

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 10/04/2024
NAME OF PROVIDER OR SUPPLIER Alfredo Gonzalez Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 301 E Yuma Ave McAllen, TX 78503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301</p> <p>Based on observations, interviews, and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 4 residents (Resident #49) reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #49 received oxygen at the prescribed rate.</p> <p>This failure could place residents at risk for respiratory distress.</p> <p>The findings included:</p> <p>Record review of Resident #49's face sheet dated 10/4/24 reflected the resident was a 76 -year-old male admitted to the facility on [DATE]. Resident #49 had diagnoses which included the following: congestive heart failure (a long-term condition in which the heart weakens and causes fluid buildup in the feet, arms, lungs, and other organs) and pleural effusion (abnormal buildup of fluid in the lungs and chest cavity).</p> <p>Record review of Resident #49's Quarterly MDS assessment, dated 8/18/24, reflected the resident had a BIMS score of 7 which suggests severe cognitive impairment. Self-care assessment reflected he was dependent on staff for putting on/taking off footwear, lower body dressing, shower/bathing self, and toileting hygiene; required substantial/maximal assistance for personal hygiene, upper body dressing and oral hygiene; and required setup or clean-up assistance for eating. Special treatments, procedures, and programs reflected resident received oxygen therapy.</p> <p>Record review of the most recent Care Plan for Resident #49, dated 8/27/24, reflected the resident had Oxygen Therapy r/t Congestive Heart Failure. Date Initiated: 04/5/2024.</p> <p>Record review of the Doctor's Order Summary reflected Resident #49 was prescribed continuous Oxygen 2 Liters per NC every shift. Start Date 04/05/2024.</p> <p>Record review of the MAR/TAR for September 2024 reflected the resident was prescribed continuous Oxygen 2 Liters per NC every shift. Start Date - 04/05/2024 0700. D/C Date - 10/01/2024 1425.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the MAR/TAR for October 2024 reflected the resident was prescribed continuous Oxygen 2 Liters per NC every shift. Start Date - 04/05/2024 0700. D/C Date - 10/01/2024 1425 and the resident was prescribed continuous Oxygen 2-4 Liters per NC every shift. Start Date - 10/01/2024 1900.</p> <p>Observation on 10/1/24 at 10:30 am Resident #49 observed in room asleep lying in bed with head of bed elevated and receiving O2 at 3Lpm via NC.</p> <p>In an interview on 10/1/24 at 10:50 am with LVN B, she said she was the nurse assigned to Resident #49. She said the floor nurses were responsible for ensuring the O2 rate was set accurately. She said that she usually checked vital signs and the O2 rate for those on oxygen between 6:00 and 7:00 am when she comes on shift. She said she checked the O2 rate for Resident #49 that morning and it was set at 2Lpm. The State Surveyor requested the LVN check the O2 settings, and she said she did not know how it changed to 3Lpm. She said Resident #49 was not known to change his O2. The State Surveyor asked Resident #49 how he was feeling, and he denied SOB, difficulty breathing, heart racing or dizziness by shaking his head no. LVN checked Resident #49's O2 saturation and it was at 95%.</p> <p>In an interview on 10/2/24 at 2:36 pm with LVN C, she said as soon as her shift started, she got report, completed her rounds, and checked vitals and O2 rates. She said she currently had one resident on oxygen at 2 Lpm. She said she was responsible for ensuring the O2 rate of her residents was accurate. She said it was always the floor nurse who received report for residents receiving oxygen who was responsible for ensuring the O2 rates were accurate. She said she had never known Resident #49 to adjust the rate on his own, but she had noticed his wife moved the O2 machine to sit next to him. LVN said they would get in trouble if the O2 rate was not accurate, and the resident would receive too much O2. She said too much oxygen could cause a resident to get dizzy and sometimes clammy skin. She said they had a respiratory care in-service/training about a month ago.</p> <p>In an interview on 10/2/24 at 3:03 pm with ADON D for skilled hallways, she said that the nurses who received report for their residents were responsible for ensuring the O2 flow rates were accurate. She said the nurses assessed the oxygen rate settings during their initial rounds or the first time they saw the residents. She said the nurses should be checking the settings every shift. She said there were no other staff who go around to do that specific task, but everyone helps. She said if a resident received too much oxygen, nothing would happen if the resident needed it, but if the resident had a diagnosis of COPD (chronic obstructive pulmonary disease - damage to the lungs resulting in swelling and irritation inside the airways limiting airflow into and out of the lungs), their body would shut down. She said if the resident did not have COPD, the possibility of over oxygenation could happen, but it was not definite. She said everyone was different. If a resident experienced over oxygenation, they could have tachypnea or get a headache.</p> <p>In an interview on 10/02/24 at 3:20 pm with DON, she said the nurses were responsible for ensuring O2 flow rates were accurate. She said the nurses should check on O2 rates when they did rounds and every time, they walked into the room to ensure it was at the right setting. She said no one else was assigned to the task to assist. She said if a resident received more oxygen than prescribed by the doctor, they could experience chest pain, nausea/vomiting, headache, or dizziness. She said the nurses get trained once a year by the RNs on their anniversary date.</p> <p>Record review of the Licensed Nurse Competencies Checklist dated 11/21/23 reflected the LVN B was checked off on Respiratory:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Oxygen Mask/Nasal Cannula .</p> <p>Oxygen Equipment Set Up (may include C-Pap, Trach, High Flow Oxygen & Ventilation) & Storage & Documentation MARs</p> <p>Oxygen Equipment Maintenance/Cleaning .</p> <p>Respiratory Training i.e., Nebulizer tx, Respiratory Exercises & Required Documentation.</p> <p>Record review of the Oxygen Administration policy, revised January 2022, reflected:</p> <p>A resident receives oxygen therapy when there is an order by a physician.</p> <p>Procedure .</p> <p>3. Obtain physician orders for oxygen administration. Orders should include the following: .</p> <p>c. flow rate of delivery</p> <p>Documentation:</p> <p>Place documentation in the Treatment Administration Record (TAR) and/or Medication Administration Record (MAR), and resident EHR progress notes: .</p> <p>oxygen flow rate</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49301</p> <p>Based on observations, interviews, and record review, the facility failed to ensure nurse staffing data was posted and readily accessible to residents and visitors with all required information for 2 (10/2/24 and 10/3/24) of 4 days reviewed for nurse staffing information.</p> <p>The facility failed to ensure the daily staffing information was posted in a prominent location on 10/2/24 and 10/3/24.</p> <p>This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts.</p> <p>Findings included:</p> <p>Record Review on 10/1/24 of the facility's Direct Care Staff form dated 10/1/23 revealed the form had all the required information and was posted in an area accessible to residents and visitors.</p> <p>During a walkthrough of the facility on 10/3/24 at 10:00 am, The State Surveyor observed Direct Care Staff sign not updated since 10/1/24.</p> <p>In an interview on 10/3/24 at 10:20 am with the scheduler CNA A, she said that she was in charge of updating the staffing information. She said that she obtained the census information from the business office then replaced the prior day information. She said the staffing information should be updated every day. She said during the weekend the RN supervisor updated the staffing information. She said she came in today and went straight to the floor to work with the residents because her priority was the residents. She said she planned to update the staffing information after she finished working the 600-hallway at 2:00 pm today. She said she had been informed it's a requirement to update the staffing information daily by the DON. She said she did not update the staffing information yesterday, 10/2/24 because she was working as a monitor in the lounge from 7am to 2 pm. She said she was also completing evaluations and annual performance for closed enrollment and that was her priority yesterday.</p> <p>In an interview on 10/3/24 at 10:30 am with the DON she said that CNA was made A aware that she was responsible for posting the Direct Care Staffing and she was aware that it should be updated daily. The DON said on the weekends, the RN supervisors had that responsibility. She said right now, they don't have anyone to ensure that the staff information was being posted. She said that she was aware it was a requirement that the staffing information must be updated and posted daily and must be available for anyone to observe.</p> <p>In an interview on 10/4/24 at 5:17 pm with the Administrator, she said that the staff posting was a regulation. She said she knew it was supposed to be posted every day. She stated that she walked by the posting, but she took it for granted that it was there and that it was updated.</p> <p>On 10/4/24 at 5:36 pm the DON said she could not find a facility policy on staff postings. She said they follow HHSC LTC regulations.</p>		