STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 2 of 20 resident reviewed for accidents. (Resident #1 and Resident #2) The facility failed to provide adequate supervision which resulted in Resident #1 spilling hot coffee on himself and obtained 2nd degree burn to right thigh that measured 27cm x 20cm x 0.1cm; 540cm of surface area. The facility did not provide adequate supervision while transporting Resident #2 in the facility van which resulted in Resident #2 obtained wedge compression fracture mid thoracic spine. An IJ was identified on 05/06/24. The IJ template was provided to the facility on [DATE] at 5:56pm. While the IJ was removed on 05/08/24, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. This failure could place residents at risk for serious injury and accidents. Findings included: 1)Record review of Resident #1's face sheet, printed on 5/4/24, indicated he was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses including muscle weakness (a lack of muscle strength), tremors (an unintentional and uncontrolled rhythmic muscle movement of one or more parts of the body), PTSD (a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety), and Type 2 diabetes with chronic kidney disease (a chronic condition that happens when you have persistently high blood sugar levels), polyneuropathy (affects the peripheral nerves, which are the nerves that control the movement of the arms and legs) and major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the revised care plan initiated on 3/5/24 indicated the following: Focus - Resident #1 was at risk for complications due to coffee burn to right thigh and abdomen. Goal: Resident will have no complications through the review period. Interventions: Allow time for hot liquids to cool down some before consuming, at his request, Apron to be provided while hot liquids are consumed, encourage fluid intake and to take slow sips of hot liquids, Resident provided with a Spill-proof coffee cup, Resident to be verbally informed when hot liquids are being provided, and Treatment with Silvadene as ordered. Record review of Resident #1's quarterly MDS dated [DATE] indicated he had difficulty communicating some words or finishing thoughts but is able if prompted and usually understands others. Resident #1 had a BIMS score of 11, which indicated he had moderately impaired cognition. Section GG - Indicated Resident #1 had the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident. Record review of the complaint and incident intake worksheet in TULIP created on 3/5/24 on Resident #1 indicated: Date and time of the incident 3/2/24 at 8:00am; Date facility first learned of incident 3/2/24 at 1:30pm. Immediate action taken to protect client: reading of temperatures for coffee was obtained. Narrative of the incident: resident received a 2nd-degree coffee burn to his right thigh; treatment was provided. After an assessment by the Wound Nurse on 3/5/24, it was determined to send the resident out for further treatment. Record review of Resident #1's provider investigation report dated 3/12/24 revealed Description of the Allegation: Resident #1 spilled coffee on his leg, did not report to staff until several hours later. Description of injury: 2nd degree burn to right thigh, 27cm x 20 cm x 0.1cm; 540cm of surface area. Investigation Summary: On March 2, 2024, at 2:30pm, Resident #1 reported to the Charge Nurse that he had spilled coffee on his right thigh that morning. Resident #1 stated that he did not tell anyone earlier because he was not worried about it. Upon assessment a reddened area was noted to Resident #1's right thigh. Skin was intact. Resident #1 did not complain of pain to area. Nurse Practitioner was contacted and ordered Silvadene cream to the area. During staff interviews, staff stated that Resident #1's coffee cup did not have a lid that morning. CNA's stated that they had seen the coffee spill on the floor around him but did not observe the spill on his clothes due to he was wearing denim jeans. Resident #1 has a history of tremors with decreased range of motion to both arms. Resident #1 had been provided with a cup with a lid but refused to use the lid. On 3/5/24 at 10:20am, Resident #1's skin was evaluated by the ADON and the wound care nurse. Resident #1's right thigh had developed weeping blisters and the skin had begun to peel. The Nurse Practitioner was updated, and an order was received to send Resident #1 to the ER for further evaluation and treatment. Record review of the wound doctor's report dated 3/8/24 indicated Resident #1 had a burn wound of the right thigh full thickness. Wound Size (L x W x D): 27 x 20x 0.1cm. Dressing Treatment Plan: Collagen sheet apply once daily for 30days. Secondary dressing: Gauze Island with bandage apply once daily for 30days. During an attempted interview on 5/5/24 at 1:25 p.m., Resident #1 was in his room napping in his wheelchair right in front of his television, he did not answer questions asked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/5/24 at 1:38 p.m., CNA J said she worked the 7am to 3pm shift and on 3/2/24 the morning of the incident with Resident #1 she went to work early a little after 6am and Resident #1 was at the table finishing breakfast and she cleaned up spilt coffee from the floor. She said Resident #1 was wearing dark colored pants so she could not tell at that time he spilt his coffee on himself. CNA J said she asked Resident #1 if he was alright and in a harsh tone Resident #1 replied I'm okay, give me some more coffee. She said later that morning, she was doing patient care and that was when she discovered a large red mark on his right thigh. CNA J said she asked Resident #1 what happened and that was when he told her he spilt his coffee. She said she finished patient care and immediately notified LVN K. CNA J said prior to the coffee incident with Resident #1, facility did not have the plastic lids to put on the coffee cups, since the incident they were to now put the lids on all coffee cups before giving to the residents. During an interview on 5/5/24 at 2:01 p.m., LVN K said he was working as Resident #1's charge nurse the morning of the incident. He said CNA J reported to him about Resident #1's right thigh coffee burn. He said he went to assess Resident #1, documented it on his chart, and notified NP and family. LVN K said he recalled Resident #1's thigh pink in color whenever he initially looked at Resident #1's thigh and Resident #1 told him he spilt his coffee. LVN K said prior to Resident #1's coffee burn incident residents were able to use self-dispensing canister to pour their own coffee and they were not using the white plastic lids for the coffee cups. He said since the coffee burn incident staff were to temp the coffee prior and staff was now pouring all coffee for the residents and putting the white plastic lids on all cups prior to giving to the residents. During an observation on 5/6/24 at 5:50 p.m., the DON took measurements of Resident #1's thigh with measuring tape; the visible red burn scar was 18 cm x 6.5 cm. Record review of the revised hot liquid safety policy dated March 2024 revealed the following: Policy: Hot liquids are to be served at proper (safe and appetizing) temperatures using appropriate safety precautions. Procedure: 1.Hot liquids can cause scalding and burns. The degree of injury depends on the temperature, the amount of skin exposed, and the duration of exposure. Refer to the table attached to this policy for an illustration of the time required for a burn to occur at various temperatures. 2.The temperatures of hot liquids will be checked in the dietary department prior to distribution to the nursing units. If the temperature is greater than 140 degrees Fahrenheit, hold the liquid in the dietary department until it reaches an appropriate temperature. 3.Residents are assessed for their ability to handle containers and consume hot liquids. This includes but is not limited to residents with cognitive loss, vision issues, loss of hearing, weakness of upper extremities and/or tremors. 4.Residents with difficulties will receive appropriate supervision or use of assistive devices in order to consume hot liquids. Interventions will be individualized and noted on the resident's plan of care. Interventions include, but are not limited to: a. Wide based cups b. Cups with lids and handles (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Limit Styrofoam cups to residents with no difficulties d. Aprons e. Disallow hot liquids while lying in bed. f. Therapy Referrals 5. Staff shall respond immediately to spills or other accidents with hot liquids to minimize the risk for burns. Wet clothing should be immediately removed, and cool compress applied to affected area. Follow procedures regarding incidents/accidents should anyone experience exposure to hot liquids. 6. Monitor residents for at least 24 hours following exposure to hot liquids, as redness or blisters may not appear initially. 7. General safety precautions when serving hot liquids include, but are not limited to: A .Make sure resident is alert and in proper position to consume hot liquids. b.Use cups, mugs, or other containers that are appropriate for hot beverages. c. Do not overfill containers. d. Regulate temperature of hot liquids to which residents have direct access. e. Place filled containers directly on table. Do not hand them directly to residents. f. Keep hot liquids away from edges of the table. g. Do not refill containers while the resident is holding the container. h. Provide supervision as needed. 2) Record review of Resident #2's face sheet, printed on 5/4/24, indicated he was a [AGE] year-old male who admitted on [DATE] with diagnoses including hypertension (blood pressure that is higher than normal), Type 2 diabetes(a chronic condition that happens when you have persistently high blood sugar levels), low back pain(A common, painful condition affecting the lower portion of the spine), and back spasm (sudden tightness and pain in your back muscles). Record review of Resident #2's revised care plan dated 4/22/24 revealed Focus: Resident #2 at risk for complications and pain due to T-7 fracture (Tylenol #4). Goal: Resident #2 will not have any complications related to the fracture. Interventions/Tasks: Appointment with Neuro, Routine Pain Assessments, Wear brace as ordered until follow up appointment. Record review of Resident #2's Quarterly MDS dated [DATE] indicated he had clear comprehension and made himself understood. Resident #2 had a BIMS score of 15, which indicated he was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's incident report dated 4/1/24 completed by LVN C revealed the incident location: Out of Facility / During Transport; Nursing Description: Transportation driver came to RN supervisor and stated that when she took off from a red light she looked up in the mirror and seen resident's legs in the air. She had the rider go check him and she pulled over as fast as she could and they assisted the resident upright and secured wheelchair properly before proceeding to doctor appointment. Resident Description: Resident stated that the transportation staff hadn't strapped him in properly on the van. No Injuries Observed Post Incident. Notes: per resident and transportation staff he hit his back and right shoulder. No discoloration noted at this time. Record review of the complaint and incident intake worksheet in TULIP created on 4/3/24 indicated: Date and time of the incident 4/1/2024 at 2:15pm; Dated facility first learned of incident 4/1/2024 4:00pm. Immediate action taken to protect client: Investigate Bus/Driver taken out of transport service pending safety investigation of staff and bus, Send patient for additional diagnostic testing. Narrative of the incident: During a transport to a physician appointment on April 1, 2024, Resident #2 was riding in the facility bus and while enroute the wheelchair tilted backwards causing Resident #2 to fall to the floor of the bus. On April 2, 2024, he complained of pain , X rays were obtained and showed a fracture to his mid thoracic vertebrae. Physician notified and new orders for orthopedic consult received. Actions and Notifications: Facility bus has been taken out of use for transports and is being inspected for safety standards. Investigation /interview with multiple staff members to determine the root cause of the incident. Transports have been suspended for the staff involved pending safety analysis of both Driver/vehicles. Physician notified. Resident is his own Responsible party. Record review of Resident #2's Progress notes indicated the following: -On 4/1/24 at 2:00pm; completed by LVN C: Resident #2 is leaving via facility transportation at this time to go to an eye appointment. - At 5:15pm; completed by LVN C: Resident #2 asked nurse if he had any discoloration on his back or right shoulder. LVN C nurse did not see any discoloration. A few minutes later a member of transportation went to LVN C and stated that Resident #2 had fallen into his chair when boarding the van. Resident #2 stated that the transportation staff did not strap him in properly on the van. Assessed Resident #2's skin and started neuroes. RN supervisor and NP notified. Resident is his own RP. -On 4/2/24 at 9:01am; completed by LVN D: Resident #2 reported to LVN D that he has neck pain, right shoulder pain, and right rib pain and states it is from when he fell in transportation bus yesterday. Notified NP and received an order for right shoulder x-ray, c spine, rib series and skull series. -At 9:08am; x-ray orders called in. -At 2:00pm; Resident #2 was administered Tramadol 50mg pain medication due to Resident #2 requested for pain to neck, right shoulder and right rib pain. -At 4:09pm; completed by the Social Worker: Visited Resident #2 to check on him. Resident #2 reported that he was in an accident on the bus where he fell backwards in his chair going to an appointment. Resident #2 stated that he did not unlock his brakes on his wheelchair. This social worker validated Resident #2. Resident #2 was pleasant but said that he was in pain. Nurse aware. -At 4:47pm; completed by LVN C: Per NP refer to orthopedics for wedge compression fracture mid thoracic spine for possible kyphoplasty. Informed RN supervisor of x-ray findings and new order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 4/3/24 at 10:14am; completed by RN E: Administered tramadol 50mg for pain to right upper back. - at 2:36pm; new from DON to send Resident #2 to the ER via EMS for spinal Xray to confirm fracture. Resident #2 who is his own RP notified. -At 3:12pm; completed by PTA F: in preparation for gait training nurse came in and informed this therapist and Resident #2 that the x-ray showed possible spinal fracture and Resident #2 is going to ER via Ems. Resident #2 had stated he was sore from the incident but that he wanted to go sit on the porch. Therapist was unaware that x-ray had been ordered or administered. -At 3:38pm; completed by DON: Due to Resident #2 recent fall and mobile x-ray determined fracture of mid-thoracic spine, the NP was notified. The resident was sent to the ER for further evaluation. -On 4/4/24 at 9:02am; completed by RN E: Resident #2 returned to facility via EMS, resident was transferred to bed by EMS personnel, Resident #2 had a brace on there is no order on removal. Resident #2 stated they didn't tell him if could sleep in it or take it off, Resident #2 was dx with Compression fracture of T7 Vertebra, Chronic bilateral low back pain without sciatica and Hyperglycemia due to Diabetes Mellitus. CT of Cervical spine, Head, Lumbar Spine and Thoracic Spine without contrast without contrast and Chest Xray 1 view was performed. CBC with auth diff and BMP was also done. Results was not sent with resident. Resident #2 reports pain of 9/10 to back BP 115/75 hr 55 temp 98.2, O2 sat 93 RR20. NO new orders, RN Sup and NP notified of resident's return. -At 9:34am; Administered tramadol 50mg for pain to right upper back. - At 1:02pm; Follow-up Pain Scale was: 5 PRN Administration was: Ineffective. - At 1:04pm; Administered tramadol 50mg for pain to midback. - At 1:15pm; completed by RN Supervisor G: Resident #2's pain level has increased due T7 compression fracture and Tramadol is not controlling the pain. NP informed and new order for Tylenol #3 1 Q 4 hr PRN received. Order entered, pharmacy notified, and CN informed. CN to inform resident.- at 9:45pm; completed by RN E: Administered and was effective. -at 10:56pm; completed by RN E: new order from RN Sup per NP for Tylenol #3 1 tab Q 4 hrs Order entered, resident. Who is his own RP notified. -On 4/5/24 at 1:06pm; completed by RN H: Acetaminophen-Codeine Tablet 300-30 MG Give 1 tablet by mouth every 4 hours as needed for Mild / Moderate Pain Acetaminophen Warning: Do not Exceed 3GM (3,000mg)of acetaminophen total from all sources in 24hr period. Resident #2 c/o pain to back of 7.5-8/10, was wearing back brace. Oriented to new pain medication, voiced understanding and stated he would contact staff for assistance with adls if needed. -At 2:54pm; Follow-up Pain Scale was: 3, PRN Administration was: Effective but Resident #2 stated pain continues but had decreased. -At 3:36pm; Resident #2 expressed anxiety r/t recent compression fracture diagnosis and accompanying movement restrictions. Denied need for PRN anxiety medication but voices understanding that it is available if needed. Questions answered as needed and resident reassured that staff would be there to assist with adls or any tasks he may need. Resident #2 voiced that eased anxiety. Resident #2 voiced understanding of education regarding movement restrictions and back brace given by therapy. New PRN pain medication administered this shift per orders as needed, education provided at time of administration and resident voiced understanding. Medication was effective in lowering pain level. Call light and desired belongings within reach. -At 5:13pm; completed by Director of Rehab: Resident #2 had a back brace that is to be worn at all times when out of bed. He is not to twist, bend/reach to floor level or lift anything over 3lbs. -On 4/5/24 at 9:00pm; completed by LVN C: ECA at bedside with this nurse to help assist with turning due to recent back injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 4/6/24 at 7:29am; Completed by LVN D: Per Director of Therapy regarding showers- usually a person can't shower until cleared by a doctor. If Resident #2 choose to shower, he would have to do so with the brace on. Normally should be done before bed so it can hang to dry overnight. Notified Resident #2 and he verbalized understanding at that time. -At 7:30pm; Completed by LVN D: Administered Acetaminophen-Codeine Tablet 300-30 MG, Resident #2 requested for back pain. - At 9:55pm; Completed by LVN C: back pain r/t T7 compression fracture. -On 4/7/24 at 6:49am; Completed by LVN D: Resident #2 stated that his overall back pain was at a 7/10 at that time. Resident #2 declined pain med at that time. -At 9:00am; Completed by LVN D: Administered Acetaminophen-Codeine Tablet 300-30 MG, Resident #2 requested for back pain. -At 11:30am; Completed by LVN D: PRN T#3 administered at 0900 that morning was effective per resident. Resident #2 back brace applied and transferred to a back supporting chart in his room with 2 staff members assisted. Resident #2 stated he wanted to remain in chair until after his son left from visiting. Educated resident on using call light, placed within reach, when assistance was needed. -On 4/8/24 at 9:45am; Completed by LVN D: Administered Acetaminophen-Codeine Tablet 300-30 MG, Resident #2 requested for back pain. -On 4/9/24 at 10:39am; Completed by RN E: Administered tramadol 50mg for pain to upper back. -On 4/10/24 at 1:48pm; Completed by LVN D: Administered Acetaminophen-Codeine Tablet 300-30 MG, Resident #2 requested for back pain at a 7/10 while sitting on side of bed. -At 1:49pm; Completed by LVN D: Administered Ativan 0.5mg tablets, due to Resident #2 requested for increased anxiety at this moment due to sitting upright with back brace on. --At 3:08pm; Completed by NP: Chief Complaint: Resident #2 presents with back pain related to a recent T7 compression fracture. History of Present Illness: The patient reports that his pain is an 8 out of 10 without the prescribed pain medication, Tylenol number three, which is ordered every four hours as needed. He stated that the pain reduces to a 5 out of 10 after taking the medication, indicating ineffective pain relief. He has a follow-up appointment scheduled with a neurosurgeon. Relevant Symptoms and Experiences: Resident #2 has severe COPD and is currently on continuous oxygen therapy with a BiPAP at night. He was experiencing bilateral lower extremity edema, rated as plus two, and his LASIX dosage was recently increased to 40 milligrams POQ day to address that issue. He was wearing a back brace due to the compression fracture. - General: Patient is alert and oriented x3, pleasant, with clear speech. - Musculoskeletal: Wearing a back brace due to T7 compression fracture. No swelling in bilateral upper extremities. Plus two edema in bilateral lower extremities. Assessment & Plan: 1. T7 compression fracture - Continue wearing back brace for support and stabilization - Follow-up with neurosurgeon as scheduled - Monitor pain levels and effectiveness of current pain management 2. Inadequate pain relief (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Continue Tylenol #3 every 4 hours as needed - Consider discussing alternative or additional pain management options with the neurosurgeon during follow-up -On 4/11/24 at 9:19am; Completed by Social Worker: This social worker stopped by to visit the veteran. Resident #2 stated that he was still in pain. Resident #2 reported that he was nervous to see the neurosurgeon. -At 10:55am; Completed by LVN D: Administered Acetaminophen-Codeine Tablet 300-30 MG, Resident #2 requested for back pain. -At 7:00pm; Completed by: LVN C: Administered Acetaminophen-Codeine for pain r/t compression fracture of the T7 vertebrae. During an interview on 5/5/24 at 10:07 a.m., with the Administrator and Regional Clinical Consultant. The Administrator said she first learned of the van incident during morning meetings the following morning on 4/2/24, but incident was told differently as if Resident #2 fell while transporting and loading onto the van because that was how the original incident report was documented. She said she did not hear of how the actual van incident occurred and about the fracture until late 4/3/24 whenever the x-ray results came back. The Regional Consultant said she found out about the van incident around 11:00am on 4/3/24. She said she would have expected for Driver B to not touch Resident #2 and to immediately call the DON, or RN Supervisor immediately after the incident occurred and to then call 911 for EMS to check out resident and for them to transport Resident #2 to the hospital. She said CNAs were not qualified to assess residents, it would have to be a nurse or EMS staff. The Regional Clinical Consultant said since the van incident she developed a Facility Transportation policy dated April 2024 on what to do in event of any issues that involved a resident tripping, falling, or becoming unsecured or any other situation that may cause an injury to anyone during transportation. During an observation and interview on 5/5/24 at 12:56pm revealed Resident #2 was in his room sitting in a chair wearing a full coverage back brace. Resident #2 said on the day of the incident, he had an eye appointment and was going by facility van. He said as the van driver approached the railroad track his wheelchair started tilting backwards, and as the driver gassed the van to go over the track his wheelchair flipped back and he was looking at the roof of the van. Resident #2 said everything happened so fast and he was shocked by what had happened. He said the driver and the helper untangled him from the belt strap and helped him off the floor. Resident #2 said the driver offered to take him to the emergency room but since he had already missed a previous eye appointment, he did not want to miss another eye appointment. Resident #2 said having vision issues was scary and serious, so all he could think about at the time was not missing another eye appointment. He said he did think his wheelchair was properly strapped in because he had ridden on the facility van in the past and he had not had that issue before. Resident #2 said he had not been back on the facility van since the incident and said he did not know how he would feel once he was back in the van and he possibly could have anxiety once he looked at the back of the driver seat as a reaction to the incident. He said he wanted to know if the driver had been retrained, did the facility figure out what went wrong, if the facility van was adequate and had this happened before. Resident #2 said he needed answers to those questions before he felt safe riding on the van again. He said his back hurts daily and was able to manage the pain with pain medication. He said the pain was most severe whenever he moved. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/6/24 at 12:06pm, Driver B said she had been a van driver for about four years, and this was her first incident with a wheelchair flipping over during transport. She said on the day of the incident, they were running behind for Resident #2's eye appointment due to staff did not have him up and ready. She said she loaded Resident #2 onto the van and strapped down Resident #2's wheelchair. Driver B said as she was driving up to a railroad track, she could see in her rearview mirror Resident #2's wheelchair slightly tilting back, but as she went across the railroad track, she looked up at her rearview mirror again and could see Resident #2's feet in the air. She said she had to pull over out the way of traffic to help with Resident #2. Driver B said Resident #2 was lying on his back with portable oxygen tank wedge between the floor of the van and the back of the wheelchair and Resident #2 on his back on top of the oxygen tank. She said Resident #2 repeatedly said his head was hurting, she said she did not ask for location of head pain and assumed it was the back of Resident #2's head because that was the part he hit during the incident. She said she unstrapped Resident #2 and proceeded to get Resident #2 up onto all fours, and he was in that position for a few minutes trying to catch his breath and he continued complaining that his head was hurting. Driver B demonstrated all fours as being on hands and knees. She said after a few minutes herself and the helper moved Resident #2 from on all fours to sitting on the side of the van and at that time he was still catching his breath, he was wearing oxygen tubing and complained of head hurting. Driver B said she asked Resident #2 if he was okay and offered to take Resident #2 to the emergency room , but he declined and insisted on going to the eye appointment. Driver B said the only phone call she made at that time was to the eye doctors to verify it was okay for Resident #2 to still come since he was so late for the appointment, and she was informed they would still see him. Driver B said prior to incident she had been trained on how to properly secure a wheelchair but had not been trained in the case of a wheelchair flipping over. Driver B said after she returned Resident #2 back to the facility, she notified a RN Supervisor and Resident #2's charge nurse about the incident. During an observation on 5/6/24 at 11:51a.m., Driver B demonstrated how to load and unload a Resident on the van. One of the straps used to secure the wheelchair would not catch and made the chair feel loose. Observation of a total of 17 straps on the van used to secure residents in wheelchair for transporting, showed 5 of the 17 straps were not functioning correctly. During an interview on 5/6/24 at 12:38pm LVN B said she worked as Resident #2's charge nurse on 4/2/24 during the 7am to 3pm shift, which was the following day after the incident. She said during her rounds Resident #2 complained of pain to several parts of his body and that was unlike him because he rarely complained of pain prior to incident. She said Resident #2 told her the van driver did not strap him in good and his wheelchair had flipped over the previous day in the van on his way to an eye appointment. LVN B said she had not been informed during rounds, and she checked Resident #2's chart to see what had been done regarding the incident, and she did not see anything on his chart other than a statement that Resident #2 asking the LVN C if he had any bruises to his back. LVN B said at that point she notified the NP and ordered an x-ray. She said during her shift Resident #2 appeared tensed and was lying in bed complaining of pain. LVN B said x-rays were done during her shift, and the results came back after her shift, during the 3p to 11p shift. She said she completed a grievance/concern form on behalf of Resident #2 regarding the incident he told her. Record review of the grievance/concern form dated 4/2/24 completed by LVN B on Resident #2 revealed Concern: Wheelchair was not properly secured by driver of facility transport vehicle. After going over railroad tracks Resident #2 was thrown out of the wheelchair onto the floor of vehicle. Being on the floor caused shortness of breath and anxiety to worsen as well as pain from impact with floor. Action Recommended: Driver to round and secure residents then escort to round and double check. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the employee counseling form dated 4/5/24 and completed on 4/8/24 indicated Driver B received a written counseling. Employer Statement: On 4/1/24 during a transport to an appointment, a resident tipped over backwards in his wheelchair and landed on his back in the bus. This incident would not have occurred if the wheelchair had been properly secured. As the driver of the vehicle, Driver B was responsible for ensuring that the residents were secured in place for a safe transport. Performance Expectation: As listed on the driver job description, Driver B was expected to provide safe and timely transportation of residents on both a scheduled an as needed basis. Record review of the facility transportation policy dated April 2024 revealed .9. Wheelchair residents will utilize vehicle lift according to manufacturer instructions. Wheelchairs will be secured per manufacturer instructions. 10. Prior to moving vehicle, driver will personally assure that all riders have been safely secured . 12. In the event of any issue that involves a resident tripping, falling, or becoming unsecured or any other situation that may cause an injury to anyone during transportation, including any vehicle accident, the following procedures will be followed. a) The van will immediately moved to the nearest safe location off the road and emergency flashers are to be turned on. b) The resident or injured person should not be moved. c) The Nursing Supervisor is to be contacted immediately, director of nursing, and/or administrator. d) In the event of an injury or accident 911 is to be called and EMS and/or police to respond as indicated to evaluate the situation. e) Obtain in writing all details of incident, time, locations, and all persons in the vehicle. f) Prior to moving the transportation vehicle driver must ensure all persons are safe. g) Any time an incident occurs during transport that results in wheelchair tipping in any direction or a resident landing on floor of van, EMS is to be called. Resident is to be evaluated at emergency room . Under no circumstances is the resident to continue to be transported by facility vehicle. h) Upon learning of any incident regarding more that basic first aid from bumping against the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35340 Based on interview and record review the facility failed to maintain medical records on each resident that were complete and accurately documented for 1 of 20 residents (Resident #2) reviewed for clinical records in that. -RN Supervisor G changed contents entered on Resident #2's risk management (incident report). This failure could place the residents at risk for incomplete and inaccurate clinical records which could lead to miscommunication, a delay in services or a potential decline in resident 's health. Findings included: Record review of Resident #2's face sheet, printed on 5/4/24, indicated he was a [AGE] year-old male who admitted on [DATE] with diagnoses including hypertension (blood pressure that is higher than normal), Type 2 diabetes(a chronic condition that happens when you have persistently high blood sugar levels), low back pain(A common, painful condition affecting the lower portion of the spine), and back spasm (sudden tightness and pain in your back muscles). Record review of Resident #2's Progress notes indicated the following: -On 4/1/24 at 2:00pm; completed by LVN C: Resident #2 is leaving via facility transportation at this time to go to an eye appointment. - At 5:15pm; completed by LVN C: Resident #2 asked nurse if he had any discoloration on his back or right shoulder. LVN C nurse did not see any discoloration. A few minutes later a member of transportation went to LVN C and stated that Resident #2 had fallen into his chair when boarding the van. Resident #2 stated that the transportation staff did not strap him in properly on the van. Assessed Resident #2's skin and started neuroes. RN supervisor and NP notified. Resident is his own RP. Record review of Resident #2's incident report dated 4/1/24 completed by LVN C revealed the incident location: Out of Facility / During Transport; Nursing Description: Transportation driver came to RN supervisor and stated that when she took off from a red light she looked up in the mirror and seen resident's legs in the air. She had the rider go check him and she pulled over as fast as she could and they assisted the resident upright and secured wheelchair properly before proceeding to doctor appointment. Resident Description: Resident stated that the transportation staff hadn't strapped him in properly on the van. No Injuries Observed Post Incident. Notes: per resident and transportation staff he hit his back and right shoulder. No discoloration noted at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/24 at 10:46 a.m., RN Supervisor G said she normally made corrections to the risk management (incident reports) because that was what she was taught to do by another staff who no longer worked there. She said on 4/1/24 Driver B had come to her about the incident on the van with Resident #2 and she instructed for Driver B to notify LVN C which was Resident #2's charge nurse at the time. RN Supervisor G said on the following day which was 4/2/24 during the clinical morning meeting the team was reviewing Resident #2's risk management and she had to step out so she missed it and had she not missed Resident #2's risk management she could had corrected it at that time, but it was not until 4/3/24 the previous DON went to her about Resident #2's x-ray results and she read over the Nursing description section and it was incorrect. She said LVN C documented Resident #2 had fall during transporting onto the van and she knew that was not what Driver B had told her happened on 4/1/24, so she reentered and corrected the Detail section only to reflect the actual incident of what Driver B had told her. RN Supervisor G said the original note was deleted from risk management once she went back in and made her edits, but the progress note entered by LVN C was what the risk management originally had before she made her changes. Record review of a written statement from RN Supervisor G dated 4/4/24 revealed she was asked .if it was normal to edit another nurse documentation and RN Supervisor G replied was and still is whenever she became ADON the DON at the time trained her and had her check and correct risk managements (incident reports) every morning before clinical meeting. The corrections were generally grammar/spelling related or if she had questions about how something happened, she would call the nurse that opened the risk and then add what they told her. IF they put the skin tear on the right leg but it was really on the left leg, she would correct that. She Never corrected vital signs or pain assessments. If there were names of other residents or staff, she would remove the names and use room numbers or position titles. If there were injuries and they were noted on one page but not on the next she would add it to the second page. If check boxes were not marked that should be then she would add them. The editing was not to change what the nurses said happened, it was to complete and make the risk management paint the correct picture of the incident. She had opened risk managements for charge nurses so that it would put a time stamp on when incident happened, and they would edit and complete it. It was not always just one person working on a risk management and it was not always the person that originally opened it completing anything on it at all. So no, she never thought of editing a risk management wrongful. During an interview on 5/5/24 at 10:07 a.m., with the Administrator and Regional Clinical Consultant. The Administrator said she first learned of the van incident during morning meetings the following morning on 4/2/24, but incident was told differently as if Resident #2 fell while transporting and loading onto the van because that was how the original incident report was documented. She said she did not hear of how the actual van incident occurred and about the fracture until late 4/3/24 whenever the x-ray results came back. The Regional Consultant said she found out about the van incident around 11:00am on 4/3/24. The Administrator said whenever she went to work on 4/4/24 to review the incident report it had been changed and that to reflect Resident #2 wheelchair flipped back when going over a railroad track. The Administrator said on 4/2/24 during clinical morning meetings if she had seen that she would have handle the incident differently and called it in sooner. The Administrator and Regional Clinical Consultant both said they were not aware and did not know a staff could go back in and make changes to the risk management (incident reports) and there was no way of knowing if the document had been edited or changed because unlike a progress note, risk management does not make a strikeout mark indicating edits. They said no staff should be going back into records and making changes without reflecting that changes or edits had been done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676311	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watkins-Logan-Garrison Texas State Veteran's Home	11466 Honor Lane Tyler, TX 75708

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an attempted telephone interview on 5/6/24 at 12:37 p.m., LVN C, was unreachable, a voice message was left; however, there was no return call received. Record review of in-service and signature sheet dated 4/4/24 for RN Supervisor G completed by Regional Clinical Consultant revealed Education on prohibiting change in content entered on risk management. If information is incorrect, you must strike out and restart a new one. Record review of medical records policy dated October 2021 revealed Purpose: The medical record shall contain a representation of the experiences of the resident and include information to provide a picture of the resident's status through complete documentation. Procedure: 1) Licensed staff and interdisciplinary team members shall document observation and services provided in the resident's medical record in accordance with state law. 2) Documentation shall be completed at the time of service, but no later than the shift in which the documentation or care service occurred. 3) When documentation occurs after the fact and outside of the acceptable time limits, the entry shall clearly be indicated as late entry.