

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Ussery Roan Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Tascosa Rd Amarillo, TX 79124	
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 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. Based on observation, interview, and record review, the facility failed to provide or obtain pharmaceutical services to meet the needs of its residents for 3 out of 4 medication carts (Hall 400, Hall 500, and Hall 600 Medication Carts) reviewed. The facility failed to complete mandatory daily quality control (QC) checks on glucometers to ensure accurate diagnostic readings for 3 out of 4 medication carts (Hall 400, Hall 500, and Hall 600 Medication Carts) from December 1st, 2025 to July 27th, 2026 on night shift. This failure could place residents at risk for severe medication errors, inappropriate dosing, and serious injury or hospitalization. Findings included: During a record review on 07/28/2026 at 12:05 PM, it was noted that glucometer control logs for Hall 400 and Hall 500 medication carts were missing information. The missing information spanned a period from December 2025 through July 2026. Missing dates for Hall 400 glucometer logs included December 12th, 17th, 18th, 19th, 21st, 23rd, and 31st of 2025, January 3rd, 4th, 11th, 13th, 14th, 15th, 16th, 18th, 19th, 20th, 22nd, 24th, 28th, and 31st of 2026, February 1st, 2nd, 3rd, 10th, 12th, 17th, 18th, 19th, 20th, 25th, 27th, and 28th of 2026, March 2nd, and 31st of 2026, April 24th and 27th of 2026, May 4th, 8th, 9th, 11th, 12th, 13th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 24th, 25th, 26th, 27th, 29th, 30th, and 31st of 2026, June 1st, 9th, and 10th of 2026, and July 2nd, 3rd, 13th, 14th, and 22nd of 2026. Missing dates for Hall 500 glucometer logs included January 5th, 6th, 14th, 15th, and 21st of 2026, February 6th, 7th, and 8th of 2026, April 3rd, 4th, 5th, and 18th of 2026, May 3rd and 17th of 2026, June 5th, 14th, 21st, and 28th of 2026, and July 1st, 2nd, 11th, 12th, and 13th of 2026. During an interview on 07/28/2026 at 12:05 PM, LVN F stated that glucometers should be checked every night shift. She stated that the preceptor training the employee or new staff oversaw training them how to complete the QC checks. During a record review on 07/29/2026 at 8:55 AM, glucometer control logs were checked for the Hall 800 medication cart, which revealed that logs for March 2026 through July 2026 were present, though all available logs were completed. During a record review on 07/29/2026 at 9:00 AM, glucometer control logs were checked for the Hall 600 medication cart for dates including December 2025 through July 2026. It was noted that glucometer control logs for Hall 600 medication cart were missing information. The missing information spanned a period from December 2025 through July 2026. Missing dates included December 1st, 4th, and 24th of 2025, February 10th, 14th, 15th, 16th, 19th, and 28th of 2026, March 2nd, 5th, 6th, 10th, 15th, 16th, 19th, 23rd, 24th, 27th, 28th, 29th, 30th, and 31st of 2026, April 13th and 17th of 2026, May 13th of 2026, June 2nd and 15th of 2026, and July 3rd, 4th, 5th, 17th, and 18th of 2026. During an interview on 07/29/2026 at 9:00 AM, LVN E stated that glucometers should be checked every night shift. LVN E stated that a negative outcome for not checking the glucometers every night could be getting a resident's blood sugar reading that was not accurate. LVN E stated that a negative outcome to the residents could be giving the wrong dose of insulin, which could lead to a blood sugar that was too high or too low. LVN E further stated (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that the preceptor training new staff oversaw training them on QC checks, and that the Unit Manager oversaw to ensure they were completed. During an interview on 07/29/2026 at 9:05 AM, RN P revealed that glucometers should be checked every night shift. RN R stated that a negative outcome for not checking the glucometers every night could be getting a false reading. RN R stated that a negative outcome to the resident could be that the residents receive insulin they may or may not need, which could lead to low blood sugar, hospitalization, and serious injury. During an interview on 07/29/2026 at 9:10 AM, LVN F revealed that glucometers should be checked every night shift. LVN F stated that a negative outcome for not checking the glucometers every night was getting a blood sugar reading that was off, resulting in too much or too little insulin. LVN F stated that a negative outcome to the resident could be having hypoglycemia or going into DKA and being hospitalized. LVN F further stated that Unit Manager LVN N oversaw ensuring it was completed. During an interview on 07/29/2026 at 1:14 PM, the ADON revealed that glucometers should be checked every night shift by the nurse. The ADON stated that preceptors training new employees should be training staff how to do this and that it needs to be done. The ADON confirmed that a negative outcome for not completing these checks was false readings that could affect the resident's blood sugar results, which could result in giving too much or too little insulin, leading to hypoglycemia and hospitalization. During an interview on 07/29/2026 at 2:15 PM, Unit Manager (RN M) (for Halls 600 and 800), revealed that glucometers should be checked every night shift by the nurse. RN M stated that preceptors training new employees should be training staff in how to do this and that it needs to be done. RN M confirmed that a negative outcome for not completing these checks was false readings that could affect the resident's blood sugar readings, resulting in too much or too little insulin, which could lead to hypoglycemia. Requested additional logs for Hall 800. RN M stated she did not know where they were. During an interview on 07/29/2026 at 2:30 PM, Unit Manager LVN N revealed that glucometers should be checked every night shift by the nurse. LVN N stated that preceptors training new employees should be training staff in how to do this and that it needs to be done. LVN N confirmed that a negative outcome for not completing these checks was false readings that could affect blood sugar readings, resulting in too much or too little insulin. LVN N further stated that the RN house supervisor should be verifying that these checks were completed. Record review of the facility's policy titled Glucometer Use and Cleaning (dated March 2019) revealed the following directive: Follow the manufacturers' directions and recommendations for glucometer use and cleaning. Record review of the manufacturer's guidelines for the Assure Platinum glucometers, which the facility utilized on 4 out of 4 medication carts, revealed that quality control (QC) checks should be completed every 24 hours. The guidelines noted that while there was a bypass to not complete these checks, it was the strict recommendation to complete them every 24 hours.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record review, the facility failed to ensure current daily Menus were posted for residents in 1 of 1 kitchen/dining area (locked unit). The facility failed to update the posted daily menus for 4 consecutive days for residents who resided on the locked unit. This failure could place residents at risk of not knowing the meals scheduled to be served and contributing to confusion and frustration when the posted menu did not match the food provided. Findings included: During an observation on 07/28/26 at 9:12 AM, the posted menu in the locked unit dining area reflected Saturday, July 25, 2026, indicating residents would be served ham for lunch. During an observation on 07/28/26 at 11:48 AM, the posted menu remained unchanged and continued to display the menu for Saturday, July 25, 2026. During an observation on 07/29/26 at 8:40 AM, the posted menu still reflected Saturday, July 25th, 2026, rather than the current day's menu. During an interview on 07/29/26 at 10:05 AM, CNA D observed the posted menu and stated it did not reflect the correct day's menu and should have displayed Wednesday's menu. CNA D stated that if menus were not updated daily, residents would not know what meals were being served. During an interview on 07/26/26 at 10:10 AM, LVN E, the charge nurse for the locked unit, she confirmed the posted menu remained on Saturday's menu instead of the current day's menu. She stated residents had become frustrated because they expected to receive ham, as reflected on the posted menu, and residents on the locked unit could become fixated on the menu and upset when the meal served did not match what was posted. LVN E stated it was the dietary department's responsibility to ensure menus were changed daily. During an interview on 07/29/26 at 10:13 AM, AA Q stated the menu should reflect the correct day and confirmed the kitchen was responsible for updating menus daily. She stated that if menus were not changed, residents would not know what meal choices were available that day. During a confidential interview with an anonymous resident stated the outdated menus were bothersome because they did not know what would be served for lunch. During an interview on 07/29/26 at 3:19 PM, the DM stated it was the dietary department's responsibility to update menus daily and acknowledged she was unaware the locked unit menus had not been changed since Saturday. The DM stated staff were typically consistent about updating menus but acknowledged a mistake had occurred. She stated residents could become upset if they expected a meal listed on the menu but were served something different. During an interview on 07/29/26 at 10:22 AM, the ADM stated dietary staff were responsible for posting updated menus each morning in accordance with facility policy and acknowledged the locked unit menu not being changed since Saturday was an issue. He stated that residents relied on the posted menu and expected to receive the meal listed. The ADM stated when the meal served differed from the posted menu, residents could become unhappy and stressed because they had anticipated receiving a different meal. Record review of the Facility Menu, dated Spring/Summer 2026, Tuesday, Week 5 reflected lunch menu would be meatloaf with brown gravy, mashed potatoes, mixed vegetables, and wheat roll. Record review of Facility policy titled, Menu Planning, dated 2023, revealed the following information in part: 1. All current menus will be posted during the appropriate time period. 5. Menus will be posted in areas that are accessible to patients/residents and at a height where all individuals can easily view them.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for food safety. The facility failed to ensure freezer, refrigerator, and pantry items were properly stored, labeled, and dated. This failure could place residents at risk of food-borne illnesses. Findings included: Observation of the prep area in the kitchen on 07/28/26 at 8:07 AM revealed the following: 1. (1) clear plastic bin full of individual creamers, not dated. 2. (3) bags of bread - not labeled or dated. 3. (1) clear plastic bin, 1/2 full, contained white substance, not labeled or dated. Observation of the pantry on 07/14/26 at 8:09 AM revealed the following: 1. (1) large bin with lid, full of individual snacks, not labeled or dated. 2. (3) bags of chips, not dated. 3. (2) bags of cereal, half empty, not labeled or dated. 4. (2) bags of marshmallow, not dated. 5. (5) boxes of cream of wheat, not dated. 6. (9) containers of grits, not dated. 7. (6) containers of oats, not dated. Observation of the freezer on 07/28/26 at 8:15 AM revealed the following: 1. (4) meat patties, not labeled or dated. 2. (2) bags of shrimp, not labeled or dated. 3. (1) opened box of shrimp, not labeled or dated. 4. (1) tray of frozen biscuits, not labeled or dated. 5. (1) [NAME] cake covered with plastic wrap, not labeled or dated. 6. (7) individual ice creams, not labeled or dated. 7. (1) tray of cobbler, not labeled or dated. 8. (1) box with undetermined items inside, not labeled or dated. Observation of the refrigerator on 07/28/26 at 8:19 AM revealed the following: 1. (1) tray of uncovered eggs, not labeled or dated. 2. (1) gallon of milk, 1/4 full, not dated. 3. (3) cups of covered glasses with liquid that appeared to be either tea or juice, lids were not labeled or dated. 4. (2) trays containing individual cartons of health shakes, not dated. In an interview on 07/28/26 at 8:25 AM, [NAME] A stated she had worked at the facility for four months and was trained to label and date food when they were delivered from the truck and any leftover food as well. She stated it was everyone's responsibility to label and date the food in the kitchen. [NAME] A stated if that did not happen, they could serve expired food which could make residents sick. In an interview on 07/28/26 at 8:26 AM, [NAME] B stated she had worked at the facility for four weeks and was trained to label and date all food in the kitchen. She stated that everyone who worked in the kitchen was responsible for labeling and dating food. [NAME] B stated that if it did not happen, residents could get food poisoning or consume spoiled food. In an interview on 07/28/26 at 8:28 AM, [NAME] C stated it was everyone's responsibility to label and date food, and she was trained to do that. She stated the kitchen could serve spoiled food to residents if food was not labeled and dated properly, which could make residents sick. In an interview on 07/28/26 at 8:31 AM, the DM stated she had worked at the facility for over a year as the DM and it was everyone's responsibility to label and date all food in the kitchen. The DM stated not labeling and dating food could put residents at risk of foodborne illnesses and the kitchen could cause an outbreak if the food being served from the kitchen was not served during the proper time. Record review of facility policy, titled General Food Preparation and Handling, dated 2023 revealed the following information in part: 4. Food Service d. Leftovers must be dated, labeled, covered, cooled and stored in a refrigerator. Record review of facility policy titled, Food Storage, dated June 2019, revealed the following in part: 1. Dry Storage Rooms. d. All containers must be labeled and dated. 2. Refrigerators. d. Date, label and tightly seal all refrigerated foods. 3. Freezer. e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated.		

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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 care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #52) of 25 residents reviewed for resident rights. Urine was observed in Resident #52's catheter bag during the noon meal in the dining room on 7/28/26 because no privacy bag was provided to cover his catheter bag. This failure could place residents at risk of feeling uncomfortable and disrespected, leading to isolation. Findings included: Record review of Resident #52's face sheet printed 6/11/26 revealed he was an [AGE] year-old male resident admitted [DATE] with diagnoses to include hemiplegia (a condition characterized by severe or complete paralysis on one side of the body, typically resulting from brain damage), obstructive and reflux uropathy (a blockage that stops urine from flowing normally through the body, while reflux uropathy was kidney damage caused by urine flowing backwards from the bladder), and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that commonly affects men as they age, often causing bothersome urinary symptoms). Record review of Resident #52's annual MDS assessment completed 5/28/26 listed Resident #52 with a BIMS of 4 indicating he was severely cognitively impaired, he had a functionality of being dependent on staff for his toileting hygiene, and he required an indwelling catheter. Record review of Resident #52's care plan with admission date of 8/27/24 revealed the following: Focus - Resident has an indwelling catheter r/t obstructive uropathy. Date Initiated: 08/30/2024. Record review of Resident #52's Order Summary Report printed 7/28/26 with Active Orders As Of: 7/28/26 revealed the following order:- Foley catheter care with perineal (an anatomical adjective that means relating to the perineum-the diamond-shaped area of the soft tissue located at the bottom of the pelvis between the thighs) wipes and/or soap and water Q SHIFT and PRN- schedule . Active 10/14/2024. During an observation on 07/28/2026 at 11:46 AM Resident #52 was in the dining room sitting by the front entrance in a Geri-chair (a specialized padded medical recliner with wheels designed for elderly patients or individuals with limited mobility) with approximately 40 residents and 7 staff present in the dining room. Resident #52's catheter bag was hanging from under his Geri-Chair in view of the dining room. A small amount of amber urine was observed in the catheter bag. Eleven residents could be observed seated at three tables located in front of Resident #52 that could observe the uncovered catheter bag while eating their meal. This surveyor attempted to interview Resident #52, and he did not respond to introduction or any questions. Resident #52 just stared blankly. During an interview and observation on 07/28/2026 at 12:28 PM CNA G (a CNA working the hallway Resident #52 was located on this shift) was asked to go to the dining room and evaluated Resident #52's current condition. CNA G observed the catheter was hanging from the foot of Resident #52's Geri-Chair in view of the dining room and stated, they must have replaced it (Resident #52's catheter bag) yesterday because it was usually in a privacy bag. I bet they forgot to cover it. CNA G reported this was an issue because other people could see the urine in the bag and it could be a dignity issue for Resident #52. CNA G reported she would immediately get Resident #52 a privacy bag and make sure his catheter bag was covered. CNA G reported she was not the CNA that got Resident #52 up for the noon meal. During an observation and attempted interview on 07/30/2026 at 9:22 AM Resident #52 was observed in his bed sleeping and did not wake. His catheter bag could be observed hanging from the left side of his bed between the bed and wall with no privacy bag. The bag could not be observed from the hallway or in the room. During an interview on (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/30/2026 at 9:58 AM CNA H (the CNA working on the hall Resident #52 was on this shift) reported a resident's catheter should be stored in a privacy bag off the floor with a cover. CNA H reported if a resident's catheter bag was exposed it could affect the resident and it could affect other residents especially when they were eating. CNA H reported she was not sure when the last time she was trained on catheter care that she just knew what to do, and that it had been maybe 6 months since the last time they were trained by the facility on catheter care. During an interview on 07/30/2026 at 10:03 AM LVN F (the nurse working on the hall Resident #52 was on this shift) reported a resident's catheter bag should be stored in a privacy bag and if the catheter bag was not stored in a privacy bag and that resident was in the hallway or the dining room then you have the eww factor and other residents might not like that. LVN F could not remember when the last training on catheter care was provided by the facility. During an interview on 07/30/2026 at 10:11 AM the DON reported all catheters should be stored in a privacy bag and if they were not, it would be a dignity issue affecting the resident with the catheter and if another resident saw it they might not react well. The DON reported the facility's staff development coordinator who was responsible for all staff training. During an interview on 07/30/2026 at 10:33 AM the SDC reported she trained all staff and all catheters should have a leaf cover or be in a blue bag. The SDC reported that if the resident's catheter bag was not stored in a blue bag and the bag touched the floor then it was an infection control issue. The SDC reported if residents saw discolored urine such as red with blood, then it would probably bother them. Record review of the training titled Foley Catheter Drainage Bag Safety In-Service dated 3/13/26, revealed the following: Policy Statement: All Foley Catheter drainage bags must be placed inside a designated black catheter bag holder and must remain off the floor at all times. Noted this training had been provided to 44 staff and CNA G, CNA H and LVN F did not receive the training. Record review of facility provided policy titled, Resident Rights - Statement of Resident Rights undated, revealed the following: Purpose: The purpose of this policy is to affirm and protect the fundamental rights of all patients/resident receiving care in accordance with federal and state regulations. This policy ensures that all residents are treated with dignity and respect. Record review of the facility policy provided as part of the resident admission packet titled Resident Rights revised February 2020, revealed the following: Resident Rights - The resident has the right to a dignified existence,.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to allow residents privacy of communications sent to the facility by a postal service for 2 of 25 residents reviewed for resident rights (Resident #35 and Resident #108). The facility failed to allow Resident #35 and Resident #108 to receive unopened mail at the facility. This failure could place residents at risk of decreased quality of life, hinder autonomy, and increase symptoms of depression. Findings Included: Resident #35 Record review of Resident #35's face sheet, dated 07/28/2026, revealed a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE]. Resident #35's diagnoses included chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe), hypertension (high blood pressure), age-related physical debility (decline in physical abilities due to age), and cognitive communication deficit (mental processes for communication are disrupted). Face sheet provided a Decision-Making Resident Representative, [name of Resident #35's family member]. Record review of Resident #35's Annual MDS Assessment, dated 06/25/2026, revealed a BIMS score of 15, indicating Resident #35 was cognitively intact. Record review of Resident #35's care plan, dated 7/5/2026, revealed no focus or intervention related to Resident #35's ability to receive mail in the facility. Resident #108 Record review of Resident #108's face sheet, dated 07/30/2026, revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #108's diagnoses included Type 2 diabetes (chronic condition due to insulin resistance and high blood sugar levels), Parkinsonism (group of movement symptoms found in several conditions), and post-traumatic stress disorder (mental health condition by witnessing or experiencing a traumatic event). Record review of Resident #108's Comprehensive MDS Assessment, dated 07/12/2026, revealed a BIMS score of 14, indicating Resident #108 was cognitively intact. Record review of Resident #108's care plan, dated 07/15/2026, revealed no focus or intervention related to Resident #108's ability to receive mail in the facility. In an interview on 07/28/2026 at 8:49 AM, Resident #108 stated he received a piece of mail opened from the VA regarding an appointment. Resident #108 stated that he knew it was open because it was taped shut. Resident #108 stated that his FM had the envelope that was opened. In an interview on 07/28/2026 at 10:12 AM, AA Q stated that some mail was found in a closet. AA R went into the closet after bingo. AA Q stated that the activities department just completed ANE training. AA Q stated that mail was opened because some of it wasn't appropriate for the resident. AA Q stated she saw some mail in a trashcan and identified it as mail AA R had opened and thrown away. AA Q stated that Resident #35 was not present when mail was opened. AA Q stated that the AD presented a piece of mail for Resident #35 that stated something inappropriate. AA Q stated she notified the VLB, ADM, and DON. AA Q stated the VLB stated the resident must be present when opening mail. AA Q stated AA R stopped opening the resident's mail. AA Q stated a negative outcome of not honoring residents' rights of receiving mail would be residents' stuff should be taken. In an interview on 07/28/2026 at 2:00 PM, Resident #35 stated he received cards that were opened. In an interview on 07/29/2026 at 9:16 AM, AA R stated they did online training and classes once a month for ANE. AA R stated there was some mail that was filtered out as it shouldn't be read to Resident #35. AA R stated the letters they went through were from the school and the classrooms in the area. AA R stated they did not talk to Resident #35 but talked to Resident #35's family member. AA R stated the AD was the person who gave the instructions to sort through the mail and give Resident #35 the cards. AA R stated the policy stated residents have the right to open their own mail. AA R stated Resident #35 was not asked if he wanted the cards opened in front of him or to have them filtered. AA R stated residents have the right (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to open their own mail. AA R stated based off of Resident #35's family member it was appropriate to filter them. AA R stated facility staff should take the direction of the family member. AA R stated a better way was to pull Resident #35 into the room and not read the bad ones. AA R stated a negative outcome of not honoring residents right to receive unopened mail would be depends on what the mail is. Resident #35's rights were violated overall. The way it played out made sense. Resident #35 did receive some mail unopened. AA R stated it was the residents' right to receive the mail unopened. In an interview on 07/29/2026 at 2:36 PM, the FM stated the facility had permission to do everything they did. The FM stated the facility read a bad card and the FM told the facility not to read it to him. The FM stated they did not remember the staff member they spoke with. In an interview on 07/29/2026 at 2:51 PM, the AD stated the VLB requested cards for veterans from the public for Resident #35's 100th birthday. The AD stated they started in May 2026 and AA R was assisting. The AD stated there was a meeting with the staff and stated the cards must be read to him. The AD stated it was the activities department's responsibility to finish reading them. The AD stated there was a box or two with cards in them. The AD stated that some of the cards were opened but cannot confirm they were all sealed. The AD stated that Resident #35 had a right to all the cards and believed he had the right to read or hear the cards or not. The AD stated Resident #35 has not read the card that was inappropriate, but it was sitting on AD's desk. The AD stated that it was determined for him that he would not read the card. The AD stated a negative outcome for violating resident rights where the resident could take it personally and feel bad. In an interview on 07/29/2026 at 3:35 PM, the ADM stated the letters were found after a long time. The ADM stated the boxes were taken to Resident #35 and read to him. The ADM stated it was two boxes and they had to open the boxes to see what the letters were. The ADM stated he was unaware if Resident #35 was asked about opening mail and reading it to him. The ADM stated he had not talked to the FM. The ADM stated Resident #35 should have made the decision to read the cards and it should be his choice to read some cards or not. The ADM stated one card was filtered out and Resident #35 should have been able to say one way or the other. The ADM stated Resident #35 was [AGE] years old but could still make his own decisions. The ADM stated a negative outcome for residents' receiving opened mail was that people knew stuff was sent to them and they knew information that the resident may not want them to know. In an interview on 07/30/2026 at 9:24 AM, Resident #108 stated his mail was opened and didn't notice until Resident #108 had seen it was taped. Resident #108 stated that was the only piece of mail he received since being admitted to the facility. Resident #108 stated that no one was supposed to open mail without permission. In an observation and interview on 07/30/2026 at 9:34 AM, FM stated she still had the opened envelope for Resident #108. FM provided an envelope that was opened on the left side with a smooth cut and frayed edges that appeared it was opened by a letter opener and taped. FM stated they didn't know why it was delivered opened. Observation indicated the opened envelope was post-marked dated 07/15/2026. In an interview on 07/30/2026 at 9:39 AM, the REC stated that she and the security guard handled mail. The REC stated that she sorted the mail and the security guard delivered it. The REC stated she was given instructions that service-connected people did not get their mail. The REC stated that she sorted the mail when it was received and then sent it to the family of the residents and kept what corporate paid for. The REC stated the mail arrived addressed in the resident's name or the name of the facility. The REC stated they were opened and then sent to the corporate office. The REC stated that residents have the right to receive mail unopened. The REC was provided with open mail for Resident #108 and stated she did not understand why it was opened. The REC stated a negative outcome could be some residents could not pay their own bills. Record review of an in-service titled, Resident Rights, Cleaning Surfaces, Medication Errors, New (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Ussery Roan Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 Tascosa Rd Amarillo, TX 79124	
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Admits/Readmits, instructed by the DON, dated 02/17/2026 and 02/18/2026, revealed the REC completed the training. Record review of [name of facility corporate] Resident Rights policy, dated October 2012, reflected, , Policy Explanation and Compliance Guidelines: 4.: Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time. Record review of Nursing Facility Resident Rights, provided by Texas Long-Term Care Ombudsman, dated November 2021, reflected, Privacy and Confidentiality: Send and receive unopened mail and to receive help in reading or writing correspondence. Record review of document titled [name of facility] Resident Mail Rights, Privacy, and Staff Assistance, dated 07/14/2026, revealed a purpose statement of, All Veterans retain the right to receive personal correspondence unopened unless they voluntarily request assistance or have otherwise authorized assistance in accordance with their wishes and facility policy. Resident Rights: Every Veteran has the right to: receive mail unopened and privacy in written communications. Prohibited Conduct:, staff shall not: remove, retain, conceal, destroy, or discard personal correspondence contrary to the Veteran's wishes. AA R signed the document on 07/14/2026. Record review of policy titled, Resident Rights, dated February 2020, stated under heading, Resident Rights, 1., Resident rights: The resident has the right to a dignified existence, self-determination, and communication with an access to persons and services inside and outside of the facility. 7.- Information and Communication: The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility- i.: The resident has the right to send and receive unopened mail and to receive letters, packages and other materials delivered to the facility for the resident through a mean other than a postal service, including the right to: l- Privacy of such communication consistent with this section. 8. Privacy and Confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal and medical records- a.: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups but this does not require the facility to provide a private room for each resident.		

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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 an assessment accurately reflected a resident's status for 1 of 25 residents (Resident #4) reviewed for accuracy of assessments. The facility failed to accurately code Resident #4's MDS assessment by incorrectly identifying the resident as receiving dialysis while being a resident in the facility. This failure could place residents at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Findings included: Record review of Resident #4's admission record, dated 07/28/2026, revealed a [AGE] year-old male, admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis (autoimmune disease that affects joints), unspecified, depression (feeling of sadness and atrial fibrillation (irregular heart rhythm)). Record review of Resident #4's quarterly MDS assessment, dated 06/11/2026, revealed he had a BIMS of 15 indicating he was cognitively intact. Further record review of the MDS assessment in Section 0 (Special Treatments, Procedure and Programs) J1 was marked to indicate the resident received dialysis while a resident of the facility within the 14 day look back period. Record review of Resident #4's comprehensive care plan, dated 07/25/2026, revealed no focus areas, goals, or interventions related to dialysis. During an observation and interview on 07/28/2026 at 3:01 PM, Resident #4 was observed sitting in his wheelchair and appeared clean and well groomed. Resident #4 stated he had never received dialysis while residing at the facility or prior to admission. During an interview on 07/29/2026 at 10:58 AM, the ADM stated the MDS Coordinator was responsible for completing the MDS assessments. The ADM stated the Resident Assessment Instrument (RAI) was used as the primary resource when completing the MDS Assessment. The ADM stated a potential negative outcome for documenting inaccurate information on the assessment could result in the residents not receiving care that accurately reflected the residents' needs. During an interview on 07/30/2026 at 8:03 AM, the MDS RN stated she was employed at the facility for approximately 10 months and the information entered into the MDS assessment was based on physician orders and the resident's current clinical status. She stated the RAI Manual served as the primary reference for completing MDS assessments. The MDS RN further stated the MDS Director conducted periodic audits of completed MDS assessments and provided feedback to ensure accuracy. The MDS RN further stated the MDS Director and DON were responsible for oversight of the MDS process ensuring compliance. The MDS RN stated a potential negative outcome of an inaccurate MDS assessment was that a resident care may not be accurately identified or addressed. She stated the MDS assessment for Resident #4 was incorrectly documented that the resident was receiving dialysis and stated the error was likely the result of a data entry mistake since Resident #4 was not receiving dialysis care. The MDS RN said she did not believe the inaccurate MDS assessment affected reimbursement because most residents at the facility were private pay, however, she stated the inaccurate assessment remained a state compliance concern. During an interview on 07/30/2026 at 10:20 AM, the DON stated it was the responsibility of the MDS RN to ensure each MDS assessment accurately reflected the resident's status. The DON stated the MDS Director was responsible for overseeing the MDS process and ensuring assessments were completed accurately but stated she was equally responsible as the DON. The DON further stated that a potential negative outcome of an inaccurate MDS assessment was that the resident's care needs may not be accurately identified or addressed. During an interview on 07/30/2026 at 10:25 AM, the Clinical VP stated it was the responsibility of the MDS RN to ensure each MDS assessment accurately reflected the resident's status. The Clinical VP stated the MDS Director was responsible (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for auditing assessments completed by the MDS RN to ensure their accuracy. The Clinical VP further stated the facility had systems in place to verify the accuracy of MDS assessments but was unsure how the inaccurate MDS assessment for Resident #4 was not identified. The Clinical VP stated a potential negative outcome of an inaccurate MDS assessment was that a resident might be unable to access services and resources for which the resident was eligible. During a telephone interview on 07/30/2026 at 11:11 AM, the MDS Director stated she was responsible for overseeing and auditing MDS assessments completed by the MDS RN. She stated the inaccurate MDS assessment for Resident #4 must have been a data entry error. The MDS Director stated the MDS assessment served as the foundation of the RAI process and that information entered into the MDS generated triggers used to develop the resident's care plan. She stated that if the MDS assessment contained inaccurate information, the care plan could be wrong, and the residents might not receive accurate care for their needs. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025, revealed the following: SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods. O0110J1, Dialysis Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCU, Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0520A (Parenteral/IV), O0110H (IV medications), or O0110I (transfusions). This item may be coded if the residents perform their own dialysis.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance for 1 of 1 resident (Resident #13) reviewed for significant weight loss. The facility failed to ensure that dietary interventions were accurately provided according to the resident's meal ticket preferences, failed to accurately reconcile meal consumption data with active medical records, and failed to report systemic supplement refusals to the Physician and Registered Dietitian (RD) for Resident #13. This failure could place residents at risk for severe malnutrition, skin breakdown, and physiological decline. Findings included: Record review of Resident #13's admission record, undated, revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (memory loss), cerebral infarction (the death of brain tissue caused by a blocked blood vessel), hypertension (high blood pressure), delusional disorders (a mental health condition defined by holding a strong false belief), benign prostatic hyperplasia (an enlargement of the prostate gland causing difficulty in urinating), atrial fibrillation (a heart condition that causes blood to stay in the heart and produce an abnormal heartbeat), anemia in chronic kidney disease (lack of the ability to make red blood cells due to damage within the kidney), presence of cardiac pacemaker (a small electronic device placed under the skin in the upper chest to manage abnormal heart rhythms), generalized muscle weakness, stage 4 kidney disease (severe damage of the kidneys), cognitive communication deficit (a breakdown in communication caused by problems thinking), hypothyroidism (a condition of the thyroid gland where the gland does not produce effect thyroid hormone), vitamin D deficiency (low vitamin D levels), and hearing loss. Record review of Resident #13's quarterly MDS assessment, completed on 05/25/26, revealed a BIMS score of 6 which indicated severely impaired cognition. Section GG (Functional Abilities) revealed Resident #13 was dependent on staff for toileting, bathing, and dressing and required setup or clean-up assistance with eating. Record review of Resident #13's care plan, completed on 05/07/26, revealed he had an ADL self-care performance deficit, required setup or clean-up assistance with eating, and weight loss interventions such as monitoring monthly weights and offering snacks if resident eats less than 50% of meals. During a dining observation on 07/28/2026 at 12:10 PM, Resident #13 was observed struggling to eat meatloaf and could not get the food onto his fork. The resident was observed eating bread without difficulty but appeared visibly frustrated during the meal. During a record review on 07/28/2026 at 2:11 PM, Resident #13's medical record was reviewed and revealed a significant, progressive pattern of weight loss: a 2.04% weight loss in 1 month from June 2nd, 2026 to July 3rd, 2026, a 6.40% weight loss in 3 months from April 6th, 2026 to July 3rd, 2026, and a 13.17% weight loss over a 6-month period from November 1st, 2026 to July 3rd, 2026. During a record review on 07/29/2026 at 11:25 AM, Resident #13's chart showed he was care planned for weight loss, including refusing to eat. The care plan mandated that staff offer alternative foods if the resident consumed less than 50% of meals. Activities of Daily Living (ADL) documentation revealed staff consistently recorded that the resident ate 51% or more of his meals. A review of the Registered Dietitian (RD) progress notes showed the RD saw the resident monthly, with the last visit dated 06/09/2026. To address the significant weight loss, the RD recommended interventions including supplemental health shakes twice daily (BID) with meals, Magic Cups with meals, and an appetite stimulant. The physician ordered health shakes twice daily (BID) at 8:00 AM and 1:00 PM with meals, Magic Cups with meals, and an appetite stimulant. During an observation and record review of the lunch meal on 07/29/2026 at 12:15 PM, Resident #13 was (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed eating his meal and did not appear to be struggling. Staff served the resident a chocolate supplemental shake, which the resident told staff he did not want. Review of the resident's meal ticket revealed a printed preference for a strawberry shake. Staff did not offer a strawberry shake and failed to provide the ordered Magic Cup. During a telephone interview on 07/29/2026 at 1:28 PM, Resident #13's representative, stated he was aware of the resident's weight loss and had no concerns regarding his care. He stated that he and his family participated in Care Plan meetings to discuss the weight loss and that the facility was addressing the issue. He noted that when he sat with the resident during meals, he did not notice any issues with the resident struggling to eat or use utensils. During an observation of the breakfast meal on 07/30/2026 at 7:33 AM, staff failed to provide Resident #13 with either the supplemental health shake or the Magic Cup as printed on his breakfast meal ticket. During an interview on 07/30/2026 at 7:55 AM, House Supervisor RN L revealed that sometimes the resident was offered the shake and Magic Cup, and sometimes he was not because he refused them. RN L stated that she did not report these continuous refusals to anyone else. She stated that a negative outcome of this practice would be the resident failing to gain the weight needed to meet his nutritional demands. During an interview on 07/30/2026 at 8:02 AM, the DM revealed that Resident #13 should be given his supplemental shakes and Magic Cups regardless of whether he was refusing them, due to his severe weight loss history. The DM stated that a negative outcome of skipping these items was continued weight loss. She stated that the kitchen had both strawberry and chocolate shakes fully available in stock at that time. During an interview on 07/30/2026 at 8:40 AM, LVN E revealed that she had worked with Resident #13 and had seen on many occasions that the resident liked the supplemental shakes and drank them. LVN E stated that a negative outcome of the resident not receiving his shakes would be continued weight loss and poor nutrition. During an interview on 07/30/2026 at 8:42 AM, CMA O revealed that Resident #13 liked the health shakes when they were offered to him. CMA O stated that a negative outcome of the resident not getting the shakes was that he would lose more weight. During an interview on 07/30/2026 at 8:50 AM, Unit Manager LVN N (for Halls 400 and 500), stated that she was not aware that staff were failing to give Resident #13 his shakes, nor was she aware that he actually liked them. LVN N stated that floor staff documented on records that they were successfully giving the shakes, and she did not know the resident was refusing them until RN L reported it to her moments prior. She stated that if she had known Resident #13 was not receiving the supplements, she would have reported it to the Physician and Registered Dietitian so they could order alternative interventions for his weight loss. Record review of Resident #13's Medication Administration Record (MAR) revealed documentation, showing that the patient sometimes refused the supplements and sometimes received them. This directly contradicted the ADL meal consumption records and floor observations. Record of the facility's policies for medication administration and physician services (dated July 2025 and November 2025) revealed that the policies mandated that staff must report and document any adverse side effects or medication/supplement refusals. No further policies were provided regarding nutrition, weight loss, and physician orders as requested.		

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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 1 out of 1 resident (Resident #52) observed. The facility failed to ensure that proper personal protective equipment (PPE) was worn during indwelling urinary catheter care by Certified Nursing Assistant (CNA) providing care to Resident #52. This failure could place residents at risk for cross-contamination, colonization of MDROs, and severe urinary tract infections. Findings included: Record review of Resident #52's admission record, revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hemiplegia (partial paralysis or inability to move one side of the body), hemiparesis (muscle weakness or partial inability to move one side of the body) following cerebral infarction (the death of brain tissue caused by a blocked blood vessel), dysphagia (difficulty speaking words), hypothyroidism (a condition of the thyroid gland where the gland does not produce effect thyroid hormone), iron deficiency anemia (a common blood disorder where the iron levels prevent the body from making enough red blood cells) hyperlipemia (too many fats in the blood), depression, and generalized muscle weakness. Record review of Resident #52's quarterly MDS assessment, completed on 06/03/26, revealed a BIMS score of 4 which indicated severely impaired cognition. Section GG (Functional Abilities) revealed Resident #52 was dependent on staff for toileting, bathing, dressing and eating. Record review of Resident #13's care plan, completed on 06/03/26, revealed he had an ADL self-care performance deficit requiring extensive staff assistance and required enhanced barrier precautions indicating that a gown and gloves were to be worn during high contact resident care. During an observation on 07/29/2026 at 1:43 PM, CNA G was observed providing incontinent and urinary catheter care on Resident #52. An Enhanced Barrier Precautions (EBP) sign was noted on the door with PPE stationed outside of the resident's room. CNA G did not apply a gown prior to or during the high-contact care as indicated by the door signage. During a record review on 07/29/2026 at 2:17 PM, the facility policy entitled Infection Prevention and Control (dated April 2025) was reviewed and revealed the following directive: Enhanced Barrier Precautions will be used based upon guidance from CDC, CMS or the state health department. (Refer to the policy titled, Enhanced Barrier Precautions). Enhanced Barrier Precautions policy requested. During an interview on 07/29/2026 at 2:30 PM, Unit Manager, LVN N (for Halls 400 and 500), revealed that when caring for residents with an indwelling urinary catheter, PPE should be worn. LVN N stated a negative outcome of not wearing PPE could cause an infection to the resident and/or other residents, if the urine was infected. During a record review on 07/29/2026 at 3:00 PM, a review of Resident #52's medical records revealed active physician orders for Enhanced Barrier Precautions due to the presence of a Foley catheter started 01/11/2026 and active to this date 07/29/2026. During an interview on 07/30/2026 at 8:22 AM, CNA K revealed that they had been working at the facility since April of 2026. CNA K stated that only gloves needed to be worn when providing indwelling urinary catheter care. CNA K further stated that not all residents on Foley care needed EBP per training received from SDC. CNA K stated a negative outcome of not wearing proper PPE would be that infection could be spread to other residents and staff caring for the resident. During an interview on 07/30/2026 at 8:24 AM, CNA J revealed that they had been working at the facility for about a year and a half. CNA J stated that not everyone who had an indwelling urinary catheter required EBP precautions, and stated that the SDC, was the person who provided her with that (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information. However, CNA J stated that for residents who did have an EBP sign on the door, staff should be wearing gloves and a gown. CNA J also noted that other staff CNAs trained new CNAs and stated a negative outcome of not wearing the correct PPE was cross-contamination and infection to self and other residents. During an interview on 07/30/2026 at 8:27 AM, CNA G revealed that everyone with an indwelling urinary catheter would be placed on EBP, which included a gown and gloves. CNA G stated a negative outcome of non-compliance was contamination and infection to self and other residents and noted that other CNAs train new staff on procedures. During a record review on 07/30/2026 at 8:29 AM, the facility policy entitled Enhanced Barrier Precautions (dated October 2022) revealed the following: Purpose: To reduce the transmission of resistant organisms during high contact resident care activities. Enhanced Barrier Precautions (EBP) may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: Wounds and indwelling medical devices, regardless of MDRO (multidrug resistant organism) colonization status. Examples of high-contact resident care activities requiring gown and gloves and use for EBP includes: Devices care or use of central line urinary catheter, feeding tube, tracheostomy/ventilator. EBP are intended to be in place for the duration of a resident's stay in the facility or until the resolution of the wound or discontinuation of the indwelling medical device that placed them a higher risk. During an interview on 07/30/2026 at 8:40 AM, LVN E revealed that if a resident has an indwelling urinary catheter, it is standard precautions for staff cleaning and emptying the bag to put on EBP, which included a gown and gloves. LVN E stated a negative outcome was introducing bacteria into the urine of the resident and possibly spreading infection. During an interview on 07/30/2026 at 8:45 AM, CNA I revealed that they had worked at the facility for two years. CNA I stated that when a resident has an indwelling urinary catheter, they should be placed on EBP, which included a gown and gloves. CNA I stated that the SDC oversaw training and ensuring new staff were aware the use of EBP. CNA I stated a negative outcome of not wearing PPE was infection to the residents, other residents, and staff. During an interview on 07/30/2026 at 10:33 AM, the SDC, revealed that she trained staff on proper techniques of hand hygiene, use of gloves, and wiping front to back. The SDC stated that not all residents needed EBP unless they have an active infection.		