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	04/29/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 2 of 2 shower rooms (A Hall and C Hall) reviewed for homelike environment. The facility failed to ensure the shower stalls in the C Hall shower room did not have black grime buildup. The facility failed to ensure the shower stalls in the A Hall shower room did not have yellowish-brownish and pink grime buildup. These failures could place the residents at risk for a decreased quality of life, an uncomfortable, unhomelike environment due to unsanitary conditions. Findings included: During a confidential group interview, the resident group said when they went to take their showers the shower rooms on A Hall and C hall were always dirty, and they did not like taking showers in a dirty shower room. During an observation and interview of the A Hall shower room with LVN D on 04/29/2026 at 1:52 PM, the A Hall shower room had 3 shower stalls. The 3 shower stalls had yellowish-brownish grime from the middle down to the lower part of the tile on the shower walls, and one of the shower stalls also had pink grime built up on it. LVN D said the 3 shower stalls inside the shower room on A Hall appeared clean. LVN D said after giving the residents showers the CNAs ensured the shower stalls were clean by spraying down the shower stalls, but the housekeepers performed a deeper clean. During an observation and interview of the C Hall shower room with RN L on 04/29/2026 at 2:13 PM, the C Hall shower room had 2 stalls. Both stalls had black grime buildup on the lower parts of the shower walls, corners, and scattered on the grout of the tile on the floor of the shower stalls. One of the stalls had a slightly folded over band-aid with illegible writing lying next to some bottles of body wash in a built-in cavity/shelf on the shower wall. RN L said the housekeepers cleaned the shower stalls once a day. RN L said the CNAs should be taking out the trash and should not leave used band aids in the shower stalls. RN L said it appeared like there was mold on the shower stalls inside the C Hall shower room. RN L said it was important for the shower stalls to be clean to prevent the spread of infection and for the shower stalls' appearance to be pleasant for the residents. RN L said CNA M and CNA W provided the residents' showers today, 04/29/2026. During an interview on 04/29/2026 at 2:18 PM, CNA M said she did not leave the used band aid in the shower stall inside the C-Hall shower room. CNA M said she did not know who left it there. CNA M said the CNAs should ensure trash was not left in the shower stalls after giving a resident a shower. CNA M said it was important for trash not to be left in the shower stalls for infection control. CNA M said she had not noticed the shower stalls were dirty or any mold. CNA M said the housekeepers were responsible for cleaning the shower stalls. CNA M said it was important for the shower rooms to be clean so the residents could take a shower in a clean area. During an interview on 04/29/2026 at 2:23 PM, CNA W said she did not know who left the band aid in the shower stall inside the C-Hall shower room. CNA W said trash should be bagged and placed in the bin after giving a resident a shower. CNA W said the housekeepers deep cleaned the shower rooms once a week. CNA W said it was important for trash not to be left in the shower stalls and for the shower rooms to be clean for sanitation, infection control, and to make sure everything was clean for the residents. During an interview on 4/29/26 at 2:32 PM, Housekeeper H said the housekeepers deep cleaned the shower rooms on Sundays, but they could not deep clean the shower rooms last Sunday (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(4/26/2026) because they did not have enough housekeepers. She said they had not been scrubbing the showers just mopping them, and they had a chemical they could use for the tile to get it clean. She said the shower stalls inside the A-Hall and C-Hall shower rooms were dirty, and they should be cleaner. She said it was important for the showers to be clean because it was the residents' home, and they should not have to take a shower in a dirty shower room. During an observation and interview on 04/29/2026 at 2:42 PM, Housekeeper O said the A-Hall shower room stalls looked dirty and had mold. She said they cleaned the shower stalls every Sunday, but they did not clean them on Sunday, 04/26/2026, because they did not have enough staff. Housekeeper O said the shower stalls should be clean to prevent cross contamination, so the residents did not get sick, and because mold could affect the residents breathing. During an observation and interview with the Housekeeping Supervisor and Housekeeper P on 04/29/2026 at 2:49 PM, the Housekeeping Supervisor said the shower stalls in the A-Hall shower room needed to be scrubbed. She said they looked dirty and had pink grime on them. The Housekeeping Supervisor said they had a tile and grout cleaner to clean the shower stalls. She said the shower stalls in the C-Hall shower room looked dirty and needed to be scrubbed. The Housekeeping Supervisor said she was not sure if the black grime on the shower stalls was mold. She said she was responsible for making sure the showers were cleaned by the housekeepers. The Housekeeping Supervisor said she checked on Mondays to ensure the shower rooms were deep cleaned on Sunday, but lately she had not been monitoring. The Housekeeping Supervisor said the residents should not have to get clean in a dirty shower and the dirty showers could cause cross contamination. She said the showers should be clean to prevent the residents from getting sick. Housekeeper P said the A-hall and C-hall shower stalls could be cleaner. He said the last time he scrubbed the shower stalls was 2-3 weeks ago. Housekeeper P said the showers needed to be clean to prevent the residents from getting sick During an interview on 04/29/2026 at 3:56 PM, the Administrator said he expected for the shower rooms to remain clean and hygienic. The Administrator said he and the housekeeping staff were responsible for ensuring the shower rooms were clean. The Administrator said he rounded daily and had not noticed the shower rooms were not clean. The Administrator said it was important for the shower rooms to be clean to ensure a clean and sanitary environment and so the residents did not get sick. Record review of the facility's policy titled, Resident Rights, dated October 2022, indicated, Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident and determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 7 medication carts (600 Hall Medication Aide Medication Cart) and 2 of 3 (A Hall Medication Storage Room and Memory Care Medication Storage Room) reviewed for pharmacy services. The facility failed to ensure Resident #118's lorazepam gel with expiration date of 04/14/2026 and acetaminophen 650 mg suppositories with expiration date of 03/2026 were removed from the Memory Care Medication Storage Room. The facility failed to ensure acetaminophen 650 mg suppositories with expiration date of 01/2026 were removed from the A Hall Medication Storage Room refrigerator. The facility failed to ensure 30 tablets of famotidine 10 mg with an expiration date of 11/2025 were removed from the 600 Hall Medication Aide Medication Cart. These failures could place the residents at risk of not having medications available for use.Findings included: Record review of Resident #118's face sheet dated 04/29/2026 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear). Record review of Resident #118's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. Resident #118 had a BIMS score of 3, which indicated her cognition was severely impaired. Resident #118 required setup or clean-up assistance with eating and toileting and partial/moderate assistance with bathing and personal hygiene. The MDS assessment did not indicate Resident #118 received anxiety medication. Record review of Resident #118's Order Summary Report dated 04/29/2026 indicated:Ativan gel 0.5 mg/ml apply topically to the inner wrist every 6 hours as needed with a start date of 04/24/2026 and end date of 05/08/2026. Record review of Resident #118's care plan reviewed 04/16/2026 indicated she had a potential for alteration in mood as evidenced by a history of anxiety to administer medications as ordered. During an observation and interview on 04/27/2026 starting at 3:56 PM, an observation of the Memory Care Medication Storage Room refrigerator with RN C revealed a box of acetaminophen 650 mg suppositories with 11 suppositories remaining in the box with an expiration date of 03/2026 and 1, 1ml syringe of lorazepam gel 0.5 mg/1 ml with an expiration date of 04/14/2026, which belonged to Resident #118. RN C said the acetaminophen suppositories and lorazepam gel should have been removed from the refrigerator and disposed of properly. RN C said the RN supervisors were supposed to go through the medications every night and discard expired medications. RN C the nurses should also be checking the medications daily for expired medications. RN C said expired medications could cause harm to the residents or be ineffective. During an observation and interview on 04/27/2026 starting at 4:12 PM, an observation of the A Hall Medication Storage Room refrigerator with LVN D, the unit manager, revealed a box of acetaminophen 650 mg suppositories with 7 suppositories remaining in the box with an expiration date of 01/2026. LVN D said the nurses were responsible for checking the medications daily for expiration dates. LVN D said the expired suppositories should not have been removed from the refrigerator. LVN D said expired medications administered to the residents could be ineffective. LVN D said LVN E should have checked the medications that morning. LVN E said she checked the medications in the refrigerator every morning, and she did not notice the acetaminophen suppositories were expired. LVN E said it was important for expired medications to be discarded because if administered they would not have the same effectiveness and to ensure the residents had medications that were not expired available when they needed them. During an observation of the 600 Hall MA Medication Cart and interview with (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MA K on 04/28/2026 at 3:08 PM, there were 30 tablets of famotidine 10 mg with an expiration date of 11/2025. MA K said she did not notice the famotidine was expired because she did not administer it. MA K said administering expired medications could be ineffective. During an interview on 04/29/2026 at 3:21 PM, ADON T said the MAs, nurses, and unit managers were responsible for checking the medication carts and medication storage rooms and refrigerators for expired medications. ADON T said he expected for the staff administering medications to check for expired medications and discard them when they were giving medications and when they were going in the refrigerator to get medications. ADON T said expired medications were not effective. ADON T said Resident #118's lorazepam was expired and should have been discarded upon its expiration by the nurses. ADON T said the lorazepam gel was a compounded medication and if it was administered expired it would not be effective. During an interview on 04/29/2026 at 3:47 PM, the Administrator said he expected expired medications to be disposed of so they were not administered to the residents. The Administrator said the unit managers and the nurses were responsible for ensuring expired medications were discarded. The Administrator said not discarding expired medications could result in an adverse effect to the resident or the medication being ineffective. During an interview on 04/29/2026 at 4:18 PM, the DON said the nurses should be checking medication when administering them and should ensure no expired medications were on the medication cart and in the refrigerators. The DON said he did not know there had been studies to show what effects expired medications could have on the residents, so it was unknown what effect expired medications could have. Record review of the facility's undated policy titled, Storage of Medications, indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's, provider pharmacy recommendations, or those of the supplier to maintain their integrity. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 5 residents (Resident #20, and Resident #161), 2 of 7 medication carts (200 Hall Nurse Medication Cart and 600 Hall Medication Aide Medication Cart),) medication storage rooms reviewed for drugs and biologicals. 1. The facility failed to ensure UTI-Stat and Pro-Stat on the 600 Hall Medication Aide Medication Cart were dated after opened. 2. The facility failed to ensure a package of budesonide ampules in the 200 Hall Nurse Medication cart was labeled properly. 3. The facility failed to ensure Resident #161's medication labels for his glipizide, finasteride, gabapentin, and metformin matched his physician orders. 4. The facility did not ensure Resident #20's Systane Eye Drops (eye drops) were not left on his nightstand These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion.1. Record review of a face sheet dated 04/28/2026 indicated Resident #161 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included chronic ischemic heart disease (progressive condition characterized by reduced blood flow to the heart muscle due to narrow or blocked coronary arteries), dysphagia pharyngeal phase (difficulty swallowing caused by impaired movement of food or liquid through the throat this phase ensures food and liquids are safely moved from the airway into the digestive tract), and gastrostomy status (creation of an external opening into the stomach to provide nutrition, fluids, or medications). Record review of Resident #161's Quarterly MDS assessment dated [DATE] indicated he understood others and was understood by others. Resident #161 had a BIMS score of 15, which indicated his cognition was intact. Resident #161 required setup or clean-up assistance with eating and showering and was independent for toileting, dressing, and personal hygiene. Resident #161's MDS assessment did not indicate he had difficulty swallowing or presence of a feeding tube. Record review of Resident #161's Order Listing Report dated 04/01/2026-04/30/2026 indicated Glipizide give 5 mg via PEG-tube two times a day with a start date of 04/21/2026 Finasteride 5 mg give 1 tablet via PEG-tube one time a day with a start date of 04/21/2026 Gabapentin 100 mg give 1 capsule via PEG-tube one time a day with a start date of 04/22/2026 Metformin give 1000 mg via PEG-tube two times a day with a start date of 04/21/2026 Record review of Resident #161's care plan reviewed 03/07/2026 did not address administering his medications via PEG tube. During an observation of medication administration and an interview with LVN A on 04/28/2026 starting at 9:06 AM, revealed LVN A halved Resident #161's glipizide 10 mg tablet. LVN A said she had to half the pill because his order had recently changed to glipizide 5 mg when he returned from the hospital. The medication label on Resident #161's glipizide instructed glipizide 10 mg give 1 tablet by mouth twice daily before meals. Resident #161's finasteride indicated 5 mg give 1 tablet by mouth every day. Resident #161's gabapentin indicated give 100 mg 1 capsule by mouth every day. Resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#161's metformin indicated give 1000 mg 1 tablet by mouth twice daily. LVN A administered all of Resident #161's medications via PEG tube. LVN A said Resident #161 returned from a hospitalization about 7 days ago and now required his medications administered via PEG tube. LVN A said a change of direction sticker should have been placed on Resident #161's medications to indicate the route of administration changed and to indicate the glipizide was decreased to 5 mg. LVN A said the nurses were responsible for placing the change of direction sticker on the medications when they received a new order or the pharmacy nurse, ADON T, placed the sticker on the medications. LVN A said she did not know why a change of direction sticker had not been placed on Resident #161's medications. LVN A said not having the correct route of administration on the medication label could result in medications being administered incorrectly or by the incorrect route. LVN A said Resident #161's glipizide not having the correct dose on it could result in him receiving the wrong dose, and his blood sugar dropping. 2. During an observation of the 600 Hall MA Medication Cart and interview with MA K on 04/28/2026 at 3:08 PM, there were 30 tablets of famotidine 10 mg with an expiration date of 11/2025, an opened bottle of UTI-Stat with no open date, and an opened bottle of Pro-Stat with no open date. The bottle of UTI-Stat indicated discard 3 months after opening and record date opened on bottom of container. MA K said they checked the medication carts weekly for expired medications. MA K said she did not notice the famotidine was expired because she did not administer it. MA K said she did not administer the Pro-Stat or the UTI-Stat, so she did not know they were not dated. MA K said the Pro-Stat and UTI-Stat should have been dated when opened by the person who opened them. MA K said administering expired medications could be ineffective. MA K said it was necessary to date bottles when opened because they could only be used for a certain number of days before they went bad. During an observation of the 200 Hall Nurse Medication Cart and interview with LVN F on 04/28/2026 at 3:17 PM, in the top drawer there was a package of budesonide 0.5 mg/2 ml with 5 ampules, and it did not have a pharmacy label on it or resident name. LVN F said he worked as needed, so he did not why the budesonide was not in its original box from the pharmacy. He said he did not know which resident the medication belonged to. LVN F said medications should be kept in the packaging it came from the pharmacy with the pharmacy label with the resident's name on it and directions for administration. LVN F said all medications should be labeled properly to know who the medication belonged to, how to administer it, and how long it had been on the medication cart. During an interview on 04/29/2026 at 3:21 PM, ADON T said medications should not be stored in a drawer without a pharmacy label because they would not know whose medication it was, and they would not be able to see the dosage that needed to be administered. ADON T said the budesonide should have been stored in a box inside the medication cart with the proper labeling from pharmacy. ADON T said the nurse who was responsible for the medication cart should ensure medications were labeled and stored properly. ADON T said not having the proper labels on medications could lead to a medication error. ADON T said a change of direction label should have been placed on Resident #161's medications to indicate there was a change in administration from by mouth to by PEG tube. ADON T said a change of direction label should have been placed on Resident #161's glipizide to indicate the dosage had been decreased to 5 mg. ADON T said the nurse who received the order or any of the nurses that noticed the discrepancy should have placed a change of direction label on Resident #161's medications. ADON T said not having the correct route of administration on Resident #161's medications could result in the medications being administered to him by mouth and cause him to aspirate. ADON T said Resident #161's glipizide not having the correct dosage on it could result in him receiving the wrong dosage, which could cause low blood sugars. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/29/2026 at 3:47 PM, the Administrator said he expected for the nurses to ensure the orders on the medication labels matched what they were doing during medication administration. The Administrator said he expected for the nurses to place a change of order sticker on medications when there was a change in the order. The Administrator said there could have been an adverse effect to the resident if the medication was administered via the incorrect route. The Administrator said the incorrect dosage could be administered if the medication label did not match the orders and it could harm the residents. The Administrator said he expected medications to be labeled as required and for the medications to be stored per the policy. The Administrator said the nurses and unit managers were responsible for ensuring this happened. The Administrator said not having medications properly labeled could result in the medication being given to the wrong resident or in the staff not knowing who to give the medication to. During an interview on 04/29/2026 at 4:18 PM, the DON said ADON T, the pharmacy nurse, should have ensured a change of direction label on Resident #161's medications to reflect there was a dosage change, and the route changed to PEG tube. The DON said Resident #161's medication label indicating to administer his medications by mouth could have resulted in the medications being administered by the wrong route. The DON said there was a potential for the wrong dosage to be administered to Resident #161 because his glipizide did not have the correct dosage on the medication label. 3. Record review of Resident #20's face sheet, dated 04/29/26, reflected Resident #20 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and acute conjunctivitis (inflammation of the clear membrane lining the eyelid and eye) of left eye. Record review of Resident #20's admission MDS assessment, dated 04/08/26, reflected Resident #20 made himself understood and understood others. Resident #20's BIMS score was 9, which reflected his cognition was moderately impaired. Record review of Resident #20's undated comprehensive care plan, reflected Resident #20 was at risk for irritation as evidence by complaints of dry eyes. The care plan intervention included: administer eye medication as ordered. Record review of Resident #20's order summary report, dated 04/29/26, reflected an active physician order for Systane Ultra Ophthalmic Solution 0.4 percent-0.3 percent: instill 1 drop in both eyes every 6 hours as needed for dry eyes with a start date 04/27/26. During an observation and interview on 04/26/26 at 12:46 p.m., A bottle of Systane Eye Drops was observed on Resident #20's nightstand. Resident #20's family member was at the bedside when she stated he had brought the eye drops when he was first admitted to the facility. Resident #20's family member stated she did not know if the facility knew or seen the medication. During an observation on 04/27/26 at 9:42 a.m., A bottle of Systane Eye Drops was observed on Resident #20's nightstand. During an observation and interview on 04/27/26 at 9:45 a.m., the state surveyor observed the eye drops on Resident #20's nightstand with LVN R. LVN R removed the medication from the table and stated the medication should be stored in the nurse's cart. LVN R stated if a resident was able to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-administer, he/she must be assessed for competence. LVN R stated Resident #20 could not self-administer his eye drops due to his diagnosis of dementia. LVN R stated his family member had been educated on bringing medications without the physician order to the facility. LVN R stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 04/29/26 at 10:24 a.m., CNA N stated during her rounds she did not see the eye drops on Resident #20's nightstand. CNA N stated all staff were responsible for ensuring items were stored properly and securely. CNA N stated eye drops should be stored in the medication cart. CNA N stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 04/29/26 at 2:03 p.m., RN L stated she did not see eye drops on Resident #20's nightstand when she worked 04/26/26. RN L stated Resident #20's family members tend to bring stuff without telling the nurses. RN L stated the nursing staff were responsible for ensuring medications were stored properly and securely in the nurse's cart. RN L stated during her rounds she looked to see if there were things that should not be in the resident's room. RN L stated Resident #20 was not competent to administer his own medications because he had a diagnosis of dementia. RN L stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 04/29/26 at 2:20 p.m., Unit Manager S stated she just started the position on 04/27/26 but she expected medications to be stored in the nurse's cart not at bedside. Unit Manager S stated CNAs should report to the nurse or unit manager if medications were observed at bedside. Unit Manager S stated if the nurse observed the medication he/she should remove the medication and notify the family that medication should not be brought. Unit Manager S stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 04/29/26 at 3:15 p.m., the DON stated he expected medications to be stored on the medication cart. The DON stated nursing staff were responsible for ensuring medications were not stored at bedside by observing during rounds. The DON stated he was responsible for monitoring and overseeing by entering random residents' rooms and making observations. The DON stated it was important to ensure medications were not at bedside due to the possibility of harm. During an interview on 04/29/26 at 4:17 p.m., the Administrator stated medications should be locked/secured in the nurse's cart or medication room. The Administrator stated nursing staff should be ensuring medications were not left at bedside. The Administrator stated the unit manager, DON and himself responsible for monitoring medications at bedside by spot checks. The Administrator stated it was important to ensure medications were not left at bedside for resident safety. Record review of the undated facility's policy titled Storage of Medications reflected. Medications and biologicals are stored safely, securely, and properly. B. Only licensed nurses. and those lawfully authorized to administer medication such as medication aides are allowed access to medications. Record review of the undated facility's policy titled Bedside Medication Storage reflected. Bedside medication storage is permitted for residents who can self-administer medications upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. F. All nurses and nursing aides are required to report to the charge nurse on duty any medications found at the beside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Record review of the facility's undated policy titled, Storage of Medications, indicated, Medications (continued on next page)

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	675873	A. Building B. Wing	04/29/2026

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and biologicals are stored safely, securely, and properly, following manufacturer's, provider pharmacy recommendations, or those of the supplier to maintain their integrity. The provider pharmacy dispenses medications in containers that meet state and federal labeling requirements, including standards set forth by the United States Pharmacopeia (USP) for good manufacturing practices. Medications are kept in these containers and stored in a controlled environment. This storage may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers. Transfer of medications from one container to another is done only by the pharmacy personnel. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . Record review of the facility's undated policy titled, Medication Labels, indicated, Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy can modify or change prescription labels. Labels are permanently affixed to the outside of the prescription container. Each prescription medication label includes: 1. Resident's name 2. Specific directions for use, including route of administration a. Due to the complexity and length/length/number of instructions, some medications may be labeled use as directed and refer the person administering the medication to the medication administration record for instruction details. If the physician's directions for use change or the label is inaccurate, the nurse may place a change of order—check chart label on the container indicating there is a change in directions for use, taking care not to cover important label information. 2. When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physician's order for current information. 3. The dispensing pharmacy is informed prior to the next refill of the prescription so the new container will show an accurate label.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure:The deep fryer was clean and free of food debris.One medium-sized skillet was free from black buildup on the inside and outside.One large-sized skillet with Teflon coating was free from peeling on the inside. These failures could place residents at risk for food contamination and foodborne illness. Findings included: During an observation of the kitchen on 04/26/2026 starting at 10:30 AM, the fryer had crumbs around it, one medium-sized skillet had black carbon built up on the inside and outside and one Teflon coated large-sized skillet had the coating peeling off on the inside. During an observation of the kitchen on 04/27/2026 at 10:18 AM, the fryer had crumbs around it, and hanging off the rack with pots and pans there was one medium-sized skillet with black carbon built up on the inside and outside of it and one Teflon coated large-sized skillet with the coating peeling off on the inside. During an interview on 04/28/2026 at 12:35 PM, [NAME] B said the cook in the evening, [NAME] G, was responsible for cleaning the fryer. [NAME] B said she noticed the medium skillet with the carbon buildup and the large skillet with the Teflon peeling, and the Dietary Manager was aware of this too. [NAME] B said the skillets having carbon buildup and the Teflon peeling could get in the food and make the residents sick. During an interview on 04/28/2026 at 12:49 PM, the Assistant Dietary Manager said the fryer should not have crumbs, and the Dietary Manager or the night crew were responsible for cleaning it. The Assistant Dietary Manager said the fryer having crumbs could lead to cross contamination of food and cause illness. The Assistant Dietary Manager said she had not noticed the large skillet with peeling Teflon, but she had noticed the medium skillet with carbon buildup and it should have gone in the trash a long time ago. The Assistant Dietary Manager said the Dietary Manager was responsible for ensuring the skillets were in good condition and replaced. The Assistant Dietary Manager said the carbon buildup and peeling Teflon could come off and get in the residents' food and this could result in the resident illness. During an interview on 04/28/2026 at 12:53 PM, the Dietary Manager said the deep fryer should be cleaned by the cook who used it after each meal, or he cleaned it too. The Dietary Manger said he tried to make daily rounds in the kitchen to ensure everything was clean, but he had not checked the fryer yesterday, 04/27/2026. The Dietary Manager said it was important for the fryer to be cleaned and not have any crumbs so the residents would not get sick. The Dietary Manager said he was aware the medium and large-sized skillets needed to be replaced, but he had just missed it. The Dietary Manager said he made rounds once a month in the kitchen to see what needed to be replaced, and he did not make it around to replace some of the skillets that needed replacement. The Dietary Manager said the skillet with peeling Teflon and the carbon buildup could get in the residents' food and make them sick. During an interview on 04/28/2026 at 1:07 PM, [NAME] G said the deep fryer was cleaned by the cooks. [NAME] G said after they used the deep fryer they scraped the crumbs off and washed the baskets, but sometimes they did not get around to it or forgot to clean it. [NAME] G said it was important for the fryer to be clean because it could cause issues with bacteria and could cause diseases. [NAME] G said he mentioned to the Dietary Manager that the medium skillet and large skillet needed to be replaced due to the carbon buildup and peeling Teflon, but they still had not been replaced. [NAME] G did not remember when he mentioned it. [NAME] G said the carbon buildup and peeling Teflon on the skillets could lead to health issues because the carbon buildup and Teflon could get in the residents' food. During an interview on 04/29/2026 at 3:53 PM, the Administrator said he conducted walk-throughs in the kitchen at least weekly, if not a couple times a week. The Administrator said he had not noticed the medium-sized skillet with black carbon buildup on the inside and outside and the Teflon coated large-sized skillet with the coating peeling off on the inside or the deep fryer with crumbs. The Administrator said he expected the kitchen to remain clean and hygienic. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator said the Dietary Manager and the Assistance Dietary Manager were responsible for ensuring the kitchen was cleaned and the skillets were in good condition. The Administrator said the deep fryer having crumbs could make the residents sick or cause food poisoning. The Administrator said the skillets having carbon buildup and Teflon coating peeling could make the residents sick. Record review of the facility's undated policy titled Cleaning and Sanitation of Dining and Food Service Areas, indicated, Policy: The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. Record review of the U.S. Food and Drug Administration Food Code 2022, indicated, Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident #76) reviewed for resident rights. The facility failed to ensure CNA Z called Resident #76 by his preferred name while providing care on 04/28/26. This failure could place residents at risk for diminished quality of life, loss of dignity, and self-worth.Findings included:Record review of Resident #76's face sheet dated 04/28/26 indicated he was [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses which included adjustment disorder with mixed anxiety and depressed mood (stress-related condition when individual copes with life changes) , and vascular dementia (progressive decline in thinking caused by conditions that reduce blood flow to the brain). Record review of Resident #76's significant change MDS dated [DATE] indicated usually made himself understood and usually understood others. The MDS also indicated he had a BIMS score of 03 which meant he had severe cognitive loss. Record review of Resident #76's care plan dated 11/25/25 indicated he was a male resident and preferred to be called [name] with interventions to respect resident wishes. During an observation and interview on 04/28/26 at 8:55 AM Resident#76 was lying in bed when CNA Z and CNA AA were attempting to provide care for Resident #76. CNA Z called Resident #76 by his last name and he told the two CNAs loudly that they could call him Dickhead, Asshole, or anything else but he did not want them calling him by his last name. Resident #76 said his name was [name] and that was what he wanted to be called. CNA Z called him by his last name again and Resident #76 immediately corrected her and said Dickhead. During an interview on 04/28/2026 at 10:05 AM CNA AA said she had been on floor as CNA for 12-14 days. CNA AA said she always called Resident #76 by his last name, but he has gotten mad, but that's his name. CNA AA said no nurse has ever said anything about him being called anything but his last name. CNA AA said if he wanted to be called something different, she would have called him that because that was his right. CNA AA said CNA Z was her trainer and she had never told her that. During an interview on 04/28/2026 at 10:20 AM CNA Z said no other nurse had said Resident #76 did not like to be called by his last name, but he always responded when they called him by his last name. CNA Z said she had always called Resident #76 by his last name but on 04/28/26 Resident #76 was not his normal self. CNA Z said for Resident #76's dignity and respect all staff should have been calling Resident #76 by his first name instead of his last name. During an interview on 04/29/2026 at 3:17 PM LVN W said she was not aware that Resident #76 preferred to be called by his first name and LVN W said she typically called all residents by their last names out of respect. LVN W said it was Resident #76's right to be called by his first name if he wanted to be called by his first name and what all staff should have been calling him by his first name. LVN W said it was the charge nurse's responsibility to know resident preferences and to notify CNAs. During an interview on 04/29/26 at 4:05 PM the DON said he expected the CNAs to call residents as the resident prefers. The DON said the preference should have been in Resident #76's care plan for triggers. The DON said it was Resident #76's right to be called what he preferred and avoid all triggers. During an interview on 04/29/26 at 4:10 PM the Administrator said he expected the residents to be called by their preferred names. The Administrator said the nursing staff and the leadership staff (the ADON, DON, and Administrator) were responsible for ensuring the residents were called by their preferred names. The Administrator said the failure placed a risk for triggers and upsetting the residents. Record review of the undated facility policy Resident Rights indicated:Purpose: The purpose of this policy is to affirm and protect the fundamental rights of all patients/residents receiving care at [Facility Name], in accordance with federal and state regulations.Dignity and Respect: The right to be treated with consideration, respect, and recognition of individuality.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 35 residents (Resident #28) reviewed for MDS assessment accuracy. Resident #28's quarterly MDS, dated [DATE], identified the resident was not receiving oxygen therapy. This failure could place residents at risk of not receiving adequate care and services to meet their needs. Findings include:Record review of Resident #28's face sheet, dated 04/28/26, reflected Resident #28 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #28's quarterly MDS assessment, dated 04/08/26, reflected Resident #28 made himself understood and understood others. Resident #28 had a BIMS score of 8, which reflected his cognition was moderately impaired. During the 7-day look-back period the assessment did not reflect Resident #28 was receiving oxygen. Record review of Resident #28's physician order summary report, dated 04/28/26, reflected the following: * an active order for oxygen at 3L via N/C PRN for SOB and to maintain oxygen saturation above 90 percent every shift related to COPD with a start date 04/16/26. *an active order to check, clean, and/or replace oxygen filter every week every night shift Wednesday with a start date 02/04/26. Record review of the TAR dated 04/01/26-04/30/26, reflected Resident #28 wore oxygen at 3L via N/C on 04/02/26, 04/03/26, 04/04/26, 04/05/26, 04/06/26, 04/07/26, and 04/08/26. Record review of Resident #28's undated comprehensive care plan reflected Resident #28 may receive oxygen related to acute respiratory failure with hypoxia (low levels of oxygen in body tissues), hypercapnia (too much carbon dioxide in the blood), and pneumonia (infection that inflames the air sacs in one or both lungs). The care plan interventions included administer oxygen as ordered, change oxygen humidifier bottle and tubing as per facility policy. The care plan did not address oxygen filters. During an interview on 04/29/26 at 11:41 a.m., MDS Coordinator U stated she was responsible for Resident #28's quarterly MDS assessment. After reviewing Resident #28's electronic medical records, MDS Coordinator U stated she misunderstood the physician order and TAR about Resident #28 receiving oxygen. MDS Coordinator U stated she should have coded yes to oxygen use. MDS Coordinator U stated it was important to ensure the assessment was coded correctly because it was a picture of the resident status on how to ensure his needs were being met. During a telephone interview on 04/29/26 at 2:47 p.m., the Director of MDS stated she expected Resident #28's quarterly MDS assessment to be coded accurately. The Director of MDS stated MDS Coordinator U was responsible for ensuring oxygen use was correctly coded. The Director of MDS stated her understanding was MDS Coordinator U misunderstood the order. The Director of MDS stated she monitored by random audits that addressed certain sections of the MDS and weekly team call with the MDS Coordinators that covered common miscoded items. The Director of MDS stated it was important to ensure the correct information was coded to ensure the care plan reflected the care that the resident should be receiving. During an interview on 04/29/26 at 3:15 p.m., the DON stated he expected Resident #28's quarterly MDS to be coded correctly which reflected oxygen use. The DON stated MDS Coordinator U was responsible for coding the assessment correctly. The DON stated the Director of MDS was responsible for monitoring. The DON stated it was important to code the assessment correctly, so the billing was correct and the taxpayer was not taken advantage of. During an interview on 04/29/26 at 4:17 p.m., the Administrator stated he expected Resident #28's quarterly MDS assessment to be coded correctly. The Administrator stated the Director of MDS was responsible for monitoring the MDS Coordinators to ensure accuracy. The Administrator stated it was important to code the assessment correctly to keep accurate records of his current condition. Record review of the facility's policy Clinical Services: Care Plans and Case Management, revised on 04/2025 reflected .1. The Resident Assessment Instrument will be used by the facility in accordance with federal guidelines. Record review of the Resident Assessment Instrument 3.0 Manual, dated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/2025, reflected . 1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the assessment period.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the coordination and provision of services agreed upon during the IDT meeting for 1 of 5 residents (Resident #12) reviewed for PASARR. 1. The facility failed to provide documentation of Resident #102's psychosocial rehabilitative services (group), psychosocial rehabilitative services (individual), and routine case management services as requested in the PCSP Form.2. The facility failed to refer Resident #86 for PASARR Level ll assessment when a diagnosis of major depressive disorder, was diagnosed after admission on [DATE]. These failures could cause residents with mental health disorders and psychiatric conditions to have a delay in services or not receive specialized services or equipment that may be needed.Findings included: 1. Record review of Resident #102's face sheet, dated 04/29/26, reflected Resident #102 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included Schizophrenia (severe psychiatric disorder is characterized by persistent delusions of persecution, unwarranted suspicion, and often vivid hallucinations), anxiety (excessive worry), and bipolar disorder (extreme mood changes). Record review of Resident #102's quarterly MDS assessment, dated 01/02/26, reflected Resident #102 understood others, and made himself understood. Resident #102 BIMS score was 15, which reflected his cognition was intact. Record review of Resident #102's comprehensive care plan, revised 03/12/26, reflected Resident #102 had identified that he was in need of specialized services due to mental illness. The care plan interventions included: follow up with agency representative to ensure recommendations are fully implemented. Record review of the PASARR Comprehensive Service Plan (PCSP) meeting dated 03/12/26 reflected that group therapy, individual therapy, and routine case management were recommended for Resident #102. Record review of Resident #102's electronic medical record dated 04/26/26 reflected no documentation of group therapy, individual therapy, or routine case management notes. During a telephone interview on 04/29/26 at 2:48 p.m., PASARR Case Manger stated she came to the facility monthly to get a report from Resident #102 to ensure his needs were met. The PASARR Case Manger stated she did not leave any documentation for the monthly visits at the facility. The PASARR Case Manger stated she followed up with the nurses after each visit to see if there were any concerns with his care. During an interview on 04/03/26 at 2:00 p.m., The MDS Coordinator stated she was responsible for ensuring visits were conducted by the PASARR Case Manager. The MDS Coordinator stated she was not aware when the skill trainer came to visit but the PASRR Case Manger came every month. The MDS Coordinator stated she did not coordinate with them after their visits. The MDS Coordinator stated it was important documentation was received after every visit to ensure they were receiving services. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/26 at 2:10 p.m., the DON stated he and the corporate nurse would attempt to reach out to obtain evidence of services provided. During an interview on 04/29/26 at 3:45 p.m., the DON stated he could not recall the exact services Resident #102 should be receiving. The DON stated he did not know when the PASRR Case Manger came to the facility until he received an email from the PASRR Case Manger to schedule the quarterly meeting. The DON stated it was important to ensure documentation was provided for continuity of care. During an interview on 04/26/26 at 3:59 p.m., the Administrator stated he did not know what services Resident #102 was receiving until the state surveyor intervention. The Administrator stated he had not received recommendations to know how often Resident #102 should be seen. The Administrator stated in his experience that if the facility ever needed documentation, they would ask that provider to provide the documentation. The Administrator stated there was not a system in place to monitor the MDS Coordinator oversight of needs. The Administrator stated it was important to ensure documentation was provided to ensure Resident #102 was receiving his PASARR services. 2. Record review of a face sheet dated 4/29/26 indicated Resident #86 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis which included hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction (the death of brain tissue due to a blockage in blood flow, leading to oxygen and nutrient deprivation) affecting left dominant side, anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear), and insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). Record review Resident #86's face sheet dated 4/29/26 indicated a new diagnosis of Major Depressive Disorder on 11/26/25. Record review of Resident #86's annual MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #86 had a BIMS score of 13, which indicated his cognition was considered intact. The MDS section, Preadmission Screening and Resident Review indicated Resident #86 did not have a serious mental illness. The section named Level II Preadmission Screening and Resident Review Conditions did not reflect a mental illness. Record review of Resident #86's care plan revised 3/7/2026 indicated Resident #86 required anti-depressants (Zoloft and Trazodone) related to a diagnosis of depression and used anti-anxiety medication (Buspar) related to anxiety. Record review of Resident #86's PASRR Level 1 Screening completed on 2/10/2025 indicated in section C0100 no evidence of this individual having mental illness. Record review of the electronic health record accessed on 4/27/2026 did not reveal the facility had completed a Form 1012 for Resident #86 and the new diagnosis of Major Depressive Disorder. During an interview on 4/28/26 at 9:40 a.m., the MDS Nurse stated she has worked for the facility as the MDS nurse for two years. She stated she should have completed a Form 1012 for the new diagnosis of Major Depressive Disorder dated 11/26/2025. She stated she gets the notes emailed to her from Psych Services when the diagnoses are Record review of Preadmission Screening and Resident Review (PASARR) policy revision date 8/29/25 revealed is to ensure each resident in a nursing facility screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that the individuals identified with MD or ID are (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluated and receive care and services in the most integrated setting appropriate to their needs. Record review of the facility's policy Clinical Services: Care Plans and Case Management, revised on 04/2025 reflected .1. The Resident Assessment Instrument will be used by the facility in accordance with federal guidelines.

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	04/29/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs, for 1 of 35 (Resident #28) residents reviewed for care plans. The facility did not ensure Resident #28 had a floor mat on each side of the bed. This failure could place residents at risk of accidents and falls with injuries. Findings include: Record review of Resident #28's face sheet, dated 04/28/26, reflected Resident #28 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included repeated falls. Record review of Resident #28's quarterly MDS assessment, dated 04/08/26, reflected Resident #28 made himself understood and understood others. Resident #28 had a BIMS score of 8, which reflected his cognition was moderately impaired. Resident #28 was dependent with chair/bed-to-chair transfer, and the activity sit to stand was not attempted. Resident #28 did not have any falls since admission/entry, reentry or prior assessment. Record review of Resident #28's order summary report, dated 04/28/26, reflected an active order to ensure cushioned floor mat on floor, on each side of bed if/when resident was in bed with an order date 12/27/24. Record review of Resident #28's undated care plan reflected Resident #28 had an actual fall. The care plan interventions included cushioned floor mat on floor on each side of bed if/when resident is in bed. During an observation on 04/26/26 at 11:25 a.m., revealed Resident #28 laid in bed. There was a cushioned floor mat only on Resident #28's right side of the bed. During an observation and interview on 04/27/26 at 1:00 p.m., revealed Resident #28 was lying in bed. There was a cushioned floor mat only on Resident #28's right side of the bed. Resident #28 stated he did not know if he should have a cushioned floor mat on his left side of the bed. During an observation on 04/28/26 at 9:00 a.m., revealed Resident #28 was lying in bed. There was a cushioned floor mat only on Resident #28's right side of the bed. During an interview on 04/28/26 at 9:04 a.m., CNA X stated she was Resident #28's aide. CNA X stated she just started working at the facility on 04/07/26. CNA X stated the nursing staff were responsible for ensuring a floor mat was at Resident #28's left side of the bed. CNA X stated she was unaware that Resident #28 should have a floor mat on each side of his bed. After reviewing Resident #28 electronic medical records, CNA X stated he should have a floor mat on each side of the bed. CNA X stated usually there was a sign above resident's bed to indicate if the resident should have a floor mat or go into PCC and look under the Kardex and it will tell you there. CNA X stated it was important to ensure safety measures were put in place to prevent serious injury. During an interview on 04/28/26 at 9:15 a.m., MA Y stated the nursing staff wereresponsible for ensuring a floor mat was at Resident #28's left side of the bed. MA Y stated staff should review the safety precautions in electronic medical records under the Kardex tab every day to ensure all measures were in place. After reviewing Resident #28 electronic medical records, MA Y stated he should have a floor mat on each side of the bed. MA Y stated it was important to ensure safety measures were in place to prevent serious injury. During an interview on 04/28/26 at 9:30 a.m., LVN R the nursing staff wereresponsible for ensuring a floor mat was at Resident #28's left side of the bed. LVN R stated nurses were responsible for educating the aides verbally on safety measures beginning of each shift. After reviewing Resident #28 electronic medical records, LVN R stated he should have a floor mat on each side of the bed. LVN R stated it was important to ensure fall safety interventions were put in place to prevent serious injury. During an interview on 04/29/26 at 2:20 p.m., Unit Manager S stated she just started the management position on Monday (04/27/26) but she expected both floor mats to be in place. Unit Manager S stated CNAs, MA and nurses were responsible for ensuring the fall mats were in place. Unit Manager S stated she would be monitored by daily rounds. Unit Manager S stated it important to ensure that fall safety interventions were put in place to prevent fractures or serious injuries. During an interview on (continued on next page)

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Clyde W Cosper Texas State Veterans Home	1300 Seven Oaks Rd Bonham, TX 75418

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/29/26 at 3:15 p.m., the DON stated he expected floor mats on each side while in bed. The DON stated nurses and aides were responsible for ensuring the floor mats were in place. The DON stated he monitored by random spot checks and had not noticed any issues in the past. The DON stated it was important safety measures were in place for precaution intervention. During an interview on 04/29/26 at 4:17 p.m., the Administrator stated he expected Resident #28 to have both floor mats on each side of the bed. The Administrator stated nursing staff were responsible for ensuring the floor mats were in place. The Administrator stated unit managers, DON and himself were responsible for monitoring by spot checks. The Administrator stated it was important to ensure safety measures were in place to ensure his safety. Record review of the facility's Clinical Services: Care Plans and Case Management, revised on 06/2019 reflected . to develop an interdisciplinary resident centered comprehensive care plan to meet the individual needs of each resident.1. An interdisciplinary team develops and maintains a comprehensive care plan for each resident. 2. The comprehensive care plan has been designed to: identify care needs that includes resident's strengths, history, and preferences.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 7 residents (Resident #56 and Resident #28) reviewed for respiratory care.1.The facility failed to ensure Resident #56's oxygen concentrator filter was cleaned. 2. The facility failed to ensure Resident #28's oxygen concentrator filter was cleaned.This failure could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory disease.Findings included: 1.Record review of Resident #56's face sheet dated 04/29/26 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease also known as COPD (a progressive, incurable lung disease—primarily caused by smoking—that obstructs airflow, causing chronic breathing difficulties),anxiety (the feeling of fear and worry that is both intense and excessive). Record review of Resident #56's quarterly MDS assessment dated [DATE] indicated he made himself understood and he understood others. The MDS also indicated he had a BIMS score of 15 which meant he was cognitively intact. The MDS did not indicate Resident #56 required oxygen. Record review of Resident #56's comprehensive care plan last revised 02/18/26, indicated Resident #56 had shortness of breath and received oxygen. The interventions were to check oxygen filter, clean and/or replace filter every week. Record review of Resident #56's physician order dated 08/31/23, indicated as follows: *check oxygen filter, clean and/or replace filter every Wednesday night shift. *: Oxygen at 2 Liters per nasal cannula as needed for shortness of breath. Record review of Resident #56's medication administration record indicated LVN C initialed she cleaned Resident #56's filter on 04/22/26. During an observation and interview on 04/26/26 at 12:37 a.m., Resident #56 was lying in bed and had his oxygen on at 2 liters per minute. The oxygen concentrator filter was covered in a gray-like substance. Resident #56 said he wore oxygen but when asked about the filter he would not answer. During an observation on 04/28/26 at 4:51 p.m., Resident #56's was lying in bed and had his oxygen on at 2 liters per minute. The oxygen concentrator filter continued to be covered in a gray-like substance. During an observation and interview on 04/28/26 at 4:42 p.m., LVN E verified Resident # 56 was wearing oxygen at 2 liters per minute and his concentration filter was covered in a gray-like substance. She said it was dirty. She said she thought there was a schedule for oxygen tubing and filters to be cleaned on the night shift, but said nurses were supposed to look at them daily. She said she had not looked at Resident #56's filter today (04/28/26). She said failure to keep the filter clean placed Resident #56 at risk for infection. During an attempted telephone interview on 04/29/26 at 3:28 p.m., with LVN V, the nurse for (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wednesday 04/22/26 (responsible for cleaning/changing the oxygen filter), was unsuccessful. During an interview on 04/29/26 at 11:40 a.m., the Business Office Manager said she was responsible for the ambassador rounds for Resident #56. She said she was responsible for checking and ensuring the resident had what he needed, checking for outdated items in the refrigerator or things not allowed in the room, making sure his room was clean, and making sure his oxygen tubing was dated. She said she was not aware of checking the oxygen concentrator filters. During an interview on 04/29/26 at 3:44 p.m., the DON said he expected oxygen concentrator filters to be cleaned. He said the charge nurses and the ambassadors should be checking the filters and he did random spot checks. The DON said dirty concentrator filters placed Resident #56 at an increased risk for respiratory infection. During an interview on 04/29/26 at 3:58 p.m., the Administrator said the nurses should been changing and cleaning the oxygen concentrator filters and the unit managers should be monitoring the cleanliness every Wednesday night. He said Resident #56 should have had an order to clean the oxygen concentrator filter. The Administrator said failure to have Resident #56's oxygen concentrator filter cleaned placed him at risk for infection, such as pneumonia. 2. Record review of Resident #28's face sheet, dated 04/28/26, reflected Resident #28 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #28's quarterly MDS assessment, dated 04/08/26, reflected Resident #28 made himself understood and understood others. Resident #28 had a BIMS score of 8, which reflected his cognition was moderately impaired. During the 7-day look-back period the assessment did not reflect Resident #28 was receiving oxygen. Record review of Resident #28's undated comprehensive care plan reflected Resident #28 may receive oxygen related to acute respiratory failure with hypoxia (low levels of oxygen in body tissues), hypercapnia (too much carbon dioxide in the blood), and pneumonia (infection that inflames the air sacs in one or both lungs). The care plan interventions included administer oxygen as ordered, change oxygen humidifier bottle and tubing as per facility policy. The care plan did not address oxygen filters. Record review of Resident #28's physician order summary report, dated 04/28/26, reflected an active order for oxygen at 3L via N/C PRN for SOB and to maintain oxygen saturation above 90% every shift related to COPD with a start date 04/16/26. Record review of Resident #28's physician order summary report, dated 04/28/26, reflected an active order to check, clean, and/or replace oxygen filter every week every night shift Wednesday with a start date 02/04/26. During an observation on 04/26/26 at 11:25 a.m., revealed Resident #28's oxygen concentrator filter had a thick, gray, fuzzy material. During an observation and interview on 04/27/26 at 1:00 p.m., revealed Resident #28 was lying in bed. Resident #28's oxygen concentrator filter had a thick, grey, fuzzy material. Resident #41 stated he (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wore oxygen at night due to SOB. During an observation on 04/28/26 at 9:00 a.m., revealed Resident #28 was lying in bed. Resident #28's oxygen concentrator filter had a thick, grey, fuzzy material. During an interview on 04/28/26 at 9:30 a.m., LVN R stated the nurse staff on Wednesday nights were responsible for changing/cleaning the oxygen filter. LVN R observed Resident #28's oxygen filter and stated, it's dirty. LVN R stated it was important to ensure filters were cleaned to prevent a respiratory infection. An attempted telephone interview on 04/28/26 at 3:30 p.m., with LVN Q, the nurse for Wednesday 04/22/26 (responsible for cleaning/changing the oxygen filter per the 04/22/26 schedule), was unsuccessful. During an interview on 04/29/26 at 11:31 a.m., ADON T stated he was responsible for the ambassador rounds for Resident #28. ADON T stated rounds should be done every day but there were some days he did not have time to complete. ADON T stated his last round was done on 04/27/26 and he did not look at the filter. ADON T stated it was important to ensure filters were cleaned to prevent an infection and ensure proper airflow. During an interview on 04/29/26 at 2:20 p.m., Unit Manager S stated she just started the management position on Monday (04/27/26) but she expected the filters to be cleaned/changed by the nurse on Wednesday nights. Unit Manager S stated she would be monitoring and overseeing by random rounds. Unit Manager S stated it was important to ensure filters were cleaned to prevent a respiratory infection. During an interview on 04/29/26 at 3:15 p.m., the DON stated the nurse on Wednesday night was responsible for cleaning/changing the filter. The DON stated he monitored by random spot checks and ambassador rounds. The DON stated there had not been any issues in the past. The DON stated it was important to cleaned/change the oxygen filter to prevent the possibility of infection. During an interview on 04/29/26 at 4:17 p.m., the Administrator stated he expected the filters to be cleaned/changed on Wednesday nights by the charge nurse. The Administrator stated the unit managers, DON and himself were responsible for monitoring and overseeing by random spot checks and daily ambassador rounds. The Administrator stated it was important to clean/change the oxygen filter to prevent Resident #28 from getting sick. Record review of the facility's Oxygen Administration, revised on 09/02/25 reflected . to administer oxygen to the resident with insufficient oxygen saturation.5 (b). clean the filters daily with soap and water.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide or obtain laboratory services to meet the needs of its residents for 1 of 7 residents (Resident #12) reviewed for laboratory services. 1. The facility failed to ensure Resident #12's Pre-Albumin (measures the level of a liver-produced protein in the blood to assess nutritional status and monitor for malnutrition) was drawn bi-weekly and Albumin (measures the level of albumin, a protein produced by the liver, in the blood or urine to assess liver/kidney function and nutritional status) was drawn monthly for Resident #12. 2. The facility failed to ensure Vitamin D and Lipid panel test were drawn every year for Resident #12. Vitamin D (measures the levels of vitamin D in your blood. Vitamin D helps your body absorb calcium to build healthy bones and teeth). Lipid panel (a blood test measuring cholesterol and triglycerides to evaluate cardiovascular risk) These failures could place residents at risk of not receiving lab services as ordered, not receiving timely diagnosis and treatment, and not receiving appropriate monitoring for certain diseases. Findings include:Record review of Resident #12's face sheet, dated 02/07/25, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted [DATE]. Resident #12 had diagnoses which included stage 4 pressure ulcer (a severe, full-thickness wound extending to exposed muscle, tendon, or bone, often with extensive tunneling or undermining), vitamin d deficiency (occurs when the body lacks sufficient vitamin D, causing fatigue, bone pain, muscle weakness, and mood changes), diabetics (high blood sugars and when your blood sugar is high over a long time, it can damage your internal organs, including your liver), kidney disease (a progressive condition where kidneys are damaged and cannot filter blood properly), and dementia (decline in memory, thinking, and behavior, which impairs daily functioning).Record review of Resident #12's comprehensive care plan, reviewed 04/19/24, reflected Resident #12 was at risk for complications related to diagnosis of Vitamin D Deficiency and at risk for impaired thought process related to liver cirrhosis. The care plan interventions included: labs as ordered, medication as ordered and observe for any complications. Record review of Resident #12's physician's order, dated 07/09/25, reflected: Albumin lab to be drawn monthly, and Prealbumin lab to be drawn biweekly to assist the registered dietitian with nutritional assessment of nutritional needs and pressure wound.Record review of Resident #12's physician's order, dated 07/09/25, reflected: Lipid and Vitamin D level yearly. Record review of Resident #12's electronic medical record did not indicate Resident #12 had a Lipid or Vitamin D level since labs were ordered on 07/09/25.Record review of Resident #12's electronic medical record revealed Resident #12's last Pre-Albumin and Albumin level was drawn on 02/02/26.Record review of Resident #12's comprehensive care plan, revised 03/20/26, reflected Resident #12 was at risk for complications related to wounds. The care plan interventions included: labs as ordered, medication as ordered and observe for any complications.Record review of Resident #12's quarterly MDS, dated [DATE], reflected Resident #12 usually made himself understood and was usually understood by others. Resident #12's BIMS score was 14, which indicated his cognition was intact. Resident #12 required assistance with his activities of daily living. The MDS did not indicate any weight loss.During a phone interview on 4/29/26 at 11:45 a.m., the physician said he expected labs to be done as ordered.He said labs where usually done to check different systems in the body which were important for the well-being of each resident.During an interview on 04/29/26 at 2:29 p.m., LVN W said when labs were ordered the nurses filled out the lab slip and the new order would be placed on the 24-hour report for the nurses to follow up. She said if it was a routine lab the nurses were supposed to check the lab book at the nurse's station daily. She said she was not aware of Resident #12 missing labs any labs. She said failure to follow up on labs could potentially cause the residents to miss a medication or something else they might need.During an interview on 04/29/26 at 3:44 p.m., the DON said he expected labs to be drawn as ordered by the physician order. The DON said he was unaware Residents #12, was missing labs until the state (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor intervention. The DON said the unit manager was responsible for ensuring labs were done as ordered. The DON said failure to monitor ordered labs for Resident #12 could cause his wounds to worsen and further weight loss. The DON said it was noted that there may not be an effective routine lab monitoring process however the process would be reviewed and revamped to monitor for compliance. The DON said it was important to ensure labs were drawn as ordered by the physician to ensure the resident's health had been monitored by those lab values. During an interview on 04/29/26 at 3:58 p.m., the Administrator said he expected labs to be drawn as ordered. He said the nurses were responsible for filling out the lab slip and the lab company was supposed to draw the lab ordered. He said nurse management was responsible for ensuring labs were drawn as ordered. The Administrator said it was important for labs to be drawn as ordered by the physician for the welfare of the resident's health. Record review of the facility's policy titled Laboratory Services, revised 09/02/25, indicated .Purpose: laboratory services will be performed as ordered by the physician.Policy Explanation and Compliance Guidelines: 1. Laboratory services will be ordered by the physician. 2. Laboratory services will be completed on the date specified by the physician or on the next scheduled lab day, if a specific date is not identified.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review the facility failed to ensure menus met the nutritional needs of residents in accordance with established guidelines and ensure menus were followed for 1 of 2 meals (the lunch meal) reviewed for nutritional adequacy. The facility failed to ensure [NAME] B used a #16 scoop to serve the pureed roll on 04/27/2026. The facility failed to ensure the Assistant Dietary Manager served one cup of the regular chicken cacciatore pasta on 04/27/2026. These failures could place residents at risk of weight loss, not having their nutritional needs met, and a decreased quality of life. Findings included: During an observation and interview of the lunch meal in the kitchen on 04/27/2026 starting at 11:22 AM, [NAME] B said she served the lunch meal for the residents who ate lunch in the halls. [NAME] B used a #20 scoop to serve the pureed bread. A size #16 scoop was required. During an observation and interview of the lunch meal in the main dining room on 04/27/2026 at 11:43 AM, the Assistant Dietary Manager said she was using only 1/2 scoops to serve the lunch meal. The Assistant Dietary Manager served 1/2 a cup of chicken cacciatore to the residents in the main dining room. Record review of the extended menu dated Monday, Week 2, Spring/Summer 2026 indicated:Regular 1 cup Chicken Cacciatore PastaPureed one #16 scoop wheat dinner roll. During an interview on 04/28/2026 at 12:28 PM, [NAME] B said when she got ready to serve, she checked the extended menu to see what scoop sized needed to be used. [NAME] B said yesterday (04/27/2026), she did not check the menu because they usually use the same scoop sizes to serve each meal. [NAME] B said the extended menu should be followed, and she did not notice she used the incorrect scoop size to serve the pureed rolls. [NAME] B said the #20 scoop she used was smaller than the #16 scoop. [NAME] B said not using the correct scoop size resulted in them not meeting the requirements for the residents' nutrition and they may not get full if they were not getting enough food. [NAME] B said using a smaller scoop size could result in weight loss. During an interview on 04/28/2026 at 12:42 PM, the Assistant Dietary Manager said when she served the meals, she looked at the extended menu to verify what scoop sizes should be used to serve each meal. The Assistant Dietary Manager said yesterday, 04/27/2026, she did not check the extended menu for the scoop sizes because she was not supposed to serve the lunch meal. The Assistant Dietary Manager said serving less than what was supposed to be served resulted in the residents being underfed and could lead to malnutrition. During an interview on 04/28/2026 at 12:49 PM, the Dietary Manager said when the cooks prepared the food they were supposed to have the extended menu visible because it provided all the information, they needed to ensure they used the correct scoop sizes. The Dietary Manager said he and the Assistant Dietary Manager were responsible for ensuring the staff served the meals using the correct scoop sizes, and they monitored meals to ensure the correct scoop sizes were served. The Dietary Manager said yesterday, 04/27/2026, he did not notice the incorrect scoop sizes were used by [NAME] B and the Assistant Dietary Manager. The Dietary Manager said if the residents were not served using the correct scoop sizes, they would not be getting the correct portions, they received less nutrition, and this could lead to weight loss. During an interview on 04/28/2026 at 3:53 PM, the Administrator said he expected the dietary staff to use the correct scoop sizes. The Administrator said the Dietary Manager was responsible for ensuring the correct scoop sizes were used. The Administrator said not using the correct scoop sizes could lead to weight loss. Record review of the extended menu dated Monday, Week 2, Spring/Summer 2026 indicated:Regular 1 cup Chicken Cacciatore PastaPureed one #16 scoop wheat dinner roll. Record review of the facility's undated policy titled, Accuracy and Quality of Tray Line Service, indicated, Policy: Tray line positions and set up procedures will be planned for efficient and orderly delivery. All meals will be checked for accuracy by the food and nutrition services staff and by the service staff prior to serving the meal to the individual. Procedure: 1. The menu extensions (food items and amounts for each regular or therapeutic diet) should be displayed where the tray line (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff can easily see them. The meal will be checked against the therapeutic diet spread sheet to assure that foods are served as listed on the menu. Each meal tray will be checked for: c. Proper portion sizes.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure therapeutic diets were prescribed by the attending physician for 1 residents (Resident #2) reviewed for health shakes. The facility failed to ensure Resident #2 received his health shake, as ordered by the physician. This failure could place residents at risk of not maintaining adequate nutritional status including unintentional weight loss. Findings include:Record review of Resident #2 face sheet revealed a male who was admitted to the facility 10/22/2024. Resident #2 had diagnoses which included Parkinson's (difficult movement due to decreased brain function; tremors) and dysphagia of the opharyngeal phase (difficult swallowing food from mouth to throat). Record review of Resident #2 comprehensive MDS, dated [DATE], revealed Resident p#2 had a BIMS of 10, which indicated the resident had moderate cognitive impairment. Resident #2 was dependent on assistance with all eating. Resident #2 had weight loss of 5% or more in one month or 10% or more in 6 months and was on physician-prescribed weight loss regime with a diet of mechanically altered diet and therapeutic diet. Record review of Resident #2 care plan last reviewed, dated 3/19/2026, revealed he was care planned for an actual weight loss related to diet change and decreased intake by mouth. The Care plan listed an intervention as diet as ordered. Record review of Resident #2's physician order, dated 3/20/2026, documented a health shake/supplement [mighty health shake with meals for 60 day every day] as part of a therapeutic diet plan for nutritional support. Resident #2 had an order for regular diet, puree texture, and nectar consistency, dated 3/19/2026. Record review of dietary records and meal service documentation did not consistently reflect delivery or intake of the ordered supplement on [4/26/2026] Sunday noon meal.Observation on 4/26/2026 at 11:38 p.m. during meal service revealed Resident #2 did not receive the ordered health shake with the meal tray. No substitute supplement was observed being offered or provided at that time. Meal ticket was observed with health shake listed. Interview on 4/26/2026 at 12:05 p.m., Resident #2 stated they had not received the ordered health shake as part of his lunch meal. Resident #2 stated that sometimes he gets his shake and sometimes he does not. Interview on 4/26/2026 at 12:09 p.m., the Certified Nursing Assistant (CNA) A stated they were unaware the resident had not received the ordered health shake. The CNA stated the Dietary aid was responsible for putting it on the tray and the LVN checked the trays. Interview on 4/26/2026 at 12:12 p.m., the LVN FF stated dietary orders should have been verified and implemented as written, and residents should receive ordered supplements as part of their therapeutic diet plan. The LVN FF stated she must have missed it when checking the tray. The LVN FF stated Resident #2 was at risk of weight loss. Interview on 4/26/2026 at 12:20 p.m., the Dietary Aid stated the resident had a therapeutic order for a health shake; however, the order was not reflected on the meal delivery tray because she had forgotten to put it on the tray.Interview on 4/26/2026 at 12:23 p.m., the Dietary Manager stated the resident had a therapeutic order for a health shake; however, the shake was forgotten and the dietary aid was responsible for putting it on the tray. The dietary manger stated they were supposed to follow the dietary meal tickets. Interview on 4/29/2026 at 12:45 p.m., the D Unit RN Supervisor stated she expected for Resident #2 to receive his prescribed health shake to prevent weight loss. The RN Supervisor stated the RN on duty was responsible, but she also was responsible because she was in attendance of mealtime for observation of meal tickets. Interview on 4/29/2026 at 3:45 p.m., the DON stated he expected diets to be provided as ordered. The DON stated Resident #2 was prescribed the health shake for weight loss and he was at risk of more weight loss. Interview on 4/29/2026 at 3:50 p.m., the Administrator stated he expected Resident #2 received his health shake with meals. The Administrator stated Resident #2 was at risk of weight loss and clinical decline. The Administrator stated the kitchen staff were responsible for putting the health shake on the tray with each meal, the RN was responsible for checking the trays, and the CNA who assisted (continued on next page)

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	675873	A. Building B. Wing	04/29/2026

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

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with meals were all responsible for ensuring Resident #2 received his health shake with each meal. Record review of the Therapeutic Deits policy, dated 2023, revealed diets will be offered as ordered by the physician.

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide specialized rehabilitative services such as but not limited to physical therapy, speech therapy-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity, as required in the resident's comprehensive plan of care for 1 of 7 residents (Resident #67) reviewed for specialized rehabilitative services. The facility did not ensure Resident #67 received physical therapy after a therapy screening on 03/11/26. This deficient practice could place residents at risk of a decline or decrease in their physical capabilities. Findings include: Record review of Resident #67's face sheet, dated 04/29/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #67 had a diagnosis which included repeated falls. Record review of Resident #67's significant change of status MDS assessment, dated 02/27/26, reflected Resident #67 made himself understood and understood others. Resident #67 had a BIMS score of 13, which reflected his cognition was intact. Resident #67 used a wheelchair, was independent with all self-care abilities and mobility. Resident #67 did not receive any therapy services for at least 15 minutes a day on or more days in the last 7 days. Record review of Resident #67's, undated, comprehensive care plan, reflected Resident #67 was at risk for injury (falls) related to history of falls. The care plan intervention included provide assistance with mobility as needed. Resident #67 was at risk for impaired mobility related to bone density and structure. The care plan interventions included therapy screened as indicated. Record review of Resident #67's therapy post fall screen, dated, 03/11/26 reflected Resident #67 had a fall on 03/10/26 and PT was recommended. Record review of Resident #67's therapy post fall screen, dated, 03/23/26 reflected Resident #67 had a fall on 03/20/26 and PT was recommended. Record review of Resident #67's order summary report, dated 04/29/26, reflected an active physician order for PT/OT/ST screen as needed with a start date 01/30/26. During an interview on 04/26/26 at 1:58 p.m., Resident #67 stated he had been at the facility for two weeks and therapy has not started. During an interview on 04/28/26 at 10:00 a.m. the DOR stated Resident #67 had a Fall on 03/10/26 and was screened on 03/11/26 with recommendations for physical therapy. The DOR stated she called and left a message for Resident #67 regarding the copay assistance. The DOR stated, I dropped the ball and did not follow back up. The DOR stated she was not informed by any of the nursing staff Resident #67 had a decline since the last fall on 03/23/26. The DOR stated it was important residents received therapy services to meet their needs and prevent a decline in ADLs. During an interview on 04/29/26 at 10:24 a.m., CNA N stated Resident #67 had not mentioned therapy services to her. CNA N stated Resident #67 ambulated with a wheelchair and had not had a decline in his ADLs since his last two falls. During a telephone interview on 04/29/26 at 10:46 a.m., Resident #67's family member stated she mentioned therapy services to the Director of admission when Resident #67 first was admitted but she never heard anything back. Resident #67's family member stated she would pay the copay for him to receive therapy services. Resident #67's family member stated she had not noticed a decline since his falls. During an interview on 04/29/26 at 10:54 a.m., the Director of admission stated Resident #67's family member had mentioned she would like some form of therapy when he was first admitted . The Director of admission stated she had taken her PT EE to have him explain the process. The Director of admission stated it was important for residents to receive therapy services to maintain the quality of life and prevent limited mobility. During an interview on 04/29/26 at 11:06 p.m., PT EE stated he did not recall having a conversation with Resident #67's family member about Resident #67 receiving therapy services. PT EE stated he had been waiting on the approval from the DOR to start services. PT EE stated it was important to ensure residents received therapy services to address change in function and retire any loss of function. During an interview on 04/29/26 at 2:03 p.m., Unit Manager S stated Resident #67 ambulated with a wheelchair and required one-person assistance. Unit Manager S (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #67 had not mentioned therapy to her. Unit Manager S stated she had not noticed a decline since the falls. Unit Manager S stated it was important to ensure residents received therapy services to help with muscle strengthening and transfer safety. During an interview on 04/29/26 at 3:15 p.m., the DON stated he expected all services to be available to Resident #67 as requested. The DON stated he expected the DOR to follow up for completion of resident desire pertaining to receiving therapy. The DON stated he had not noticed a decline since his fall. The DON stated it was important residents received therapy to prevent the possibility of decline in abilities. During an interview on 04/29/26 at 4:17 p.m., the Administrator stated he was informed today (04/29/26) by the DOR Resident #67 was not on rehab services. The Administrator stated he expected the DOR to contact Resident #67's family to confirm whether they approved of the copay. The Administrator stated therapy services were brought up for Resident #67 after each fall during morning meetings. The Administrator stated the DOR stated she would consult with the family to get approval for him to start therapy, but he did not follow up to ensure the family was contacted. The Administrator stated it was important for residents to receive therapy to maintain the highest level of independence. Record review of the facility's policy Rehabilitation Services-Texas, dated 08/2021, reflected .Therapy services will be available to assist residents with maintaining their maximum level of independence and enhance quality of life. Therapy may be beneficial for ambulation, activities of daily living (ADLs), positioning, joint range of motion, etc. The community will have therapy services, in the form of physical therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST), available to residents who meet criteria and may benefit from services. 1. Residents will be screened upon admission and as needed to determine if therapy services may be of benefit.3. Residents and/or the resident representative will be involved in the therapy plan.

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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 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 2 of 7 residents (Resident #73 and Resident #86) reviewed for infection control.1.The facility failed to ensure LVN E wore PPE (gown and mask) while performing a blood sugar check on Resident #73 on 04/28/26, who was on droplet precautions (Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions).2.The facility failed to ensure CNA CC and Nurse DD performed proper glove changes while providing incontinent care to Resident #86 on 4/27/2026.These failures could place residents at risk for cross-contamination and the spread of infection.Finding include:1. Record review of Resident #73's face sheet, dated 04/29/26, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted [DATE]. Resident #73 had diagnoses which included Myelodysplastic syndromes also known as MDS (a group of blood cancers occurring when immature blood cells in the bone marrow do not mature properly, resulting in low blood cell counts such as anemia, infections, bleeding), pancytopenia (a blood condition where all three major blood cell types [red cells, white cells, and platelets] are abnormally low, leading to symptoms like anemia, infection risk, and bleeding), and Iron deficiency anemia (a common, treatable blood disorder where low iron levels prevent the body from producing enough hemoglobin to carry oxygen).Record review of Resident #73's physician order, dated 01/21/26, indicated droplet precautions related to white blood count of 1.8 every shift.Record review of Resident #73's comprehensive care plan, dated 01/22/26, indicated Resident #73 had droplet precautions related to low white blood count (indicates a weakened immune system, raising the risk of infection) results. The intervention was for staff to follow droplet precautions as indicated. Record review of Resident #73's quarterly MDS assessment, dated 04/03/26, indicated Resident #73 understood and was understood by others. Resident #73's BIMS score was 15, which indicated his cognition was intact. Resident #73 was independent with his daily activities. The MDS did not indicate isolation.During an observation and interview on 04/26/26 at 12:36 p.m., Resident #73 had a droplet sign on his door and a cart outside his door which contained gloves, gowns and mask. He said he was on droplet precautions because he had a low white blood count and was anemic. He said staff had been wearing a gown and mask while in his room.During an observation on 04/28/26 at 4:30 p.m., LVN E was in Resident #73's room taking his blood sugar. LVN E had gloves on but did not have a gown or mask on. During an interview on 04/28/26 at 4:35 p.m., LVN E said she did not know if she was supposed to wear anything in Resident #73's room. She went back and looked at Resident #73's door and said she was supposed to wear gown, gloves, and a mask. She said she was not aware and did not see the sign on his door. She said failure to wear the correct PPE could cause the resident to be transmitted something that could worsen his condition. She said they had in-services on PPE in the past.During an interview on 04/29/26 at 3:58 p.m., the DON said he expected staff to wear PPE such as goggles, gloves, gown, and face mask while in Resident #73's room. He said he expected the unit managers, the ADON and himself to ensure staff were following the droplet precautions. He said if the staff were not following the droplet precautions it placed Resident #73 at risk of infection.During an interview on 04/29/26 at 3:58 p.m., the Administrator said he expected all staff to wear face masks, gowns, and gloves while in Resident #73's room or performing care. He said the unit managers, DON and himself were responsible for ensuring staff wore the proper PPE while in Resident #73's room. He said they had a skills fair in March 2026 where they went over PPE and said staff should also be aware of the signs on the resident's door and or over the resident's bed. He said if staff were not wearing proper PPE, they could contaminate Resident #73 or cause him to become sick. 2. Record review of Resident #86's face (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheet, dated 04/29/26, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #86 had a diagnosis which included hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction (the death of brain tissue due to a blockage in blood flow, leading to oxygen and nutrient deprivation) affecting left dominant side and irritant contact dermatitis due to fecal, urinary or dual incontinence (localized inflammatory skin reaction caused by direct contact with substances or environmental factors that damage the skin barrier). Record review of Resident #86's annual MDS assessment, dated 12/03/25, indicated he was understood by others and understood others. Resident #86 had a BIMS score of 13, which indicated his cognition was considered intact. Resident #86 was dependent for functional abilities which included personal hygiene, putting on/ taking off footwear, lower body dressing, upper body dressing, shower/bathing, and toileting hygiene. Resident #86 was at risk for developing pressure ulcers/injuries. Record review of Resident #86's care plan, revised 03/07/26, indicated he was at risk for skin breakdown related to fragile skin, incontinence of bowel and bladder, and impaired mobility. During an observation and interview on 04/27/26 at 12:30 p.m. revealed CNA CC and Nurse DD provided incontinent care for Resident #86. CNA CC performed hand hygiene and donned gloves. CNA CC unfastened Resident #86's dirty brief, assisted the resident as he rolled onto his side, then CNA CC got a wipe from the package, and wiped the resident's backside. CNA CC placed the dirty wipe into the trash bag and touched Resident #86's pillow and call light cord to move them out of the way, with the dirty gloves. Nurse DD entered to assist and donned gloves without performing hand hygiene. Nurse DD helped hold Resident #86 on his side as CNA CC continued with incontinent care. CNA CC continued to clean Resident #86 using multiple wipes and not changing gloves. CNA CC grabbed the clean brief with the dirty gloves and replaced the dirty brief with the clean one. Nurse DD placed it in the trash bag. Nurse DD arranged Resident #86's blanket back over Resident #86 with the dirty gloves. CNA CC stated she should have changed her gloves when going from dirty to clean. She stated she should not touch the resident's pillow or call light cord without first removing the dirty gloves and performing hand hygiene. CNA CC stated it was important to perform proper hand hygiene to prevent the spread of infection and cross contamination for safety of the resident and for ourselves. Nurse DD stated she forgot to perform hand hygiene because Resident #86 got impatient and she was in a hurry to help. Nurse DD stated she was intimidated by the state surveyors. She stated performing proper hand hygiene was important to prevent the spread of infection. During an interview on 04/29/26 at 2:50 p.m., the DON stated oversight for incontinent care was done with random checks, but did not say by whom. The DON stated the expectation was staff would follow proper protocol and procedures. He stated it was important to avoid possible infection and cross contamination. During an interview on 04/29/26 at 3:10 p.m., the Administrator stated regular in-services and annual skills check offs were performed. The Administrator stated the expectation was for those providing patient care, proper hand hygiene was always practiced. He stated it was important to practice proper hand hygiene to keep residents safe and healthy, and to prevent the spread of infection. Record review of the facility's policy titled, Droplet Precautions, dated 04/25, indicated, Purpose: To provide an environment that protects against droplet disease transmission and is safe for the health care worker. It is the policy of this facility to comply with CDC standards related to infection control practices for the residents requiring droplet precautions. Policy Expectations and Compliance Guidelines: Droplet precautions shall be used in addition to standard precautions for residents. #1 Gloves and handwashing: perform hand hygiene before entering the room [ROOM NUMBER] gloves should be worn when entering the room and while providing care.#4 gloves should be removed before leaving the room and hands should be washed. #5 gowns should be worn by staff upon entering the resident's room and discarded prior to exiting. #6 Eye protection and/or face Shields should be worn upon entering the resident's room and removed prior to exiting the room. #8 a mask should be worn upon entering the resident's room and removed prior to exiting the room.Record review of the policy titled, Incontinent/ Perineal Care, revised on 09/2/25, stated in a step by step process the guidelines for performing care. The steps (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included:* Washing hands prior to applying gloves to begin care* Removing gloves, washing hands, and applying clean gloves after cleaning the soiled resident * Removing gloves, washing hands, and applying clean gloves after applying barrier cream* Removing gloves, washing hands, and applying new gloves to apply clean brief* Removing gloves, washing hands after exiting room and disposing of supplies and linen.