STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675873	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clyde W Cosper Texas State Veterans Home	1300 Seven Oaks Rd Bonham, TX 75418

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (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: 675873	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide liquids consistent with the residents' needs for 2 of 3 (Resident #1 and Resident #2) residents reviewed for liquid inconsistency. 1. The facility failed to ensure LVN A checked the lunch tray appropriately for Resident #1, who required nectar-thick liquids on 11/10/25. 2.The facility failed to ensure Resident #1, and Resident #2 did not have thin liquids at their bedside on 11/11/25. These failures could affect residents by placing them at risk for aspiration and not receiving appropriate interventions to meet their current needs.Findings included: 1. Record review of Resident #1' face sheet dated 11/12/25, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included Parkinson's (a progressive brain disorder that affects movement, primarily caused by the death of brain cells that produce dopamine), and dysphagia (difficulty swallowing, where food or liquids cannot move easily from the mouth to the stomach). Record review of Resident #1's quarterly MDS assessment dated [DATE], indicated Resident #1 understood and was understood by others. Resident #1's BIMS score was 06, which indicated he was severely cognitively impaired. The MDS indicated Resident #1 was independent with eating. The MDS assessment indicated Resident #1 required a mechanically altered diet (change in texture of food or liquids, such as pureed food or thickened liquids). Record review of Resident #1's comprehensive care plan, revised on 05/07/25, indicated Resident #1 was at risk for choking/aspiration and dehydration related to his diagnosis of dysphagia. The care plan interventions were for staff to offer additional fluids within diet parameters and serve the diet as ordered. Record review of Resident #1's comprehensive care plan dated 10/27/25, indicated Resident #1's diet consisted of minced and moist ground texture, nectar-thickened liquids, no rice, gravy on all meats, related to his diagnosis of dysphagia for thickened fluids. The care plan intervention was for staff to serve the diet as ordered. Record review of Resident #1's order summary report dated 11/12/25, indicated Resident #1 had the following orders:*Regular diet with minced and moist ground texture, nectar-thickened liquids, no rice, gravy on all meats, with an order start date of 10/24/25. During an observation on 11/10/25 at 12:15 p.m., Resident #1 had a glass of water placed in front of him and was observed drinking twice from the glass. His meal ticket for lunch had a diet order for minced and moist ground texture and nectar-thickened liquids. During an observation and interview on 11/10/25 at 12:21 p.m., CNA B said she did not notice Resident #1's water was not nectar consistency. She said the nurse checked the trays, and she assumed it was correct. She said she thought Resident #1 was supposed to have nectar-thick liquids but went to ask the nurse to clarify it. CNA B came back and said Resident #1 should have had nectar-thick fluids. CNA B took Resident #1's thin liquid and replaced it with nectar-thick liquids. She said that since Resident #1 had thin liquids, it placed him at risk of choking. During an interview on 11/10/25 at 12:42 p.m., RN A said she was the nurse responsible for checking the trays in the dining room. She said she thought Resident #1 was on honey-thick liquids. She said she put the water on his lunch tray. She said she did not read the card correctly and it was an overcite. She said Resident #1 was at risk for aspiration because he received thin liquids. During an observation and interview on 11/11/25 at 9:47 a.m., Resident #1 had a bottle of water at bedside within reach. Resident #1 said, Yeah, I have been drinking it. It is almost empty. Resident #1 said he did not know who gave him the bottle of water or how he got it. During an observation and interview on 11/11/12 at 10:00 a.m., CNA C came into Resident #1's room and verified he had a bottle of water which contained thin liquids at his bedside. She said she was not aware how he received the bottle of water. She asked Resident #1 if he had been drinking the water, and he shook his head Yes. He said, He drank from the bottle yesterday and last night. She said Resident #1 was at risk of choking since he had drunk the thin liquids. She removed the water bottle from his bedside. During an observation and interview on 11/11/12 at 10:10 a.m., RN A said she was Resident #1's nurse. She said she had been in Resident #1's room this morning (11/11/25) but had not seen the water bottle on his bedside table. She said it was everyone's responsibility to ensure he did not have any thin liquids. She said Resident #1 was at risk for aspiration. 2. Record review of a face sheet dated 11/12/25 indicated Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (deterioration of memory, language, and other thinking abilities), diabetes, and Schizoaffective (mental health condition that combines symptoms of schizophrenia (such as hallucinations and delusions) with mood disorder symptoms like depression or mania). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #2 understood and was understood by