

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

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No. 0938-0391

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 07/28/2026
NAME OF PROVIDER OR SUPPLIER Clyde W Cosper Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for 3 of 4 residents (Resident #1, Resident #2 and Resident #3) reviewed for range of motion. The facility failed to ensure Resident #1, Resident #2, and Resident #3's referrals for customized wheelchairs were made. These failures could place residents at risk of not having their individualized needs met, decreased range of motion and a decline in their quality of care and life. Findings included: 1. Record review of a face sheet dated 07/28/2026 indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis affects left nondominant side (paralysis of the left upper and lower extremities resulting from damage to the brain and/or spinal cord), chronic pulmonary obstructive disease (lung disease making it difficult to breathe) and muscle weakness. Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and was able to understand others. The MDS assessment indicated Resident #1 had a BIMS of 14, which indicated his cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for walking and standing. The MDS assessment indicated Resident #1 had functional limitations in range of motion to upper and lower extremities of the left side. The MDS assessment indicated Resident #1 was dependent on staff for mobility with a manual wheelchair. Record review of Resident #1's Order Summary Report dated 07/20/2026 did not address the referral made for his customized wheelchair. Record review of Resident #1's care plan revised 08/10/2026 indicated he had an ADL self-care performance deficit related to hemiplegia and hemiparesis on the left non dominant side with interventions to assist with bathing, dressing and grooming as needed. Record review of an email dated 07/15/2026 from the Rehab Director to the Director of Transportation reflected the Rehab Director inquired about the 06/05/2026 requested appointment for Resident #1's power wheelchair assessment scheduled date. The email stated, Was there a response from the transportation? Record review of an email dated 07/16/2026 from the Rehab Director to an outside clinic reflected the Rehab Director inquired about an upcoming power chair evaluation for Resident #1. The outside clinic responded that Resident #1 was not scheduled for a power chair. During an observation and interview on 07/27/2026 at 09:55 AM, Resident #1 said he was aggravated that it was taking so long to get the customized wheelchair evaluation completed. Resident #1 said that therapy said they were working on the appointment, but it had been well over a month and still nothing had transpired. Resident #1 said he could not use his left side to propel the wheelchair very well, and this had resulted in him bumping his right foot on many occasions. Resident #1 was concerned he would get skin lacerations from attempting to propel himself in the manual wheelchair. He reported he was concerned because (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he does not heal fast or well. Resident #1 said he had been propelling backwards in his manual chair and used a mirror to look behind him. Resident #1 was observed using his right foot to push himself backwards in his manual wheelchair in his room from the side of the bed to the bathroom. During an interview on 07/27/2026 at 12:00 PM, the Rehab Director said she made the request into the EDS on 06/05/2026 and attempted to follow-up by email with the Director of Transportation on 06/18/2026 but never received a response or update regarding Resident #1's power chair evaluation being scheduled. The Rehab Director said she had voiced this concern to the DON and the Administrator during a morning meeting but never received a response from them. The Rehab Director said she was concerned because Resident #1's mobility was limited by his decreased range of motion of the left side of his body and propelling backwards with the mirror was not idealistic or safe. During an interview on 07/28/2026 at 12:30 PM, the Director of Transportation stated she could not locate any scheduled consults for Resident #1. The Director of Transportation said she guessed she was not doing her job correctly because she also had to be a driver for the facility. The Director of Transportation said the Administrator and the DON were aware she could not complete all the tasks assigned to her daily because of doing too many things. The Director of Transportation said it was important for consults to be made timely to prevent any decrease in mobility for the residents. The Director of Transportation said wheelchair consults were very important because it was the residents' only way to be mobile and get from place to place. 2. Record review of a face sheet dated 07/28/2026 indicated Resident #2 was a [AGE] year-old male with a readmission to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis affects left nondominant side (paralysis of the left upper and lower extremities resulting from damage to the brain and/or spinal cord), chronic pulmonary obstructive disease (lung disease making it difficult to breathe) and muscle wasting and atrophy. Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and was able to understand others. The MDS assessment indicated Resident #2 had a BIMS of 11 and was moderately cognitively impaired. The MDS assessment indicated Resident #2 was dependent on all ADLS except eating and required set up and clean up assistance. The MDS assessment indicated Resident #2 had functional limitations in range of motion to upper and lower extremities of the left side. The MDS assessment indicated Resident #2 used a manual wheelchair for mobility. Record review of Resident #2's Order Summary Report dated 07/28/2026 indicated Resident #2 needed to be evaluated by an outside clinic for custom standard wheelchair to improve posture, improve comfort in wheelchair, provide specialty cushion with a start date of 01/02/2025. Record review of Resident #2's care plan revised 04/21/2026 indicated he had impaired mobility related to CVA with left sided hemiparesis, and he used a wheelchair by using his right foot and right hand. His care plan included interventions of one person to assist with all transfers, positioning, and ambulation and therapy screens as indicated. Record review of an email dated 07/15/2026 from the Rehab Director to the Director of Transportation reflected the Rehab Director inquired about the 05/14/2026 requested appointment for Resident #2's wheelchair assessment for a new chair related to skin damage caused by Resident #2's current wheelchair. Record review of an email dated 07/16/2026 from the Rehab Director to an outside clinic reflected the Rehab Director inquired about an upcoming wheelchair evaluation with a response of Resident #2 was not scheduled for a wheelchair evaluation. During an observation and interview on 07/27/2026 at 10:15 AM, Resident #2 was slumped down and leaning forward in the wheelchair. Resident #2 was being repositioned by the CNA to an upright angle. Resident #2 said he sure needed another wheelchair due to the curvature of his spine was causing him to lean onto his left arm with pressure. Resident #2 said the staff told him they were getting him a different (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair but that had been over a month or more that he could remember. Resident #2 said, maybe they forgot about me. During an interview on 07/27/2026 at 12:00 PM, the Rehab Director said she had made the request into the EDS on 05/14/2026 and attempted to follow-up by email with the Director of Transportation on 7/15/2026 but never received a response or update regarding Resident #2's power chair evaluation date being scheduled. The Rehab Director said she voiced this concern to the DON and the Administrator during a morning meeting but did not receive a response from them. The Rehab Director said she placed another consult request in the EDS on 07/14/2026 because the Treatment Nurse stated concerns regarding potential skin breakdown due to Resident #2's current wheelchair was rubbing his arm. The Rehab Director stated she had not received a response from the Director of Transportation. The Rehab Director stated Resident #2 could experience skin breakdown, infection and decreased, limited mobility due to not having a timely wheelchair evaluation. During an interview on 07/28/2026 at 12:30 PM, the Director of Transportation stated she could not locate any scheduled consults for Resident #2. The Director of Transportation said Resident #2's consult request must have gotten lost or maybe she was waiting to hear back from the outside clinic before she could schedule the consult. The Director of Transportation said it was important for wheelchair consults to be completed timely when received to prevent skin breakdown if the wheelchair was irritating the resident's skin which could lead to infection. 3. Record review of a face sheet dated 07/28/2026 indicated Resident #3 was an [AGE] year-old male with an admission date of 03/20/2026 with diagnoses which included hemiplegia and hemiparesis affects left nondominant side (paralysis of the left upper and lower extremities resulting from damage to the brain and/or spinal cord), and muscle wasting and atrophy. Record review of Resident #3's Quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and was able to understand others. The MDS assessment indicated Resident #3 had a BIMS of 10 and was moderately cognitively impaired. The MDS assessment indicated Resident #3 was dependent on all ADLS except eating and required set up and clean up assistance. The MDS assessment indicated Resident #3 had functional limitations in range of motion to upper and lower extremities of the left side. The MDS assessment indicated Resident #3 used a manual wheelchair for mobility. Record review of Resident #3's Order Summary Report dated 07/28/2026 indicated Resident #3 was to be evaluated by an outside clinic for a custom wheelchair with a start date of 06/16/2026. Record review of Resident #3's care plan revised 03/23/2026 indicated he had impaired mobility related to weakness and nontraditional posture with the following interventions to allow and encourage resident to perform task and assist only as needed, give verbal cues and reminders as needed. Record review of an email dated 07/22/2026 from the Rehab Director to the Administrator and DON stated, it was brought to my attention another consult for a custom wheelchair request was put in on 06/16/2026 for [Resident #3]. His [family member] is asking about the appointment. I have not heard an answer from the Director of transportation. During an interview on 07/27/2026 at 10:20 AM, Resident #3's family member stated it had been at least a month since the consult was made, and she still had not heard anything about the wheelchair evaluation. Resident #3's family member said she hoped he would be more mobile with a motorized wheelchair throughout the facility so that he was not depending upon others to move him around due to the hemiplegia of the left side. During an interview on 07/27/2026 at 12:00 PM, the Rehab Director said she had not received a response from the Director of Transportation, DON, or the Administrator regarding Resident #3. The Rehab Director stated Resident #3 could experience skin breakdown, infection and decreased, limited mobility due to not having a timely wheelchair evaluation. During an interview on 07/28/2026 at 12:30 PM, the Director of Transportation stated she could not locate any scheduled consults for Resident #3. During an interview on 07/28/2026 at 04:00 PM, the (continued on next page)		

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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 all drugs were stored in a locked compartment, only accessible by authorized personnel for 1 of 13 medication carts (Treatment cart) reviewed for pharmacy services. The facility failed to ensure the Treatment Cart was properly secured when it was left unattended on 07/23/2026. These failures could place residents at risk for not receiving drugs and biologicals as needed and a drug diversion. Findings include: During an observation on 07/23/2026 at 10:46 AM, the Treatment Cart was observed on 600 Hall unlocked. The Treatment Cart was able to be opened by the surveyor and triamcinolone cream tubes were noted in the top drawer. No staff noticed or attempted to stop the surveyor from opening the cart. During an interview on 07/23/2026 at 11:15 AM, the treatment nurse said she usually locked the treatment cart because it contains items and some medications such as wound cleanser and creams that could be potentially dangerous if ingested by an individual. The Treatment Nurse stated she stepped into a resident's room because a family member had requested help with a resident and did not take the time to lock the treatment cart. During an interview on 07/23/2026 at 5:15 PM, the Administrator stated he expected the Treatment Nurse to keep the treatment cart locked at all times to prevent any accidents from occurring such as a resident drinking or spraying a harmful substance into their eyes resulting in a potential injury. During an interview on 07/23/2026 at 5:35 PM, the DON said he expected the treatment cart to be under the supervision of the Treatment Nurse directly or locked at all times to prevent accidental ingestion of any items that the cart holds such as creams, ointments, and skin cleanser which could result in harm. The DON said the treatment nurse was just nervous with state being in the building because she had never left a treatment cart open before. Record review of the undated facility's policy titled, Medication Storage in Facility, indicated, . Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.		