

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER William R Courtney Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1424 Martin Luther King Jr LN Temple, TX 76504	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services which includes the accurate acquiring and administering of medications to meet the needs for 1 (Resident #1) of 5 residents reviewed for pharmacy services, in that: The facility failed to administer Resident #1's Lorazepam medication according to physicians' orders on 12/16/2025, 12/17/2025, and 12/18/2025 resulting in Resident #1 getting double the amount of his scheduled medication. This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, could result in worsening or exacerbation of chronic medical conditions, and hospitalization. Review of Resident #1's face sheet dated 2/3/2026 reflected an [AGE] year-old male admitted on [DATE] with diagnoses that included vascular dementia (decline in cognitive function caused by impaired blood flow to the brain), Alzheimer's disease (progressive neurological brain disorder leading to cognitive decline), type 2 diabetes (blood sugar disorder), atrial fibrillation (heart rhythm disorder), chronic kidney disease and repeated falls. Review of Resident #1's quarterly MDS assessment reflected a BIMS score of 6 suggesting severe cognitive impairment. Review of Resident #1's care plan dated last review completed 12/10/2025, reflected the following problem: the resident is on pain medication therapy (opioid) [related to] pain or shortness of breath/pain or distress with intervention administer analgesic medications as ordered by the physician. Monitor/document side effects and effectiveness Q-Shift. Review of Resident #1 orders in the EMR reflected a current physician order dated 10/19/2025 for: Lorazepam Tablet 0.5 MG Give 1 tablet by mouth every morning and at bedtime for Anxiety/Agitation related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, MODERATE, WITH OTHER BEHAVIORAL DISTURBANCE. And another physician order dated 10/23/2025 for Ativan Oral Tablet 1 MG (Lorazepam) Give 1 tablet by [sic] mouth every 4 hours as needed for Anxiety for 90 Days, discontinued on 1/21/2026. Review of Resident #1's December 2025 MAR reflected it had been signed off for his schedule Lorazepam tablet, 0.5 mg on: 12/16/2025 at AM 12/16/2025 at Bedtime 12/17/2025 at AM 12/17/2025 at Bedtime 12/18/2025 at AM Review of Resident #1's December 2025 narcotic count sheet reflected his Lorazepam 1.0 mg had been signed off as being given on 12/16/2025 at 6:50 am 12/16/2025 at 8:00 pm 12/17/2025 at 8:00 am 12/17/2025 at 8:00 pm 12/18/2025 at 8:00 am During an interview on 2/3/2026 at 2:40 pm, the DON stated the issues with Resident #1 medications were not a med error - it was a documentation error. The DON stated Resident #1 had two orders for Lorazepam, one scheduled at 0.5 mg and one prn at 1.0 mg. The nurses were using the 1 mg tablet and halving it - giving the resident half and wasting the other part. It was just a documentation error from the nurses wasting the other part of the tablet. During an interview on 2/3/2026 at 3:18 pm, the medical director stated she was aware of the narcotic med errors with Resident #1 and that nurses were wasting medications. She stated her concerns with Resident #1 getting more than his scheduled dose of Lorazepam was that he could have been more fatigued, tired, somnolent which could have translated to less activity and less eating. It may</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675857
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>have made him unsteady on his feet, but he was already a high fall risk with a long history of falls and behaviors. During an interview on 2/3/2026 at 3:24 pm, LVN A stated she had worked on 12/17/2025 and gave Resident #1 his Lorazepam at 8pm. She stated she gave him a 1 mg tablet and signed off on the narcotic sheet that she gave a 1 mg tablet. LVN A denied wasting any part of the medication. She stated she signed off in the MAR that she gave Resident #1 0.5 mg, but she gave him 1.0 mg of Lorazepam. She stated she did not follow the order for the 0.5 mg tablet of Lorazepam. During an interview on 2/3/2026 at 4:04 pm, LVN B stated he had worked 12/18/2025 and gave Resident #1 his Lorazepam at 8:00 am. He stated Resident #1 ran out of his scheduled 0.5 mg tablet of Lorazepam, so he came him the 1 mg tablet of Lorazepam and signed it off in the MAR under his 0.5 mg tablet. LVN B denied wasting any part of the medication. LVN B stated he did not follow the order for the scheduled 0.5 mg tablet of Lorazepam. During an interview on 2/3/2026 at 4:18 pm, LVN C stated she had worked on 12/16/2025 and gave Resident #1 his AM dose of Lorazepam. She stated if she signed out on the narcotic sheet that she gave a 1 mg tablet, then that's what she gave the resident. She denied wasting any medication and stated if she had wasted any part of the medication she would have noted it in the narcotic count sheet and had another nurse witness the wasting. She stated she did not follow the order for the 0.5 mg Lorazepam that was scheduled. During an interview on 2/3/2026 at 4:36 pm, LVN D stated she had worked on 12/17/2025 and gave Resident #1 his AM dose of Lorazepam. She stated if I signed it [narcotic count sheet] , I'm assuming I gave it. She stated the 0.5 mg tablet was not there, so she gave the 1 mg tablet instead. She wanted resident #1 to have something for his anxiety. She stated later I realized I had signed off the MAR on the 0.5 mg order, and it was wrong, but I didn't get a chance to go back and check and fix it. LVN D denied wasting any medication and stated she gave Resident #1 the 1 mg tablet. An attempt was made to contact LVN E on 2/3/2026, but the call was not returned. During an interview on 2/4/2026 at 11:46 am, the pharmacy nurse stated she was aware of the issue with Resident #1's Lorazepam. She stated she had talked to the nurses (LVN A, B, C, D, E) and they said they were taking the 1 mg PRN tablet and administering half of it and the nurses just hadn't put that they had wasted half of the tablet on the narcotic count sheet. She stated, no one gave her a sufficient answer as to why they didn't document the wasting and she did not ask any of the nurses if they had had a witness when they wasted the medication. She stated Resident #1 was out of his scheduled 0.5 mg Lorazepam due to a lack of communication, so the nurses were using the PRN 1 mg dose instead. During an interview on 2/4/2026 at 3:06 pm, the ADM stated he was aware of the issues with Resident #1's Lorazepam medication. He stated his expectation was that staff will followed physician orders and they should not be signing them out on the narc sheet and not documenting appropriately in the MAR. He stated his concerns would be that we don't know if the patient actually got them - possible diversion. During an interview on 2/4/2026 at 3:14 pm, the DON stated her expectations are that staff will administer medications as ordered and they are supposed to document that way. She stated if staff was wasting medications, they should be doing that with another nurse as a witness and documenting this on the narcotic count sheet including the date and signature of the person that witnessed and the nurse giving the medication. She stated if medications were not documented correctly in the MAR, we don't know if residents got the medication as ordered - medication is not therapeutic as it's supposed to be. Review of the facility's policy Administering Medications, revision April 2019, reflected the following: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation4. Medications are administered in accordance with prescriber orders, including any required time frame.22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication</p> <p>(continued on next page)</p>		

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