

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/10/2026
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible, for 1 of 3 residents (Resident #1) reviewed for urinary catheters. The facility failed to ensure Resident #1's indwelling catheter was appropriately placed while lying in bed. This failure could place residents at risk for a decline in their health status. Findings included: Record review of Resident #1's admission record, dated 07/08/26, reflected a [AGE] year-old male admitted [DATE]. His relevant diagnoses included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract), and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lung). Record review of Resident #1's significant change MDS assessment, dated 03/30/26, reflected a BIMS score of 00, which indicated his cognition was severely impaired. Resident #1 had an indwelling catheter. Record review of Resident #1's quarterly care plan assessment, dated 03/30/26, reflected: Focus: [Resident #1] requires a catheter: at risk for infection and catheter related injury/issues. Revised on 03/30/26. Interventions. Infection risk: EBP. Date initiated 03/26/26. Record review of Resident #1's admission record, dated 07/08/26, reflected a [AGE] year-old male admitted [DATE]. His relevant diagnoses included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract), and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lung). Record review of Resident #1's significant change MDS assessment, dated 03/30/26, reflected a BIMS score of 00, which indicated his cognition was severely impaired. Resident #1 had an indwelling catheter. Record review of Resident #1's quarterly care plan assessment, dated 03/30/26, reflected: During an observation and interview on 07/08/26 at 9:35 a.m., Resident #1 was observed lying in bed awake. He had no facial grimacing. Resident #1's had an indwelling catheter collection bag was secured to his lower right leg while lying in bed. Dark yellow urine noted in the drainage bag. Resident #1 was not interviewable. During an interview and observation on 07/08/26 at 9:40 a.m., LVN B was observed as she assessed Resident #1's indwelling catheter collection bag was strapped on his lower right leg while lying in bed. She said she was not sure how long Resident #1's indwelling catheter collection bag had been strapped to his lower right leg. She said, Resident #1's indwelling catheter collection bag was secured to his lower right leg because it's probably because he gets up several times a day. She said when a resident with an indwelling catheter was lying down, the collection bag should be hanging on the side of their bed hanging below his bladder to prevent leakage, backflow which could (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause an infection. She said it was her responsibility to ensure Resident #1's indwelling catheter collection bag was appropriately placed when lying in bed. LVN B said she had been in-serviced on the topic of indwelling catheters. During an interview on 07/08/26 at 9:59 a.m., ADON C said Resident #1 was under EBP due to him having an indwelling catheter. She said all staff going into his room to provide direct contact care should practice appropriate PPE. She said Resident #1 had the proper EBP signage and supplies by his door to alert staff. ADON B said Resident #1's collection bag should not have been strapped to his lower right leg when lying down. She said when a resident with an indwelling catheter was lying in bed, the collection bag should be on his hanging on the side of their bed, off the floor, and below their bladder. ADON B said a negative outcome for Resident #1 having his indwelling catheter collection bag strapped on his lower right leg would be the possibility of an infection and not enough room for the urine output. During an interview on 07/08/26 at 11:00 a.m., ADON E said she was the acting DON. ADON E said when a resident with an indwelling catheter was lying down, their collection bag was supposed to be hanging on the side of his bed, lower than the resident. She said a negative outcome to Resident #1 having his indwelling catheter collection bag strapped to his leg while lying down in bed would an infection if there is any urine in the bag. Record review of the facility's Infection and Prevention Control policy, revised April 2024, reflected: Compliance Guideline: the infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of quality assurance and performance program. The elements of the infection prevention and control program consist of coordination/oversight, guidance/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. In addition to isolation practices, Enhanced Barrier Precautions (EBP) may be implemented as an infection control intervention designed to reduce transmission of resistant organisms. The use of PPE, such as gown and glove use during high contact resident care activities. EBP may be indicated as a recommendation by the CDC (when contact precautions do not otherwise apply) for residents with the following wounds or indwelling medical devices.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 (500 hall cart) of 5 medication carts reviewed for storage. The facility failed to ensure LVN D locked his medication cart on 07/09/26 when he walked away to care for a resident. This failure could place residents at risk of injury to other residents if medication left unsecured were consumed. Findings included: During an observation on 07/09/26 at 10:15 a.m., revealed the 500 Hall nurse's medication cart was left unlocked and unattended in the hallway. The length of time it had been left unlocked prior to this observation is unknown. During the observation, no residents, visitors, or staff were in the hallway. Approximately three minutes after this observation started, LVN D was observed coming down the hallway towards the medication cart. During an interview on 07/09/26 at 10:20 a.m., LVN D stated he was the charge nurse for Hall 500, and the medication cart was assigned to him. He said he was called by a CNA to assist her in repositioning a resident and he had forgotten to lock the medication cart. LVN D said he knew medication carts needed to be locked each time they were not in front of them, he said I know, but I got distracted. LVN D said the facility's protocol was to lock the medication cart each time the medication cart was left unattended. LVN D said Nursing staff are constantly reminded to lock the medication carts. LVN D said a negative outcome for leaving a medication cart unlocked would be a resident could open the cart and did not elaborate. During an interview on 07/08/26 at 10:22 am, ADON E said she was the acting DON. She said the facility's protocol for medication carts was they should be locked whenever the nurse is not in front of it. She said the nursing staff were regularly in-serviced lock their medication carts and in-serviced annually on keeping their medication carts secured. She said a negative outcome of leaving a medication cart unsecured would be anybody could go in. Record review of the facility's policy titled, Medication Cart Use and Storage revised January 2023, reflected: Compliance Guidelines: The nursing Team Members (Nurses and CMA's) use the medication cart to systematically distribute physician ordered medications to residents. Responsible Disciplines: Licensed nurses, C.M.A.s Guidelines: Security The medication cart and its storage bins should be kept closed, secured.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, 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 3 (Resident #1) residents reviewed for infection control. The facility failed to ensure CNA A wore proper PPE while feeding Resident #1 in bed on 07/08/26. This failure could place residents at risk for infection. Findings included: Record review of Resident #1's admission record, dated 07/08/26, reflected a [AGE] year-old male admitted [DATE]. His relevant diagnoses included dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life), obstructive and reflux uropathy (occurs when urine cannot drain through the urinary tract), and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). Record review of Resident #1's significant change MDS assessment, dated 03/30/26, reflected a BIMS score of 00, which indicated his cognition was severely impaired. Resident #1 had an indwelling catheter. Record review of Resident #1's quarterly care plan assessment, dated 03/30/26, reflected: Focus: [Resident #1] requires a catheter: at risk for infection and catheter related injury/issues. Revised on 03/30/26. Interventions. Infection risk: EBP. Date initiated 03/26/26. Record review of Resident #1's physician's order summary, dated 07/08/26, reflected an order for EBP : Practice EBP as indicated. Every shift, effective dated 04/21/26. During an observation on 07/08/26 at 9:15 a.m., an EBP signage and supplies by Resident #1's door. During an observation on 07/08/26 at 9:17 a.m., CNA A was observed sitting on Resident #1's bed while feeding him. LVN A was not wearing the required PPE (gown and gloves). 1. During an interview on 07/08/26 at 9:25 a.m., CNA A said Resident #1 required assistance with feeding and preferred eating in his room. CNA A said Resident #1 was under EBP because he had an indwelling catheter. She said EBP meant whoever walked in his room to provide direct care was required to wear a gown and gloves. CNA A said she was supposed to have worn a gown and gloves while she fed Resident #1 because he was under EBP and was not supposed to have been sitting on his bed because of the possibility of coming in contact with his gown or linen. She said a negative outcome of her not wearing the appropriate PPE and sitting on Resident #1's bed while she fed him was she could spread germs. CNA A said she was in-serviced on the topic of infection control and EBP when she was hired 2 months ago. During an interview on 07/08/26 at 9:38 a.m., LVN B said Resident #1 required EBP due to having an indwelling catheter. She said anyone that went into Resident #1's room to provide direct care was required to gown up and wear gloves. LVN B said Resident #1 had the EBP signage and supplies by his door to alert staff. LVN B said CNA A was supposed to have worn a gown and gloves while she fed Resident #1. LVN A said CNA A was not supposed to sit on Resident #1's bed due to infection control. LVN A said a negative outcome for CNA A not wearing the appropriate PPE and sitting on Resident #1's bed was the spreading of infection and her scrubs coming into contact with the resident's linen. During an interview on 07/08/26 at 9:59 a.m., ADON C said Resident #1 was under EBP due to having an indwelling catheter. She said, All staff going into his room to provide direct contact care should practice appropriate PPE. She said Resident #1 had EBP signage and supplies by his door to alert staff. ADON C said due to the fact that Resident #2 was under EBP, CNA A should have worn a gown, gloves and should not have sat on his bed due to the possibility of coming into contact with his linen. ADON C said the facility's protocol when a resident needed assistance in feeding was for the person assisting them to sit on a chair next to the resident. ADON C said a negative outcome of CNA A not (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wearing the appropriate PPE and sitting on Resident #1's bed could be cross-contamination. During an interview on 07/08/26 at 11:00 a.m., ADON E said she was the acting DON. She said a resident required to be under EBP when they had anything invasive like indwelling catheters. She said, Anytime there was hands on care, staff needed to gown up and wear gloves. She said if a resident was under EBP and required assistance with feeding staff needed to wear the appropriate PPE and not sitting on the resident's bed. Record review of the facility's Infection and Prevention Control policy, revised April 2024, reflected: Compliance Guideline: the infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of quality assurance and performance program. The elements of the infection prevention and control program consist of coordination/oversight, guidance/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. In addition to isolation practices, Enhanced Barrier Precautions (EBP) may be implemented as an infection control intervention designed to reduce transmission of resistant organisms. The use of PPE, such as gown and glove use during high contact resident care activities. EBP may be indicated as a recommendation by the CDC (when contact precautions do not otherwise apply) for residents with the following wounds or indwelling medical devices.		