STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676063	A. Building B. Wing	04/01/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 two 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 4 residents (Residents #1 and #2) reviewed for reporting alleged allegations of abuse.The facility did not report to HHSC within two hours, when Resident #1 hit Resident #2's hand with an empty water bottle on 03/13/26.This failure could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being.Findings included:1. Record review of Resident #1's face sheet dated 04/01/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included Alzheimer's disease (causing severe memory loss, cognitive decline, and behavioral changes), Schizoaffective disorder (combination of hallucinations, delusions, and mood disorder), anxiety disorder (chronic, excessive, and uncontrollable worry), depression (persistent feeling of sadness and loss of interest), and muscle weakness. Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 02, indicating severe cognitive impairment. Resident#1 had 1 to 3 days with behaviors of physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing). Record review of Resident #1's care plan, dated 04/01/26 reflected [Resident #1] was at risk of psychosocial concerns such as emotional distress related to diagnosis of Alzheimer's, depression, and anxiety. Resident to resident physical aggression on 03/13/26. Interventions included: Resident was redirected during incident, placed on a 1:1 monitoring, and sent to the behavioral hospital as per section 28 request. Date initiated: 03/13/26. Record review of Resident #1's progress note, dated 03/13/26 at 11:14 AM, reflected head to toe assessment done. No new skin abnormalities noted. No sign and symptoms of emotional distress or pain noted. Resident on one to one. 2. Record review of Resident #2's face sheet, dated 04/01/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included unspecified dementia (decline in cognitive function with memory loss affecting language, problem-solving and other cognitive abilities), anxiety disorder (chronic, excessive, and uncontrollable worry), restlessness and agitation, and muscle wasting and atrophy (decrease in muscle mass and strength). Record review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #2 did not exhibit physical or verbal behavioral symptoms directed towards others. Record review of Resident #2's care plan, dated 04/01/26, reflected [Resident #2] was at risk of psychosocial concerns such as related to diagnosis of unspecified dementia, anxiety, and restlessness/agitation. Interventions included: Redirect resident, calm and reassure resident is safe, monitor for behaviors. Date initiated: 06/27/25. Record review of Resident #2's progress note, dated 03/13/26 at 11:14 AM, reflected head to toe assessment done. No new skin injuries or abnormalities noted. No signs or symptoms of emotional distress or pain noted or verbalized by resident. During an interview and observation, on 03/31/26 at 12:00 PM, Resident #1 was not interviewable as he did not (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	answer basic questions. Resident #1 had no visible injury and was not in distress. During an interview and observation, on 03/31/26 at 12:10 PM, Resident #2 was not interviewable as he did not answer basic questions. Resident #2 had no visible injury and was not in distress. During an interview, on 04/01/26 at 11:40 AM, the Administrator stated she was the abuse coordinator and was responsible for reporting any incidents of abuse to HHSC within a two-hour timeframe. The Administrator stated Resident #1 hit Resident #2's hand with an empty water bottle on 03/13/26 at around 10:00-10:10 AM. The Administrator stated she was notified of the incident between Residents #1 and #2 on 03/13/26 at around 10:45 AM. The Administrator stated the incident between Residents #1 and #2 should have been reported within two hours, but she reported the incident to HHSC on 03/13/26 at 2:26 PM. The Administrator stated she reported late because she was conducting interviews and gathering information. The Administrator stated the facility policy indicated the facility had to report any allegations or incidents of abuse within two hours. The Administrator stated failing to report an incident within two hours did not result in a negative outcome to Resident #1 and #2 as the facility staff ensured their safety. The Administrator stated reporting incidents of abuse within two hours was important because HHSC could have had follow-up questions to assess the urgency of the situation. Record review of the facility's Abuse Guidance: Preventing, Identifying and Reporting policy, date implemented of February 2017, revised date of January 2024, reflected - Report alleged or suspicions of abuse to HHSC by email reporting or via online portal reporting within the designated time frame Are reported immediatelyBut not later than two hours after allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury.