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 02/27/2026
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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (Resident #2) reviewed for abuse. The facility failed to put interventions in place to protect Resident #2 from abuse after a reported resident to resident physical altercation with Resident #1 on 02/07/26. On 02/08/26 a 2nd altercation between Resident #1 and Resident #2 occurred which resulted in Resident #2 being found on the floor with bilateral skin tears to arms and right knee and stated Resident #1 had pulled him down to the floor on 02/08/26. The non-compliance was identified as past non-compliance. The Immediate jeopardy began on 02/07/26 and ended on 02/08/26. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of physical harm, mental anguish and, emotional distress. The findings included: 1. Record review of Resident #1's face sheet dated 02/25/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseased classified elsewhere, severe, with agitation, generalized anxiety disorder (a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday events, activities, or potential disasters), major depressive disorder (persistent, intense feelings of sadness, worthlessness, and a lack of interest in life lasting at least two weeks), single episode, severe without psychotic features and insomnia (persistent difficulty falling asleep, staying asleep or waking too early) due to other mental disorder. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 04, indicating severe cognitive impairment. Resident #1 had 1 to 3 days with behaviors of verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. Record review of Resident #1's closed Care Plan initiated on 09/02/25 revealed the focus Psycho-social / Behavioral Risk: GENRERALIZED ANXIETY and MDD. currently on treatment for these diagnosis. 11/20/25:Resident refused peri care and raised his voice at staff to leave his room. 12/2/25:Resident to resident verbal aggression. 12/11/25: Resident to staff verbal aggression. 12/21/25:Resident to staff Verbal aggression. 12/29/25:Resident to resident verbal aggression. 2/7/26:Resident to resident verbal aggression. 2/8/26: Residnet [SIC] to resident physical and verbal aggression. Record review of Resident #1's nursing notes documented by LVN B and dated 02/07/26 at 7:37am stated, Resident noted by CNAs attempting to remove his roommate from his room. Resident began to is [SIC] his roommate and attempt to close the door with him in the doorway. At this point nurse was there and able to help hold the door open and remove the roommate from the doorway. Roommate brought to the front common area. no injuries noted on either resident. RN Supervisor notified, DON and Administrator notified. resident redirectable at this time. scheduled anxiety medication given as prescribed. Resident asked if about incident and did not remember what occurred; could not tell nurse if someone was here with him and denies being upset. No emotional distress noted no injuries noted. no signs of pain (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or discomfort. Record review of Resident #1's IDT: Star - VA ABC tool completed by LVN B and dated 02/07/26 stated, there was a resident to resident verbal and physical aggression on the morning of 02/07/26 with his roommate (Resident #2) at the entrance of their room. Record review of Resident #1's IDT: Star - VA ABC tool completed by LVN D and dated 02/08/26 stated, at 4:00am Resident was standing over roommate with table, per CNA. Resident was upset saying that he would hit roommate again. Record review of Resident #1's transfer form completed by LVN D and dated 02/08/26 reflected Resident #1 was being transferred to the hospital due to behavioral symptoms and stated, Resident got physically aggressive with roommate. Record review of Resident #1's nursing noted completed by LVN D and dated 02/08/26 at 6:25am stated he had been picked up by EMS at 6:25pm. Record review of Resident #1's social service note completed by Social Worker I and dated 02/08/26 at 12:47pm stated family was in agreement for a referral to another facility. Record review of Resident #1's nursing note completed by RN J and dated 02/08/26 at 10:20pm stated he arrived back to facility and was placed on a one to one. Record Review of the observation sheet reflected Resident #1 had observations documented every 15 minutes intervals started on 02/08/26 at 10:45pm and ending on 02/10/26 at 2:00pm. Record review of notification of room change form completed by Social Worker I for Resident #1 reflected he was moved rooms on 02/09/26 due to not being compatible with current roommate. Record review of the application for emergency apprehension and detention completed by Social Worker I and dated 02/09/26 reflected emergency commitment was sought for Resident #1 and stated [Resident #1] has been in 2 physically aggressive episodes in the past 48 hours. [Resident #1] pushed his roommate out of his chair and caused him to get skin tears. He stood over his roommate threatening to hit him. Record review of Resident #1's social services note completed by Social Worker I dated 02/10/26 at 10:12am stated Signed Section 28 signed by [Judge] d/t physical aggressive behaviors demonstrated in facility. Record Review of Resident #1's nursing note completed by LVN K and dated 02/10/26 2:34pm stated, Resident #1 was transferred out of facility to hospital. Record review of Resident #1's nursing note dated 02/10/26 at 4:24pm by MD Z stated, I was informed this patient had to be referred to a behavioral unit due to uncontrollable aggressive behavior towards staff and other residents. He poses a threat to other residents in our community, and I recommend he gets discharged . Record Review of nursing note completed by ADON L dated 02/16/26 at 9:41am stated, Resident sent out to behavioral center; as per BOM resident RP discontinued bed hold on 2/15 at 0951a; [SIC] resident belonging packed and placed in storage for pick up; 2. Record review of Resident #2's face sheet dated 02/25/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, unspecified (causing severe memory loss, cognitive decline, and behavioral changes), chronic kidney disease (kidneys do not filter waste effectively), stage 3 (moderate kidney damage) unspecified, acute on [SIC] chronic diastolic (congestive) heart failure (left ventricle becomes stiff and can't relax properly and prevents it from filling with enough blood)and bradycardia (slow resting heart beat under 60 beats per minute), unspecified. Record review of Resident #2's admission MDS, dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. Resident #2 had 1 to 3 days with behaviors of physical and verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. Record review of Resident #2's care plan initiated on 01/10/26 revealed the focus Psycho-social / Behavioral Risk: ALZHEIMER's. As per family he used to have some form of anger issues with them at home but nonphysical. 2/7/26 resident has a res-to-res physical Altercation 2/8/26 resident has a res-to-res physical altercation Record review of Resident #2's nursing note completed by LVN B and dated 02/07/26 at 7:40am stated, Resident on receiving end of resident to resident physical aggression. Resident attempted to enter his room where (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	roommate would not let him in, he began to push him out of the room (CNA reports seeing resident get hit in the face by roommate). Then roommate attempted to close the door on resident, by that time nurse was there and able to separate residents. Resident remembers incident, denies being hit in the face and denies any pain. No signs of emotional distress, no injuries noted no redness; resident states his roommate only his [SIC] his wheelchair. RN supervisor aware, ADON, DON and Administrator aware. Record review of Resident #2's IDT: Star - VA ABC tool Completed by LVN D and dated 02/08/26 stated, at 4:00am Resident was in [SIC] floor asking for help. Record review of nursing note completed by RN J with effective date of 02/08/26 at 4:30am stated, Late Entry: RN supervisor did head to toe assessment on resident, skin tear to right arm, left arm and right knee noted, a red discoloration noted on bridge of nose, no other injuries noted. Resident is A&Ox 2, lungs clear, on room air, VS WNL, able to move all extremities with ease, he is continent of bowel and bladder, says he has pain from his arm, pain meds offered but resident refused. Resident denies any emotional distress. Record review of Resident #2's nursing note completed by LVN D and dated 02/08/26 stated [Resident #2] was calling for help, CNA entered room and found resident on the floor. He had skin tear on BIL arms and R knee. Statedroommate had pushed him. No emotional distress. No pain to body. Going out as a precaution. Record review of Resident #2's skin: abrasion/bruise/edema/mole/rash document completed by LVN D and dated 02/08/26 reflected a skin tear to bilateral antecubital (shallow, triangular depression located on the anterior surface of the elbow) and to front of right knee. Record review of change in condition for Resident #2 completed by LVN D and dated 02/08/26 reflected a skin tear to bilateral antecubital.' Record review of Resident #2's nursing note completed by RN J and dated 02/08/26 at 5:28am stated Resident #2 was transferred to hospital by EMS at 5:20am. Record review of Resident #2's hospital records from 02/08/26 did not identify any fractures. Record review of Resident #2's nursing note completed by LVN M and dated 02/08/26 at 8:18am stated, spoke with [staff] from [hospital], resident is being discharged with no critical findings. no fractures and coming back withimaging results. During an interview with Resident #2 on 02/24/26 at 2:24pm he would only answer that yes he had an incident with Resident #1 and that yes he did get hurt. Resident #2 would not answer any other questions related to the incidents and would respond with, Its none of your business when asked. During an interview with the DON on 02/25/26 at 4:40pm she stated on 02/07/26 CNA A had reported to the nurse that Resident #2 was hit by Resident #1 on the chest but LVN B had assessed Resident #2 and he had no injuries. During an interview with CNA A on 02/25/26 at 4:57pm she stated on 02/07/26 she was doing her rounds with her partner CNA E when she heard a resident yelling in the hall at around 7:00am. CNA A stated when she went to go check she saw Resident #1 standing at the entrance of his room door holding the door open and Resident #2 on his wheelchair trying to get out of the room. CNA A stated Residents #1 and #2 were facing each other and Resident #1 had a hold of Resident #2's shirt when she witnessed Resident #1 hit Resident #2 with a closed fist hand, once on the jaw and once on the chest. CNA A stated she yelled for them to stop and for help separating them. CNA A stated LVN B went to assist in separating residents, and took Resident #2 to the common area. CNA A stated she informed LVN B that she saw Resident #1 hit Resident #2 once in the face and once in the chest and to check Resident #2. CNA A also stated she told LVN B that Residents #1 and #2 could not be together because of the incident and that Resident #1 was aggressive and if they were to put them back together that Resident #1 could attack Resident #2. CNA A stated LVN B asked Resident #2 about being hit and he denied it. CNA A stated she did not know why staff did not listen to her about what she had witnessed and reported. CNA A stated throughout the rest of that morning staff was alternating who was in the room between Resident #1 and #2 until about 10:00 or 11:00am when LVN B took Resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1 to the room while Resident #2 was already in there. CNA A stated she informed LVN B that they could not be together because Resident #1 could kill Resident #2. CNA A stated Resident #1 had been aggressive before but had never hit Resident #2. CNA A mentioned Resident #1 had aggressive episodes with his wife previously when she would visit him at the facility but did not mention any incident with other residents. During an interview with the DON on 02/25/26 at 6:11pm she stated LVN B had reported to her an incident between Resident #1 and #2 where Resident #1 didn't let Resident #2 into the room and stated LVN B questioned Resident #2 about the incident and he stated Resident #1 hit his wheelchair and not him. The DON stated because of this they did monitoring and had an aide out there and RN F stayed outside the room. The DON stated there was no other indication of any behaviors and stated Resident #2 had documentation completed every hour. The DON stated they did not do a room change because they were doing close monitoring and Resident #2 had hourly checks on his chart. The DON stated there was no other behaviors and no indication something else was going to happen. The DON was unable to answer if the 2nd incident on 02/08/26 was preventable. During an interview with RN F on 02/25/26 at 7:40pm she stated she was made aware of the incident between Resident #1 and #2 and went to assess and interview Resident #2 who denied being hit and had no injury. RN F stated in response to incident she was doing monitoring and had an aide posted outside the door. RN F stated Resident #1 had no indications of continued behaviors. During an interview with LVN D on 02/26/26 at 9:56am she stated she did not witness the incident on 02/08/26 between Resident #1 and #2 and was called by the aide and when she arrived to their room she saw Resident #1 standing up and Resident #2 on the floor. LVN D stated she assessed both residents and Resident #2 had skin tears around bilateral elbows that were not greater than 3.5 inches and superficial, a skin tear to his knee about .5 inches and some redness to his nose bridge. LVN D stated Resident #2 stated Resident #1 hit him on his arms and LVN B could not recall if Resident #2 told her how he ended up on the floor. LVN D stated both residents were sent out for further evaluation and stated Resident #1 was eventually discharged or transferred but was no longer at the facility. LVN D stated she entered work on 02/07/26 at 10:00pm and was made aware of an argument the residents had the prior but nothing about hitting and stated she did not know about other behaviors before. LVN D stated she was told to keep a close eye on them and monitor them but stated there was not any form or documentation for them to document and stated there weren't any behaviors to document either. During an interview with CNA C on 02/26/26 at 10:28am she stated on 02/08/26 she heard someone calling for help and when she went to Resident #1 and Resident #2's room she saw Resident #2 on the floor and Resident #1 carrying his bedside table at his waist. CNA C stated Resident #1 put the table down and got close to her and she called for help at that same time and Resident #1 went to the door and was taken to the common area. CNA C stated once the nurse got there she left to another room. CNA C stated Resident #2 had some skin areas with blood on 1 side and stated Resident #2 did not tell her how he got on the floor and neither resident spoke to her about the incident. CNA C stated she did not know of any previous behaviors and had not been told to monitor either resident when she entered her shift on 02/07/26 at 10:00pm. During an interview on 02/26/26 at 11:27am CNA A stated when she saw Resident #1 and #2 on 02/07/26 she did not see any injury on Residents #1 or #2. CNA A stated in response to the incident they had her sit outside the resident's room for about 10 minutes and stated she did not see anyone else sitting outside their room that day on 02/07/26. CNA A stated she does not know what else the facility did in response to the incident but stated they could have prevented the second incident that occurred between Resident #1 and #2 on 02/08/26 but stated she was not able to do anything and that it was up to the nurses and leadership. CNA A stated she was told by staff leadership that her statement was false and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated the facility wrote her up for it. CNA A stated Resident #1 had been aggressive before but had never hit Resident #2. CNA A stated she did not report what she saw to the Administrator because she reported to her supervisor LVN B who she assumed would report to the Administrator. During an interview with the DON on 02/26/26 at 6:32pm she stated on 02/07/26 LVN B notified her of an incident with Resident #1 and #2 when Resident #1 would not allow Resident #2 in the room. The DON stated LVN B did not mention any hit. The DON stated it as RN F who notified her that CNA A reported that she saw Resident #1 punch Resident #2 but there was no redness or anything. The DON stated both LVN B and RN F reported right after the incident occurred. The DON stated in in response they had close monitoring and had an aide posted outside the door for about an hour and then when CNA A had to get back on the floor RN F was on the floor and had the door open to Resident #1 and #2's room with RN F checking them and stated staff tried to alternate them in the common area. The DON stated the only monitoring they had was what was in the chart. The DON stated in general residents had been verbally aggressive but had no previous incidents with each other. The DON stated neither resident expressed fear and stated Resident #2 stated he was not hit and only his wheelchair was. The DON stated on 02/08/26 an aide heard someone yelling for help and found Resident #2 on the floor with Resident #1 standing next to him, the DON stated Resident #2 was moved and the aide called for help and the nurses arrived to assess and evaluate. The DON stated on 02/08/26 Resident #2 stated that Resident #1 grabbed him by the arms and pushed him to the floor when he was sitting at edge of bed. The DON stated Resident #2 had paper thin skin and that why the skin to his bilateral arms occurred. The DON stated Resident #1 was sent out to the emergency room for admission to behavioral and Resident #2 was sent out for to get evaluated. The DON stated both residents returned to the facility and stated Resident #1 was placed on a one to one with room change and they implemented a monitoring tool, orders for counseling and psychiatric services and stated Resident #1 got sectioned and transferred out of the facility. During an interview with LVN B on 02/26/26 at 7:21pm she stated on 02/07/26 she was made aware by CNA A of Resident #1 hitting Resident #2 in the face or the head but when she arrived to the incident the residents were already being separated and she did not witness any hit. LVN B stated she took Resident #2 to the common area and assessed him and found no injuries and no pain and stated Resident #2 denied being hit. LVN B stated she then went to assess Resident #1 who had no injuries and did not recall the incident. LVN B stated neither resident expressed fear. LVN B stated in response to the incident they removed Resident #2 from the room, provided Resident t#1 his schedule anxiety medication and educated the residents on their shared room and stated she would escort Resident #2 back to his room when he wanted to go to his room and would educate Resident #1 that Resident #2 was roommate and not to be alarmed. LVN B stated neither resident had any other incidents during her shift. LVN B stated she believed Resident #1 had a history of similar behaviors but was not sure about Resident #2. LVN B stated within 20 minutes she reported to and made the ADON, DON and administrator aware of everything that CNA A had reported. LVN B stated when she reported to her supervisors they did not mention who would be a good room change and LVN B stated she did not think there were any rooms at that time and stated changing rooms could increase agitation. LVN B stated she asked the aides to stay close outside of the door while charting and stated she tried to park her cart outside the room as well. During an interview with the Administrator on 02/26/26 at 8:06pm she stated on 02/07/26 CNA A was the responding and reporting aide that stated Resident #1 had hit Resident #2. The Administrator stated she was notified about this report by LVN B. The Administrator stated she asked LVN B if they needed to do a one to one of a urinary analysis and stated that LVN B stated there was no injury or redness and that Resident #2 had denied being hit and had stated that it was his (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Reporting with a implemented date of February 2017 and revised date of January 2024 stated, Protection - Our community will protect residents from harm during the investigation of abuse allegations. And The community should prevent occurrences of abuse, will monitor for triggers that may results in abusive behavior and monitor prevention measures on a regular basis through the community's QAPI process.The noncompliance was identified as PNC. The IJ began on 02/07/26 and ended on 02/08/26. The facility had corrected the noncompliance before the survey began.The facility had corrected the noncompliance before the survey began as followed: Record review of room change consent form reflected Resident #1 had a room change on 02/09/26.Record Review of observation sheet reflected Resident #1 had observations documented every 15 minutes intervals starting on 02/08/26 at 10:45pm and ending on 02/10/26 at 2:00pm.Record Review of Residents #1's nursing notes reflected Resident #1 was sent out of the facility on 02/10/26 and his responsible party cancelled the bed hold on 02/15/26.Observations on 02/24/26 at 2:15pm and record review of nursing notes for Resident #1 reflected Resident #1 was no longer a resident at the facility.Record review of a monitoring tool form used to identify any residents with resident to resident behaviors was implemented on 02/09/26 and identified residents with incidents of behaviors and what action was taken to correct the behavior.Record review of ADHOC Quality Assurance and Performance Improvement meeting dated 02/12/26 covered the report of a resident to resident incident.Record review of Resident #1's care plan reflected it had been updated on 02/11/26 regarding his resident to resident aggression on 02/07/26 and 02/08/26. Record review of Resident #2's care plan reflected it had been updated on 02/10/26 regarding his resident to resident altercations on 02/07/26 and 02/08/26. Record review and interview on 02/26/26 at around 1:15pm the DON provided care plans with a print date of 02/26/26 for additional residents #4, #5, #6, #7, #8. #9, #12 which were reviewed and reflected residents behaviors and interventions to address them. On 02/27/26 at around 9:00am the DON provided care plans with a print date of 02/27/26 for Resident #10 and #11 which were reviewed and reflected residents behaviors and interventions to address them. The DON stated the care plans provided were for the resident's they had identified with behaviors. Record review of an email communication between the DON and the psychiatric nurse practitioner dated 02/10/26 at 9:53am reflected residents (#2,#4, #8, #9, #10, #11) and the behaviors they had and continued email communication from 02/23/26 at 10:08am and 2:09pm reflected residents (#2, #6, #7, #8 #9, #12) and behaviors they had.Record review of psychiatry notes reflected:Resident #2 was seen on 02/10/26 and 02/23/26Resident #4, #5, #10 and #11 were seen on 02/12/26Resident #8 was seen on 02/23/26Resident #6, #7 were seen on 02/26/26.Record review of staff development/in-services attendance sheet dated 02/08/26 with an audience documented as All team members covered reporting any incidents of abuse, injury of unknown origin neglect and exploitation immediately to the Administrator and included her phone number. It also covered reporting any resident to resident aggression or Inappropriate touching to the administrator and to redirect resident and keep residents safe. Also covered was that all residents needed to be put on a one to one and be kept separated.Interviews with CNA A on 02/26/26 at 11:27am, LVN B on 02/26/26 at 7:21pm, CNA C 02/26/26 at 10:28am, LVN D on 02/2626 at 9:56am,, LVN G on 02/27/26 at 6:37am, LVN H on 02/25/26 at 1:20pm, the DON on 02/26/26 at 6:29pm and Administrator on 02/26/26 at 8:06pm reflected they had been trained to report any abuse to the Administrator immediately and were aware to separate and implement one to one monitoring with any resident to resident altercation.Record review of training over abuse guidance: preventing, identifying and reporting dated 02/09/26 reflected the DON and Administrator received the training.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs for 1 (Resident #1) of 3 residents reviewed for unnecessary medications. 1.The facility failed to have an adequate indication for the use of the medication Seroquel (an antipsychotic) for Resident #1 before administering the medication with a black box warning. This failure could put residents at risk of harm from adverse reactions or harmful side effects. The findings included: 1. Record review of Resident #1's face sheet dated 02/25/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on 02/15/26 with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseased classified elsewhere, severe, with agitation, generalized anxiety disorder (a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday events, activities, or potential disasters), major depressive disorder (persistent, intense feelings of sadness, worthlessness, and a lack of interest in life lasting at least two weeks), single episode, severe without psychotic features and insomnia (persistent difficulty falling asleep, staying asleep or waking too early) due to other mental disorder. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 04, indicating severe cognitive impairment. There were no potential indicators of psychosis and 1 to 3 days with behaviors of verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. Resident #1's MDS reflected her was taking and had an indication noted for antipsychotics medication. Record review of Resident #1's Care Plan initiated on 09/02/25 revealed the focus I require Anti-psychotic medication r/t: MDD and to help me with my INSOMNIA DUE TO OTHER MENTAL disorder with an initiated date of 09/02/25 and a cancelled date of 02/11/26. Record review of Resident #1's consent for Seroquel 200mg every day at bed time was signed by Resident #'1's responsible party on 01/07/26 and completed by MD Z. Section that read, I believe the individual has the following psychiatric condition and/or maladaptive behavior; had the following diagnoses listed, DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, SEVERE WITH AGITATION; MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE WITHOUT PSYCHOTIC FEATURES; ALZHEIMER'S DISEASE WITH LATE ONSET; ANXIETY DISORDER, UNSPECIFIED; Record review of Resident #1's Order Summary reflected an order for SEROquel Oral Tablet (Quetiapine Fumarate) Give 200 mg by mouth at bedtime related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, SEVERE, WITH AGITATION.ANXIETYDISORDER, UNSPECIFIED with a start date of 01/07/26 and a discontinue date of 01/20/26. Record review of Resident #1's Order Summary reflected an order for, Antipsychotic Side Effect Monitoring. If S/E identified call physician. Side Effects: Sedation/Drowsiness, Dizziness/Gait Disturbance/Falls, Tremors/Sweating/Rashes. Increased Confusion orAgitation, Appetite Change, Insomnia, Constipation/Urinary Retention, Dry Mouth/SoreThroat, Swallowing Difficulty, BP and Cardiac Changes, Abnormal Body movements, Blurred Vision, Weakness, Headache every shift with a start date of 10/28/25 and a discontinue date of 02/11/26 Record review of Resident #1's January 2026 MAR reflected Resident #1's order SEROquel Oral Tablet (Quetiapine Fumarate) Give 200 mg by mouth at bedtime related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, SEVERE, WITH AGITATION.ANXIETYDISORDER, UNSPECIFIED was held on 01/07/25 and administered at bed time from 01/08/26 until 01/20/26. During an interview with the DON on 02/26/26 at 6:29pm she stated Resident #1 had an order for seroquel200 mg from 01/07/26 - 01/20/26 for dementia, severe with agitation and anxiety disorder. The DON stated antipsychotics such as Seroquel were not indicated for dementia. The DON did not know why they were not indicated for dementia or what negative impact it could have and stated on 01/20/26 they changed the diagnosis Resident (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 had Seroquel ordered for to insomnia. The DON stated Resident #1 was receiving the Seroquel because he had insomnia, anxiety and major depressive disorder. The DON stated it was important to ensure there was a proper indication for use of antipsychotics to make sure they were being used with the right diagnoses. The DON stated she felt the Seroquel was appropriate prescribed for Resident #1 and stated he did not have any negative impact from being given the mediation. During an interview with PA Y on 02/26/26 at 10:31am she stated she would see Resident #1 but stated he was also under the care of a mental health provider. PA Y stated whenever antipsychotics were used they usually request mental health providers to follow the resident and stated in her personal opinion antipsychotics should be used carefully with the elderly which was why they consulted with providers with specialties in those areas. PA Y stated antipsychotics could help control aggression and be helpful but stated overall there could be negative impact with use. Record review of facility's policy titled, Psychotropic Medication & Gradual Dose Reduction with an implementation date of January 2022 and a revised date of January 2023 included a guideline statement that read, Physicians and mid-level providers will use psychotropic medication appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 3 residents (Resident #2) reviewed for abuse. The facility failed to protect Resident #2 from abuse after a reported resident to resident physical altercation with Resident #1 on 02/07/26. On 02/08/26 a 2nd altercation between Resident #1 and Resident #2 occurred which resulted in Resident #2 being found on the floor with bilateral skin tears to arms and right knee and stated Resident #1 had pulled him down to the floor on 02/08/26. The non-compliance was identified as past non-compliance. The Immediate jeopardy began on 02/07/26 and ended on 02/08/26. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of physical harm, mental anguish and, emotional distress. The findings included: 1. Record review of Resident #1's face sheet dated 02/25/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseased classified elsewhere, severe, with agitation, generalized anxiety disorder (a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday events, activities, or potential disasters), major depressive disorder (persistent, intense feelings of sadness, worthlessness, and a lack of interest in life lasting at least two weeks), single episode, severe without psychotic features and insomnia (persistent difficulty falling asleep, staying asleep or waking too early) due to other mental disorder. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 04, indicating severe cognitive impairment. Resident #1 had 1 to 3 days with behaviors of verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. Record review of Resident #1's closed Care Plan initiated on 09/02/25 revealed the focus Psycho-social / Behavioral Risk: GENRERALIZED ANXIETY and MDD. currently on treatment for these diagnosis. 11/20/25:Resident refused peri care and raised his voice at staff to leave his room. 12/2/25:Resident to resident verbal aggression. 12/11/25: Resident to staff verbalaggression. 12/21/25:Resident to staff Verbal aggression. 12/29/25:Resident to resident verbal aggression. 2/7/26:Resident to resident verbal aggression. 2/8/26: Residnet [SIC] to resident physical and verbal aggression. Record review of Resident #1's nursing notes documented by LVN B and dated 02/07/26 at 7:37am stated, Resident noted by CNAs attempting to remove his roommate from his room. Resident began to is [SIC] his roommate and attempt to close the door with him in the doorway. At this point nurse was there and able to help hold the door open and remove the roommate from the doorway. Roommate brought to the front common area. no injuries noted on either resident. RN Supervisor notified, DON and Administrator notified. resident redirectable at this time. scheduled anxiety medication given as prescribed. Resident asked if about incident and did not remember what occurred; could not tell nurse if someone was here with him and denies being upset. No emotional distress noted no injuries noted. no signs of pain or discomfort. Record review of Resident #1's IDT: Star - VA ABC tool completed by LVN B and dated 02/07/26 stated, there was a resident to resident verbal and physical aggression on the morning of 02/07/26 with his roommate (Resident #2) at the entrance of their room. Record review of Resident #1's IDT: Star - VA ABC tool completed by LVN D and dated 02/08/26 stated, at 4:00am Resident was standing over roommate with table, per CNA. Resident was upset saying that he would hit roommate again. Record review of Resident #1's transfer form completed by LVN D and dated 02/08/26 reflected Resident #1 was being transferred to the hospital due to behavioral symptoms and stated, Resident got physically aggressive with roommate. Record review of Resident #1's (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nursing noted completed by LVN D and dated 02/08/26 at 6:25am stated he had been picked up by EMS at 6:25pm. Record review of Resident #1's social service note completed by Social Worker I and dated 02/08/26 at 12:47pm stated family was in agreement for a referral to another facility. Record review of Resident #1's nursing note completed by RN J and dated 02/08/26 at 10:20pm stated he arrived back to facility and was placed on a one to one. Record Review of the observation sheet reflected Resident #1 had observations documented every 15 minutes intervals started on 02/08/26 at 10:45pm and ending on 02/10/26 at 2:00pm. Record review of notification of room change form completed by Social Worker I for Resident #1 reflected he was moved rooms on 02/09/26 due to not being compatible with current roommate. Record review of the application for emergency apprehension and detention completed by Social Worker I and dated 02/09/26 reflected emergency commitment was sought for Resident #1 and stated [Resident #1] has been in 2 physically aggressive episodes in the past 48 hours. [Resident #1] pushed his roommate out of his chair and caused him to get skin tears. He stood over his roommate threatening to hit him. Record review of Resident #1's social services note completed by Social Worker I dated 02/10/26 at 10:12am stated Signed Section 28 signed by [Judge] d/t physical aggressive behaviors demonstrated in facility. Record Review of Resident #1's nursing note completed by LVN K and dated 02/10/26 2:34pm stated, Resident #1 was transferred out of facility to hospital. Record review of Resident #1's nursing note dated 02/10/26 at 4:24pm by MD Z stated, I was informed this patient had to be referred to a behavioral unit due to uncontrollable aggressive behavior towards staff and other residents. He poses a threat to other residents in our community, and I recommend he gets discharged . Record Review of nursing note completed by ADON L dated 02/16/26 at 9:41am stated, Resident sent out to behavioral center; as per BOM resident RP discontinued bed hold on 2/15 at 0951a; [SIC] resident belonging packed and placed in storage for pick up; 2. Record review of Resident #2's face sheet dated 02/25/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, unspecified (causing severe memory loss, cognitive decline, and behavioral changes), chronic kidney disease (kidneys do not filter waste effectively), stage 3 (moderate kidney damage) unspecified, acute on [SIC] chronic diastolic (congestive) heart failure (left ventricle becomes stiff and can't relax properly and prevents it from filling with enough blood)and bradycardia (slow resting heart beat under 60 beats per minute), unspecified. Record review of Resident #2's admission MDS, dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. Resident #2 had 1 to 3 days with behaviors of physical and verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. Record review of Resident #2's care plan initiated on 01/10/26 revealed the focus Psycho-social / Behavioral Risk: ALZHEIMER's. As per family he used to have some form of anger issues with them at home but nonphysical. 2/7/26 resident has a res-to-res physicalAltercation 2/8/26 resident has a res-to-res physical altercation Record review of Resident #2's nursing note completed by LVN B and dated 02/07/26 at 7:40am stated, Resident on receiving end of resident to resident physical aggression. Resident attempted to enter his room where roommate would not let him in, he began to push him out of the room (CNA reports seeing resident get hit in the face by roommate). Then roommate attempted to close the door on resident, by that time nurse was there and able to separate residents. Resident remembers incident, denies being hit in the face and denies any pain. No signs of emotional distress, no injuries noted no redness; resident states his roommate only his [SIC] his wheelchair. RN supervisor aware, ADON, DON and Administrator aware. Record review of Resident #2's IDT: Star - VA ABC tool Completed by LVN D and dated 02/08/26 stated, at 4:00am Resident was in [SIC] floor asking for help. Record review of nursing note completed by RN J with effective date of 02/08/26 at 4:30am stated, Late (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Entry: RN supervisor did head to toe assessment on resident, skin tear to right arm, left arm and right knee noted, a red discoloration noted on bridge of nose, no other injuries noted. Resident is A&Ox 2, lungs clear, on room air, VS WNL, able to move all extremities with ease, he is continent of bowel and bladder, says he has pain from his arm, pain meds offered but resident refused. Resident denies any emotional distress. Record review of Resident #2's nursing note completed by LVN D and dated 02/08/26 stated [Resident #2] was calling for help, CNA entered room and found resident on the floor. He had skin tear on BIL arms and R knee. Statedroommate had pushed him. No emotional distress. No pain to body. Going out as a precaution. Record review of Resident #2's skin: abrasion/bruise/edema/mole/rash document completed by LVN D and dated 02/08/26 reflected a skin tear to bilateral antecubital (shallow, triangular depression located on the anterior surface of the elbow) and to front of right knee. Record review of change in condition for Resident #2 completed by LVN D and dated 02/08/26 reflected a skin tear to bilateral antecubital.' Record review of Resident #2's nursing note completed by RN J and dated 02/08/26 at 5:28am stated Resident #2 was transferred to hospital by EMS at 5:20am. Record review of Resident #2's hospital records from 02/08/26 did not identify any fractures. Record review of Resident #2's nursing note completed by LVN M and dated 02/08/26 at 8:18am stated, spoke with [staff] from [hospital], resident is being discharged with no critical findings. no fractures and coming back withimaging results. During an interview with Resident #2 on 02/24/26 at 2:24pm he would only answer that yes he had an incident with Resident #1 and that yes he did get hurt. Resident #2 would not answer any other questions related to the incidents and would respond with, Its none of your business when asked. During an interview with the DON on 02/25/26 at 4:40pm she stated on 02/07/26 CNA A had reported to the nurse that Resident #2 was hit by Resident #1 on the chest but LVN B had assessed Resident #2 and he had no injuries. During an interview with CNA A on 02/25/26 at 4:57pm she stated on 02/07/26 she was doing her rounds with her partner CNA E when she heard a resident yelling in the hall at around 7:00am. CNA A stated when she went to go check she saw Resident #1 standing at the entrance of his room door holding the door open and Resident #2 on his wheelchair trying to get out of the room. CNA A stated Residents #1 and #2 were facing each other and Resident #1 had a hold of Resident #2's shirt when she witnessed Resident #1 hit Resident #2 with a closed fist hand, once on the jaw and once on the chest. CNA A stated she yelled for them to stop and for help separating them. CNA A stated LVN B went to assist in separating residents, and took Resident #2 to the common area. CNA A stated she informed LVN B that she saw Resident #1 hit Resident #2 once in the face and once in the chest and to check Resident #2. CNA A also stated she told LVN B that Residents #1 and #2 could not be together because of the incident and that Resident #1 was aggressive and if they were to put them back together that Resident #1 could attack Resident #2. CNA A stated LVN B asked Resident #2 about being hit and he denied it. CNA A stated she did not know why staff did not listen to her about what she had witnessed and reported. CNA A stated throughout the rest of that morning staff was alternating who was in the room between Resident #1 and #2 until about 10:00 or 11:00am when LVN B took Resident #1 to the room while Resident #2 was already in there. CNA A stated she informed LVN B that they could not be together because Resident #1 could kill Resident #2. CNA A stated Resident #1 had been aggressive before but had never hit Resident #2. CNA A mentioned Resident #1 had aggressive episodes with his wife previously when she would visit him at the facility but did not mention any incident with other residents. During an interview with the DON on 02/25/26 at 6:11pm she stated LVN B had reported to her an incident between Resident #1 and #2 where Resident #1 didn't let Resident #2 into the room and stated LVN B questioned Resident #2 about the incident and he stated Resident #1 hit his wheelchair and not him. The DON stated because of this they did (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	monitoring and had an aide out there and RN F stayed outside the room. The DON stated there was no other indication of any behaviors and stated Resident #2 had documentation completed every hour. The DON stated they did not do a room change because they were doing close monitoring and Resident #2 had hourly checks on his chart. The DON stated there was no other behaviors and no indication something else was going to happen. The DON was unable to answer if the 2nd incident on 02/08/26 was preventable. During an interview with RN F on 02/25/26 at 7:40pm she stated she was made aware of the incident between Resident #1 and #2 and went to assess and interview Resident #2 who denied being hit and had no injury. RN F stated in response to incident she was doing monitoring and had an aide posted outside the door. RN F stated Resident #1 had no indications of continued behaviors. During an interview with LVN D on 02/26/26 at 9:56am she stated she did not witness the incident on 02/08/26 between Resident #1 and #2 and was called by the aide and when she arrived to their room she saw Resident #1 standing up and Resident #2 on the floor. LVN D stated she assessed both residents and Resident #2 had skin tears around bilateral elbows that were not greater than 3.5 inches and superficial, a skin tear to his knee about .5 inches and some redness to his nose bridge. LVN D stated Resident #2 stated Resident #1 hit him on his arms and LVN B could not recall if Resident #2 told her how he ended up on the floor. LVN D stated both residents were sent out for further evaluation and stated Resident #1 was eventually discharged or transferred but was no longer at the facility. LVN D stated she entered work on 02/07/26 at 10:00pm and was made aware of an argument the residents had the prior but nothing about hitting and stated she did not know about other behaviors before. LVN D stated she was told to keep a close eye on them and monitor them but stated there was not any form or documentation for them to document and stated there weren't any behaviors to document either. During an interview with CNA C on 02/26/26 at 10:28am she stated on 02/08/26 she heard someone calling for help and when she went to Resident #1 and Resident #2's room she saw Resident #2 on the floor and Resident #1 carrying his bedside table at his waist. CNA C stated Resident #1 put the table down and got close to her and she called for help at that same time and Resident #1 went to the door and was taken to the common area. CNA C stated once the nurse got there she left to another room. CNA C stated Resident #2 had some skin areas with blood on 1 side and stated Resident #2 did not tell her how he got on the floor and neither resident spoke to her about the incident. CNA C stated she did not know of any previous behaviors and had not been told to monitor either resident when she entered her shift on 02/07/26 at 10:00pm. During an interview on 02/26/26 at 11:27am CNA A stated when she saw Resident #1 and #2 on 02/07/26 she did not see any injury on Residents #1 or #2. CNA A stated in response to the incident they had her sit outside the resident's room for about 10 minutes and stated she did not see anyone else sitting outside their room that day on 02/07/26. CNA A stated she does not know what else the facility did in response to the incident but stated they could have prevented the second incident that occurred between Resident #1 and #2 on 02/08/26 but stated she was not able to do anything and that it was up to the nurses and leadership. CNA A stated she was told by staff leadership that her statement was false and stated the facility wrote her up for it. CNA A stated Resident #1 had been aggressive before but had never hit Resident #2. CNA A stated she did not report what she saw to the Administrator because she reported to her supervisor LVN B who she assumed would report to the Administrator. During an interview with the DON on 02/26/26 at 6:32pm she stated on 02/07/26 LVN B notified her of an incident with Resident #1 and #2 when Resident #1 would not allow Resident #2 in the room. The DON stated LVN B did not mention any hit. The DON stated it as RN F who notified her that CNA A reported that she saw Resident #1 punch Resident #2 but there was no redness or anything. The DON stated both LVN B and RN F reported right after the incident occurred. The DON stated (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in in response they had close monitoring and had an aide posted outside the door for about an hour and then when CNA A had to get back on the floor RN F was on the floor and had the door open to Resident #1 and #2's room with RN F checking them and stated staff tried to alternate them in the common area. The DON stated the only monitoring they had was what was in the chart. The DON stated in general residents had been verbally aggressive but had no previous incidents with each other. The DON stated neither resident expressed fear and stated Resident #2 stated he was not hit and only his wheelchair was. The DON stated on 02/08/26 an aide heard someone yelling for help and found Resident #2 on the floor with Resident #1 standing next to him, the DON stated Resident #2 was moved and the aide called for help and the nurses arrived to assess and evaluate. The DON stated on 02/08/26 Resident #2 stated that Resident #1 grabbed him by the arms and pushed him to the floor when he was sitting at edge of bed. The DON stated Resident #2 had paper thin skin and that why the skin to his bilateral arms occurred. The DON stated Resident #1 was sent out to the emergency room for admission to behavioral and Resident #2 was sent out for to get evaluated. The DON stated both residents returned to the facility and stated Resident #1 was placed on a one to one with room change and they implemented a monitoring tool, orders for counseling and psychiatric services and stated Resident #1 got sectioned and transferred out of the facility. During an interview with LVN B on 02/26/26 at 7:21pm she stated on 02/07/26 she was made aware by CNA A of Resident #1 hitting Resident #2 in the face or the head but when she arrived to the incident the residents were already being separated and she did not witness any hit. LVN B stated she took Resident #2 to the common area and assessed him and found no injuries and no pain and stated Resident #2 denied being hit. LVN B stated she then went to assess Resident #1 who had no injuries and did not recall the incident. LVN B stated neither resident expressed fear. LVN B stated in response to the incident they removed Resident #2 from the room, provided Resident t#1 his schedule anxiety medication and educated the residents on their shared room and stated she would escort Resident #2 back to his room when he wanted to go to his room and would educate Resident #1 that Resident #2 was roommate and not to be alarmed. LVN B stated neither resident had any other incidents during her shift. LVN B stated she believed Resident #1 had a history of similar behaviors but was not sure about Resident #2. LVN B stated within 20 minutes she reported to and made the ADON, DON and administrator aware of everything that CNA A had reported. LVN B stated when she reported to her supervisors they did not mention who would be a good room change and LVN B stated she did not think there were any rooms at that time and stated changing rooms could increase agitation. LVN B stated she asked the aides to stay close outside of the door while charting and stated she tried to park her cart outside the room as well. During an interview with the Administrator on 02/26/26 at 8:06pm she stated on 02/07/26 CNA A was the responding and reporting aide that stated Resident #1 had hit Resident #2. The Administrator stated she was notified about this report by LVN B. The Administrator stated she asked LVN B if they needed to do a one to one of a urinary analysis and stated that LVN B stated there was no injury or redness and that Resident #2 had denied being hit and had stated that it was his wheelchair that got hit. The Administrator stated the DON then called LVN B and told her to monitor. The Administrator then the following morning at 5:00am she was called about a resident to resident where Resident #2 was on the floor and wasn't injured but had some really thin skin that kind of peeled a little bit. The Administrator stated no one witnessed anything but an aide reported she heard Resident #1 say I'm going to hit him again so they sent both residents out to the hospital. The Administrator stated Resident #1 had some verbal aggressive incidents before but nothing that caused injury. The Administrator stated when Resident #1 returned they did a room change for Resident #2 and put Resident #1 on one to one, got a section and transfer. During an (continued on next page)

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	interview on 02/27/26 at 6:37am LVN G stated he was notified of an incident going on in the 600 hall and stated when he arrived Resident #2 was on the floor and Resident #1 was standing but they had already been separated. LVN G stated Resident #2 told him that Resident #1 pulled him by his arms from his wheelchair to the floor. LVN G stated he assessed Resident #2 and noted superficial skin tears to arms and a skin tear to his knee and some redness to bridge of his nose. LVN G stated he notified the administrator and his RN supervisor of the incident and both residents were sent out. LVN G stated from what he understood this was the residents first altercation with each other. During an interview with the DON on 02/27/26 at 10:37am she stated as per their abuse policy during an abuse investigation they protect the resident by doing a one to one or room change or continuous monitoring to see for any indications of behaviors. The DON stated who ever identified the abuse reports it to the Administrator who will start the investigation and stated all staff were responsible for the protection of the resident. The DON stated in response to the incidents on 02/07/26 with Resident #1 and #2 they implemented monitoring which she stated it was only what was reflected in the chart and stated she was aware that there was no documentation for monitoring during the night shift and stated she did not know why there was not any. The DON stated because Resident #2 denied being hit they did not do an abuse investigation and only did the monitoring because of what CNA A reported. The DON stated the second incident on 02/08/26 could have been prevented had they continued the monitoring. The DON stated the facility followed their abuse policy and stated staff had been trained both before and after the incident by the administrator. The DON stated not implementing their abuse policy for the protection of the residents could negatively impact the resident because it could cause injury and stated the only negative impact Resident #2 had due to it not being implemented was superficial skin tears. The DON stated moving forward residents would be protected during abuse investigation by either doing one to one of room changes with any incident that occurs. During an interview with the Administrator on 02/27/26 at 1:13pm stated during an abuse investigation they would keep residents safe by separating them and closely monitoring them. The Administrator stated they did not initiate an abuse investigation into the incident on 02/07/26 because they did not identify abuse because Resident #2 denied being hit. The Administrator stated CNA A's report was taken into consideration but Resident #2 denied being hit. The Administrator stated Resident #2 was a fair historian. The Administrator stated she thought the incident was investigation by the nurse. The Administrator stated CNA A was not a good historian and was not very reliable based on previous history. The Administrator stated the facility should have done additional monitoring with better documentation. The Administrator stated, I think we were doing a lot when asked if they followed their abuse policy. The Administrator stated she had been trained over their abuse policy both before and after the incident and stated not implementing their abuse policy for the protection of the residents could impact a resident by not preventing another incident. The Administrator stated she felt the part of the policy that was not implemented was that CNA A did not call her.Record review facility policy titled, Abuse Guidance: Preventing, Identifying and Reporting with a implemented date of February 2017 and revised date of January 2024 stated, Protection - Our community will protect residents from harm during the investigation of abuse allegations. And The community should prevent occurrences of abuse, will monitor for triggers that may results in abusive behavior and monitor prevention measures on a regular basis through the community's QAPI process.The noncompliance was identified as PNC. The IJ began on 02/07/26 and ended on 02/08/26. The facility had corrected the noncompliance before the survey began.The facility had corrected the noncompliance before the survey began as followed: Record review of room change consent form reflected Resident #1 had a room change on 02/09/26.Record Review of observation (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sheet reflected Resident #1 had observations documented every 15 minutes intervals starting on 02/08/26 at 10:45pm and ending on 02/10/26 at 2:00pm.Record Review of Residents #1's nursing notes reflected Resident #1 was sent out of the facility on 02/10/26 and his responsible party cancelled the bed hold on 02/15/26.Observations on 02/24/26 at 2:15pm and record review of nursing notes for Resident #1 reflected Resident #1 was no longer a resident at the facility.Record review of a monitoring tool form used to identify any residents with resident to resident behaviors was implemented on 02/09/26 and identified residents with incidents of behaviors and what action was taken to correct the behavior.Record review of ADHOC Quality Assurance and Performance Improvement meeting dated 02/12/26 covered the report of a resident to resident incident.Record review of Resident #1's care plan reflected it had been updated on 02/11/26 regarding his resident to resident aggression on 02/07/26 and 02/08/26. Record review of Resident #2's care plan reflected it had been updated on 02/10/26 regarding his resident to resident altercations on 02/07/26 and 02/08/26. Record review and interview on 02/26/26 at around 1:15pm the DON provided care plans with a print date of 02/26/26 for additional residents #4, #5, #6, #7, #8. #9, #12 which were reviewed and reflected residents behaviors and interventions to address them. On 02/27/26 at around 9:00am the DON provided care plans with a print date of 02/27/26 for Resident #10 and #11 which were reviewed and reflected residents behaviors and interventions to address them. The DON stated the care plans provided were for the resident's they had identified with behaviors. Record review of an email communication between the DON and the psychiatric nurse practitioner dated 02/10/26 at 9:53am reflected residents (#2,#4, #8, #9, #10, #11) and the behaviors they had and continued email communication from 02/23/26 at 10:08am and 2:09pm reflected residents (#2, #6, #7, #8 #9, #12) and behaviors they had.Record review of psychiatry notes reflected:Resident #2 was seen on 02/10/26 and 02/23/26Resident #4, #5, #10 and #11 were seen on 02/12/26Resident #8 was seen on 02/23/26Resident #6, #7 were seen on 02/26/26.Record review of staff development/in-services attendance sheet dated 02/08/26 with an audience documented as All team members covered reporting any incidents of abuse, injury of unknown origin neglect and exploitation immediately to the Administrator and included her phone number. It also covered reporting any resident to resident aggression or Inappropriate touching to the administrator and to redirect resident and keep residents safe. Also covered was that all residents needed to be put on a one to one and be kept separated.Interviews with CNA A on 02/26/26 at 11:27am, LVN B on 02/26/26 at 7:21pm, CNA C 02/26/26 at 10:28am, LVN D on 02/2626 at 9:56am,, LVN G on 02/27/26 at 6:37am, LVN H on 02/25/26 at 1:20pm, the DON on 02/26/26 at 6:29pm and Administrator on 02/26/26 at 8:06pm reflected they had been trained to report any abuse to the Administrator immediately and were aware to separate and implement one to one monitoring with any resident to resident altercation.Record review of training over abuse guidance: preventing, identifying and reporting dated 02/09/26 reflected the DON and Administrator received the training.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were reported immediately, but not later than 2 hours after the allegation was made, if the alleged violation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 2 of 3 residents (Residents #1 and #2) reviewed for reporting alleged allegation of abuse. The facility did not report to HHSC within 2 hours, when Resident #2 was found on the floor with bilateral skin tears to arms and stated Resident #1 had pulled him down to the floor on 02/08/26. This failure could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being. The findings included:1. Record review of Resident #1's face sheet dated 02/25/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseased classified elsewhere, severe, with agitation, generalized anxiety disorder (a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday events, activities, or potential disasters), major depressive disorder (persistent, intense feelings of sadness, worthlessness, and a lack of interest in life lasting at least two weeks), single episode, severe without psychotic features and insomnia (persistent difficulty falling asleep, staying asleep or waking too early) due to other mental disorder. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 04, indicating severe cognitive impairment. Resident#1 had 1 to 3 days with behaviors of verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. Record review of Resident #1's closed Care Plan initiated on 09/02/25 revealed the focus Psycho-social / Behavioral Risk: GENRERALIZED ANXIETY and MDD. currently on treatment for these diagnosis. 11/20/25:Resident refused peri care and raised his voice at staff to leave his room. 12/2/25:Resident to resident verbal aggression. 12/11/25: Resident to staff verbalaggression. 12/21/25:Resident to staff Verbal aggression. 12/29/25:Resident to resident verbal aggression. 2/7/26:Resident to resident verbal aggression. 2/8/26: Residnet [SIC] to resident physical and verbal aggression. Record review of Resident #1's IDT: Star - VA ABC tool completed by LVN D and dated 02/08/26 stated, at 4:00am Resident was standing over roommate with table, per CNA. Resident was upset saying that he would hit roommate again. 2. Record review of Resident #2's face sheet dated 02/25/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, unspecified (causing severe memory loss, cognitive decline, and behavioral changes), chronic kidney disease (kidneys do not filter waste effectively), stage 3 (moderate kidney damage) unspecified, acute on [SIC] chronic diastolic (congestive) heart failure (left ventricle becomes stiff and can't relax properly and prevents it from filling with enough blood)and bradycardia (slow resting heart beat under 60 beats per minute), unspecified Record review of Resident #2's admission MDS, dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. Resident#2 had 1 to 3 days with behaviors of physical and verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. Record review of Resident #2's care plan initiated on 01/10/26 revealed the focus Psycho-social / Behavioral Risk: ALZHEIMER's. As per family he used to have some form of anger issues with them at home but nonphysical. 2/7/26 resident has a res-to-res physicalAltercation 2/8/26 resident has a res-to-res physical altercation Record review of Resident #2's IDT: Star - VA ABC tool (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Completed by LVN D and dated 02/08/26 stated, at 4:00am Resident was in [SIC] floor asking for help. Record review of nursing note completed by RN J with effective date of 02/08/26 at 4:30am stated, Late Entry: RN supervisor did head to toe assessment on resident, skin tear to right arm, left arm and right knee noted, a red discoloration noted on bridge of nose, no other injuries noted. Resident is A&Ox 2, lungs clear, on room air, VS WNL, able to move all extremities with ease, he is continent of bowel and bladder, says he has pain from his arm, pain meds offered but resident refused. Resident denies any emotional distress. Record review of Resident #2's nursing note completed by LVN D and dated 02/08/26 stated [Resident #2] was calling for help, CNA entered room and found resident on the floor. He had skin tear on BIL arms and R knee. Statedroommate had pushed him. No emotional distress. No pain to body. Going out as a precaution. Record review of Resident #2's skin: abrasion/bruise/edema/mole/rash document completed by LVN D and dated 02/08/26 reflected a skin tear to bilateral antecubital (shallow, triangular depression located on the anterior surface of the elbow) and to front of right knee. Record review of change in condition for Resident #2 completed by LVN D and dated 02/08/26 reflected a skin tear to bilateral antecubital.' Record review of Resident #2's nursing note completed by RN J and dated 02/08/26 at 5:28am stated Resident #2 was transferred to hospital by EMS at 5:20am. Record review of Resident #2's hospital records from 02/08/26 did not identify any fractures. Record review of Resident #2's nursing note completed by LVN M and dated 02/08/26 at 8:18am stated, spoke with [staff] from [hospital], resident is being discharged with no critical findings. no fractures and coming back withimaging results. During an interview with Resident #2 on 02/24/26 at 2:24pm he would only answer that yes he had an incident with Resident #1 and that yes he did get hurt. Resident #2 would not answer any other questions related to the incidents and would respond with, Its none of your business when asked. During an interview with the Administrator on 02/26/26 at 8:35pm she stated she was the abuse coordinator and was responsible for reporting any incidents of abuse to HHSC within a 2 hour timeframe. The Administrator stated she was notified by LVN D at 5:00am on 02/08/26 of the altercation between Residents #1 and #2 and the skin tears sustained by Resident #2 earlier that morning at around 4:15am. The Administrator stated the altercation between Residents #1 and #2 should have been reported within 2 hours. The Administrator stated she did not report to HHSC until 5:00pm on 02/08/26. She stated she reported late because she was busy doing her interviews. The Administrator stated the facility policy reflected reporting any abuse within 2 hours. The Administrator did not give clear answer when asked if she had followed the facility policy in this situation. The Administrator stated reporting incidents of abuse within 2 hours was important because depending on the allegation a surveyor may need to arrive to the facility faster. The Administration stated the negative impact on resident for not reporting within 2 hours would be questionable. Record review facility policy titled, Abuse Guidance: Preventing, Identifying and Reporting with a implemented date of February 2017 and revised date of January 2024 stated, Report alleged or suspicions of abuse to HHSC by email reporting via TULIP reporting within the designated time frame in accordance with HHSC PL19-17 (Replaces PL 17-19).Are reported immediatelyBut not later than 2 hours after allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 1.The facility failed to follow their skin and wound prevention and management policy and did not have a licensed nurse complete and document a skin assessment at least weekly for Resident #3. This failure could put residents at risk of having skin breakdowns that could go unidentified and untreated. The findings included: 1. Record review of Resident #3's face sheet dated 02/24/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITH STATUS EPILEPTICUS (seizures that continue despite adequate trials of at least two appropriate anti-seizure medications), DYSPHAGIA (difficulty swallowing) FOLLOWING NONTRAUMATIC INTRACEREBRAL HEMORRHAGE (stroke), AGE-RELATED PHYSICAL DEBILITY (state of severe, generalized weakness, fatigue, and reduced functional stamina), COGNITIVE COMMUNICATION DEFICIT (difficulties with verbal and non-verbal communication caused by underlying, disrupted cognitive process). Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS score of 11, indicating moderate cognitive impairment. Resident #3's skin section reflected she had no unhealed pressure ulcers/injuries, no venous or arterial ulcers and no other wounds or skin problems. Record review of Resident #3's care plan initiated on 06/27/25 revealed the focus Actual or At Risk for Skin Impairment R/T incontinence, I depend on staff for toileting and mobility, I have eczema to bilateral hands, I have rash to neck with an intervention of Skin Risk: Follow community's practice for assessing skin, reporting skin concerns to charge nurse, doctor, resident or representative and follow skin protocol in place as indicated with an initiated date of 09/30/25. Record review of Resident #3's Order Summary reflected an order for Weekly Skin Check 0 - for No Skin issues 1 - for No new Skin issues 2 - New skin issue identified every day shift every Thu for Skin Integrity with a discontinue date on 09/11/25. No other order for weekly skin checks were added until 02/25/26. Record review of Resident #3's nursing note documented by the DON on 02/24/26 stated, Head to toe assessment done no abnormalities noted Record review of Resident #3's assessments reviewed from 02/25/26 till 9/30/25 revealed her last skin and wound evaluation form was completed on 09/30/25 and reflected a healed surgical incision. During an interview and record review with the DON on 02/26/26 at 6:21pm she stated residents should have orders in place for weekly skin assessments that should be completed by the nurses. The DON stated Resident #3's orders for weekly skin assessments were discontinued on 09/11/25 and were reordered on 02/24/26 after she was notified by surveyor X of orders not identified in chart. The DON stated she went to do a skin assessment on her on 02/24/26 and found no skin abnormalities. The DON stated staff had not been doing skin assessments on Resident #3 and stated her last skin assessment was sometime in September 2025. The DON stated Resident #3 had not had any skin issues or deterioration since the time her skin assessments were discontinued on 09/11/25.The DON stated staff do provide Resident #3 with zinc, bathing and changes multiple times a day with no abnormalities report identified during care. The DON did not know why it was not identified that Resident #3 did not have orders in place for skin assessments or why they were not being completed. The DON stated it was important to ensure residents had skin assessments orders in place and were being completed so that if something was identified they can work on resolving it. The DON stated nursing staff had been trained over ensuring orders for skin assessments were in place and completed and documented. The DON stated the RN supervisor and herself were responsible for ensuring orders and documentation were in place. The DON stated not having skin assessment orders in place and not completing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skin assessments could negatively impact the residents because it could leave issues not treated on time.Record review of staff training reflected an Inservice on 11/24/25 for charge nurses that covered nurses obtaining and entering wound care orders at time of admission and when identified, and completing head to toe skin assessments upon admission and RN supervisors assisting to verify orders are entered at time of admission. Record review of facility policy titled Skin and wound Prevention and Management with an implemented date of 03/14/19 and a revised date of January 2023. Under the section titled, Guideline It included stated, A licensed nurse should at least weekly conduct a routine skin assessment/evaluation in order to identify new pressure injuries or other types of skin concerns. The licensed nurse should document the results of weekly skin checks in the resident's medical record.