents or documented appropriately.</p> <p>Interview with the ADM on [DATE] at 1:50 PM revealed the ADM said the facility added the personal refrigerator log to the MAR instead of having a paper log in each room. The ADM said the night nurse checked the temperature and documented on the MAR. The ADM said she was not sure when the refrigerator was taken home for Resident #1, but the order should have been discontinued when Resident #1 no longer had the refrigerator in his room. The ADM said there was no need to continue to document the temperature on the MAR for Resident #1. The ADM said she was not sure how the staff would have still obtained the temperature for [DATE]-[DATE] if there was no refrigerator to check anymore. The ADM said she was not aware of this matter. The ADM could not provide a policy specific to accurate records or documentation.</p> <p>Record review of the facility's Personal Refrigerators policy (not dated) reflected</p> <p>Monitoring: 3. Document the temperature of internal refrigerator gauges.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573</b></p> <p>Based on observation, record review, and interview, 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 1 of 5 Residents (Resident #1) that were reviewed for infection control and transmission-based precautions policies and practices, in that:</p> <p>LVN A failed to don (put on) the appropriate PPE before she entered Resident #1's room and provided care to Resident #1's PEG tube on 02/04/25 at 3:15 PM, on 02/06/25 at 7:47 PM, and on 02/18/25 at 7:25 PM and 10:13 PM.</p> <p>These failures could place residents at risk for infection through cross-contamination of pathogens and infectious diseases.</p> <p>The findings include:</p> <p>Record review of Resident #1's face sheet dated 02/10/25 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), encounter for attention to gastrostomy (feeding tube insertion), and dysphagia, oropharyngeal phase (difficulty swallowing).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 00, indicating severe cognitive impairment. Resident #1's MDS also reflected the use of a feeding tube while a resident.</p> <p>Record review of Resident #1's care plan dated 02/10/25 and initiated on 11/09/23 reflected Resident #1 had a focus of: Resident #1 required a feeding tube related to diagnosis: Adult failure to thrive; encounter for attention to gastrostomy; and dysphagia, oropharyngeal phase. Interventions included: EBP related to PEG tube.</p> <p>Record review of Resident #1's order summary report dated 02/10/25 reflected Resident #1 had an order for, EBP (Enhanced Barrier Precautions): Practice EBP as indicated. every shift. Order had an order status of active and an order start date of 11/08/24.</p> <p>Observation of video footage from Resident #1's electronic monitoring device obtained from the Texas Unified Licensure Information Portal (TULIP) system revealed:</p> <p>-On 02/04/25 at about 3:15 PM, LVN A entered Resident #1's room with only gloves and did not don a gown. LVN A applied a gauze on Resident #1's PEG tube without proper PPE.</p> <p>-On 02/06/25 at about 7:47 PM, LVN A entered Resident #1's room without donning gown or gloves. LVN A applied a gauze on Resident #1's PEG tube without proper PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 02/18/25 at about 7:25 PM, LVN A entered Resident #1's room without donning gown or gloves. LVN A applied a gauze on Resident #1's PEG tube without proper PPE.</p> <p>-On 02/18/25 at about 10:13 PM, LVN A entered Resident #1's room without donning gown or gloves. LVN A applied a gauze on Resident #1's PEG tube without proper PPE.</p> <p>Observation and attempted interview of Resident #1 on 02/12/25 at 3:20 PM revealed resident did not answer questions. Observation revealed a container of gowns outside of Resident #1's room and a box of gloves and hand sanitizer stationed inside the room at the entrance with signage posted on the outside of. There was a sign on Resident #1's door stating enhanced barrier precautions. Instructions indicated everyone must complete hand hygiene before entering and when leaving room and instructed providers and staff must also wear gloves and a gown for high contact resident care activities which included device care.</p> <p>Interview with LVN A on 02/20/25 at 1:35 PM revealed LVN A said Resident #1 was on EBP because of the PEG tube. LVN A said she was aware she needed to wear gown and gloves to provide care. LVN A said this included anything dealing with the PEG tube such as administering the feedings, medications, or handling the PEG tube in any manner. LVN A said she always ensured to wear the appropriate PPE with Resident #1 which was gown and gloves. LVN A said she wore the appropriate PPE to change or apply the gauze for the PEG tube. LVN A said she did not recall any days that she did not follow the PPE and EBP guidelines. LVN A said she was trained and in-serviced on infection control, PPE, and the different precautions including EBP. LVN A said she received training during orientation upon being hired and as refreshers but did not recall the dates. LVN A said there were plenty of gowns and gloves available to the staff. LVN A said it was important for staff to wear the proper PPE when working with residents on EBP for the safety of the residents and to prevent spreading of infections or decline in health. LVN A was not shown video footage as LVN A was not at the facility as it was her day off.</p> <p>Interview with the ADON on 02/21/25 at 10:25 AM revealed the ADON assisted and provided in-services on infection control and placed the signs and bins with PPE supplies outside the rooms of the residents that required certain precautions. The ADON said Resident #1 was on EBP because of the PEG tube Resident #1 required for feedings and medication administration. The ADON said the staff that provided direct care needed to wear gown and gloves at all times. The ADON said if the nurse handled the feeding tube in any way, such as to administer feedings, medications, or change/apply the gauze, the nurse had to wear the proper PPE which was gown and gloves. The ADON was shown the video footage of LVN A and agreed that LVN A failed to wear proper PPE on 02/04/25 at 3:15 PM, on 02/06/25 at 7:47 PM, and on 02/18/25 at 7:25 PM and 10:13 PM, when LVN A applied a gauze on Resident #1's PEG tube without donning gown and gloves. The ADON said LVN A was trained on infection control, PPE, and EBP guidelines. The ADON said failure to wear the proper PPE could place the residents at risk of not being protected from the spread of MDROs.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DON on 02/21/25 at 12:35 PM revealed the DON said Resident #1 was on EBP because Resident #1 had a feeding tube. The DON said staff were aware that they had to wear gown and gloves to provide direct care (high contact activities) for residents with EBP which included residents that had wounds, foleys, and PEG tubes. The DON said high contact activities included tasks such as transferring, changing, giving medications, administering feedings, emptying the foley, and dressing. The DON said staff were in-serviced on infection control, including EBP, during orientation upon hire, annually, and as needed. The DON said the staff had gowns, gloves, and necessary supplies available. The DON said the facility policy stated gowns and gloves should be used during high contact activities with residents on EBP. The DON said 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 as needed. The DON was shown the video footage of LVN A and agreed that LVN A failed to follow the policy regarding PPE. The DON said LVN failed to wear proper PPE on 02/04/25 at 3:15 PM, on 02/06/25 at 7:47 PM, and on 02/18/25 at 7:25 PM and 10:13 PM, when LVN A applied the gauze for Resident #1's PEG tube without donning gown and gloves. The DON said LVN A was trained on infection control, PPE, and EBP guidelines. The DON said failure to wear the proper PPE could place the residents at risk of not being protected from the spread of MDROs or other infections. The DON said LVN A would be re-educated.</p> <p>Record review of the facility's Licensed Nurse Competencies Checklist document reflected LVN A completed infection control competencies, including isolation techniques (masing, gowning, gloving, resident equipment) and proper signage - EBP. Document was signed by: LVN A and the ADON on 01/09/25.</p> <p>Record review of the facility's In-service attendance sheet dated 01/27/25 reflected LVN A's signature. The in-service covered the topic of PPE.</p> <p>Record review of the facility's Infection Prevention and Control Program policy revised on April 2024 reflected Enhanced Barrier Precautions maybe implemented as an infection control intervention designed to reduce transmission of resistant organisms. EBP requires the use of gown and gloves during high-contact resident care activities. The policy indicated high contact activities included: Device care or use (central line, urinary catheter, feeding tube).</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573</b></p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 5 rooms (room [ROOM NUMBER]) reviewed for environment.</p> <p>The facility failed to ensure the facility was sanitary when the facility did not effectively clean room [ROOM NUMBER]'s shower as there was a white dirty towel with brown colorations.</p> <p>This failure could affect all residents, staff, and the public by placing them at risk for diminished quality of life due to the lack of a well-kept environment.</p> <p>The findings included:</p> <p>Observation on 02/14/25 at 12:15 PM revealed room [ROOM NUMBER] had a white dirty towel with brown colorations in the private shower area.</p> <p>Interview with HK J on 02/21/25 at 9:15 AM revealed HK J said the rooms were cleaned every day which included cleaning the room, restroom, shower area for those with showers, and floors. HK J said she cleaned hall 300 and had no concerns brought up for room [ROOM NUMBER].</p> <p>Observation on 02/21/25 at 9:30 AM revealed room [ROOM NUMBER] had a white dirty towel with brown colorations in the same exact area of the private shower.</p> <p>Interview with HK S on 02/21/25 at 9:50 AM revealed HK S said the rooms were cleaned every day which included dusting, sweeping, mopping, cleaning the restroom, sink, toilet, and shower. HK S said for the residents with private showers, the housekeeping staff cleaned the shower and then also cleaned the main shower area in the hallway. HK S said there were no concerns or issues brought up for room [ROOM NUMBER]. HK S said it was important to keep a clean environment for the residents. HK S said staff kept the facility safe and sanitary, but it was a team effort and housekeeping as well as other staff could assist in keeping the rooms clean. HK S said if there was a dirty towel or other used linen in the shower, the housekeeper could have picked it up or told the CNAs. HK S was shown a photo of the dirty towel in the shower of room [ROOM NUMBER]. HK S said maybe when they were showering the resident, the towel fell and nobody saw it. HK S said anyone that saw the towel, should have removed it, put it in the dirty laundry or should have made the CNAs aware to get it. HK S said he was not aware of the dirty towel being in the shower for a week or more but he would ensure to address this issue with his department.</p> <p>Interview with the DON on 02/21/25 at 12:35 PM revealed the DON was shown a photo of the dirty towel in the shower of room [ROOM NUMBER]. The DON said the dirty towel should not have been there for a week or more. The DON said if someone, like housekeeping or CNAs saw the towel, they should have removed it. The DON said there was no negative outcome to the residents from the dirty towel but she would ensure to in-service staff.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the ADM on 02/21/25 at 1:50 PM revealed the ADM was shown a photo of the dirty towel in the shower of room [ROOM NUMBER]. The ADM said this issue had been brought to her attention today. The ADM said although there was no negative outcome to the residents, it was important to keep a sanitary, clean, and comfortable environment.</p> <p>Record review of the facility's Physical Environment policy revised on January 2023 reflected</p> <p>Other environment conditions: The community environment is safe, functional, sanitary, and comfortable for residents, team members, and the public.</p>