| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676063 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Alfredo Gonzalez Texas State Veterans Home | 301 E Yuma Ave<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:<br><br>LVN I failed to don (put on) the appropriate PPE before she entered Resident #1's room and provided medication on 03/10/25 at 7:27 PM.<br><br>CNA M failed to don the appropriate PPE before she entered Resident #1's room to provide care on 05/11/25 at 08:02 PM.<br><br>These failures could place residents at risk for infection through cross-contamination of pathogens and infectious diseases.<br><br>The findings include:<br><br>Record review of Resident #1's face sheet dated 05/08/25 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).<br><br>Record review of Resident #1's 02/13/25 Quarterly MDS reflected a BIMS of 04 (severe cognitive impairment) and the use of a feeding tube.<br><br>Record review of Resident #1's care plan dated 03/03/25 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.<br><br>Observation of video footage on 05/13/25 at 11:45 AM from Resident #1's electronic monitoring device obtained from the Texas Unified Licensure Information Portal (TULIP) system revealed:<br><br>(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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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 03/10/25 at about 07:27 pm, LVN I entered Resident #1's room not not donning a gown or gloves, instilling eyedrops to Resident #1's eye without proper PPE.<br><br>-On 05/11/25 at about 7:47 PM, CNA M entered Resident #1's room without donning a gown when providing incontinent care.<br><br>Observation of Resident #1's room on 05/08/25 10:15 AM, revealed the resident was not in room. Plastic drawers with PPE were outside of Resident #1's room with gowns. A box of gloves and hand sanitizer were stationed inside the room at the entrance with signage posted on the outside. There was a sign on Resident #1's door that reflected 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.<br><br>Observation of Resident #1 on 05/08/25 at 10:28 AM revealed the resident was sitting by the nurse's station television area. The resident gave no response when surveyor attempted to talk with him. He looked straight ahead.<br><br>In an interview on 05/13/25 at 01:38 PM, CNA B stated when a resident was on EBP, they were supposed to wear PPE. She said the PPE they were supposed to wear was gloves and gowns. She said she would not go into a room that had EBP sign on the door and not wear PPE because then there would be a risk of infection.<br><br>In an interview on 05/13/25 at 01:40 PM, CNA C stated both gown and gloves were worn for EBP rooms. She said it was important to wear PPE to decrease the risk of infection. She said if there was a sign (EBP), she would wear both gown and gloves.<br><br>In an interview on 05/15/25 at 04:17 PM, CNA K stated when she went into a room with EBP, she sanitized her hands, puts on a gown, and put on gloves before going into the room. She said it could cause cross-contamination if she entered the room without gown and gloves. She said she always wears gown and gloves with Resident #1 because he was EBP.<br><br>In an interview on 05/15/25 at 04:57 PM, LVN F stated whenever medications were given, gloves were worn. She stated, if gloves were not worn, it would be an infection control issue or cross-contamination could happen. LVN F stated if going into a resident's room with EBP, a gown and gloves were worn.<br><br>In an interview on 05/16/25 at 10:00 AM, the DON stated the nurse who instilled the drops was LVN I who no longer worked at the facility. The DON stated staff were in-serviced on infection control and EBP was ongoing and frequent. The DON was shown the video footage of LVN I and agreed that LVN I failed to follow the policy regarding PPE. The DON said LVN I failed to wear proper PPE on 03/10/25 at 07:27:15 PM when she had not donned gown or gloves before administering a medication. The DON was shown the video footage of CNA M and agreed CNA M failed to follow the policy regarding PPE. The DON stated CNA M failed to wear proper PPE on 05/11/25 at 08:02 PM when she did not don a gown for incontinent care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 05/16/25 at 12:12 PM, ADON E stated she completed in-services with her CNAs and LVNs frequently. ADON E stated she performed spot check-offs on incontinent care, PPE, etc. ADON E stated not wearing a gown and gloves when performing care on a resident who was on EBP, would increase the risk of infection and/or cross-contamination.<br><br>In an interview on 05/16/25 at 01:46 PM, ADON G stated CNAs were in-serviced usually once a month on infection control and incontinent care every couple days and annually. ADON G stated the ADONs observed random check-offs periodically. ADON G stated EBP training was on-going. ADON G stated Resident #1 was on EBP which meant a gown and gloves were to be donned before going into the room for infection control. ADON G said LVNs and MAs were spot checked for medication administration every time the pharmacy went in to destruct medications (varying times).<br><br>Attempted telephone interview on 05/16/25 at 03:42 PM with CNA M the CNA who had not worn a gown into Resident #1's room to provide care. Call went directly to voicemail. Voicemail left.<br><br>In an interview on 05/16/25 at 03:55 PM, LVN I stated when she worked at the facility, they were in-serviced on infection control and PPE like every other day. She said she would always gown and glove up before going into a resident's room to give medications. She said if she did not, she could pass along infections or even cross-contaminate and that would not be good.<br><br>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). |