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	06/11/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs for 1 of 7 residents (Resident #1) reviewed for care plans. The facility failed to ensure that Resident #1's care plan included interventions for aggressive behavior. This failure could place residents at an increased risk of not having individualized, person-centered care plans developed and maintained to address their identified needs, goals, and interventions necessary to attain or maintain their highest practicable physical, mental, and psychosocial well-being. The findings included: A record review of a facesheet dated 06/10/2026 indicated Resident #1 was an [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included Alzheimer's disease with late onset (a neurodegenerative disease that primarily affects memory, thinking, and behavior); chronic atrial fibrillation (a heart condition characterized by an irregular and often rapid heartbeat); type 2 diabetes mellitus without complications; heart failure; and major depressive disorder, recurrent. A record review of the Resident #1's Quarterly MDS dated [DATE] indicated Resident #1 had a BIMS of 4, which indicated severely impaired cognition. The MDS indicated Resident #1 exhibited physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others), and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) every 1 to 3 days. A record review of a progress note dated 05/23/2026 at 11:15 AM indicated Resident #1 told another resident to get the [f-word] away from me and hit that resident in the left jaw. The progress note indicated Resident #1 was transferred to the hospital following the incident. A progress note dated 05/23/2026 at 11:07 PM indicated Resident #1 returned from the hospital to the facility. A record review of Resident #1's psychiatric subsequent assessment dated [DATE] indicated an increase in Depakote Sprinkle 250 milligrams twice a day (a mood stabilizer that can reduce symptoms like agitation, impulsivity, aggression, and mood swings) from and a new prescription of Sertraline 150 milligrams once daily (an antidepressant that can improve mood and alleviate symptoms of depression and anxiety). Resident #1 was also prescribed Memantine 10 milligrams twice a day (a medication used to help manage symptoms of Alzheimer's disease including memory loss, confusion, and difficulties with daily activities) and Melatonin 5 mg every night at bedtime (a hormone that regulates and supports sleep). A record review of a progress note dated 06/01/2026 at 7:40 PM indicated Resident #1 was observed hitting another resident in the face with his hands. The progress note indicated Resident #1 was transferred from the facility to the hospital on [DATE]. A record review of Resident #1's comprehensive care plan most recently revised on 06/10/2026 indicated Resident #1 was not care planned for the potential to be physically aggressive until 06/10/2026. The care plan indicated Resident #1 had the potential to be physically aggressive related (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to Alzheimer's. Interventions indicated on the care plan included one-to-one close observation for agitation, administer medications as ordered and monitor/document for side effects and effectiveness, and psychiatric/psychogeriatric consult as needed. During an interview on 06/10/2026 at 3:13 PM, the DON stated the MDS Coordinator oversees the care plans, any member of the IDT was able to update the care plan, and the SW could have ensured Resident #1's aggressive behavior was placed in the care plan. The DON stated that her expectation was that residents' behaviors align with their care plan. The DON stated she felt that staff were completing interventions including psychiatric consultation, medication changes, and seeking further placement though these interventions were not inserted into the care plan. The DON stated that the care plan should reflect what is going on with the resident. During an interview on 06/10/2026 at 3:18 PM, the SW stated she assisted in completing care plans. The SW stated every morning she ran a report on behaviors and it provided her with the last 24 hours of behaviors and she updated the care plan. The SW stated she did not find out about Resident #1's incident of aggression on 05/23/2026 until several days later and after Resident #1's incident of aggression on 06/01/2026 he was transferred to the hospital. The SW stated she did not and should have updated Resident #1's care plan. The SW stated developing and implementing care plans are a team effort, but it was her responsibility to ensure behaviors are reflected appropriately in the care plan. The SW stated if the care plan is not updated things could be missed and there is a potential for further aggression by the resident. During an interview on 06/10/2026 at 3:39 PM, the MDS Coordinator stated she completes care plans to ensure it reflected the resident as accurately as possible, so the plan of care could be ongoing, and to ensure everyone was aware of what was going on with the resident. The MDS Coordinator stated ensuring Resident #1's aggressive behavior should have been placed in the care plan by the SW, but she reviewed assessments and would ensure anything missed was updated. The MDS Coordinator stated the risks to residents for not having an updated care plan after an aggressive incident would include other residents safety and staff not being aware of what was going on with the residents to be able to properly care for them. During an interview on 06/11/2026 at 9:41 AM, the Regional Director of Clinical Operations stated the IDT was responsible for updating care plans. The Regional Director of Clinical Operations stated care plans were updated after a comprehensive MDS and on admission and added there was no timeframe for when they should be updated after an incident occurs and the facility policy does not support a timeframe. The Regional Director of Clinical Operations stated that after a resident-to-resident altercation a review of the care plan should be completed and interventions as indicated should be updated. When asked how not updating the care plan can negatively affect the residents, the Regional Director of Clinical Operations stated there was no harm. The Regional Director of Clinical Operations stated the DON is responsible for overseeing the updating of care plans by the responsible staff. A record review of the facility's policy dated June 2019 titled Care Plans (Comprehensive) indicated the following: Purpose: To develop an interdisciplinary resident centered comprehensive care plan to meet the individual needs of each resident. Policy Explanation and Compliance GuidelinesThe interdisciplinary team develops and maintains a comprehensive care plan for each resident.The comprehensive care plan has been designed to:Identify care needs that include the resident's strengths, history, and preferences;Incorporate risk factors; Establish goals in measurable outcomes; Include individualized approaches to meet resident's goals.The resident's comprehensive care plan is developed within seven (7) days after the completion of the MDS assessment. New residents will have a comprehensive care plan within seven (7) days after the completion of the MDS assessment, not to exceed twenty one (21) days from the date of admission.Care plans are revised as changes are indicated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on observations, interviews, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 of 7 residents (Resident #1 and Resident #2) reviewed for accidents and supervision. The facility failed to ensure Resident #1 was being supervised during one-to-one supervision, resulting in a resident-to-resident altercation with Resident #2. This failure could place residents at an increased risk of avoidable accidents, abuse, and resident-to-resident altercations due to the failure to consistently implement interventions. The findings included: 1. A record review of a facesheet dated 06/10/2026 indicated Resident #1 was an [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included Alzheimer's disease with late onset (a neurodegenerative disease that primarily affects memory, thinking, and behavior); chronic atrial fibrillation (a heart condition characterized by an irregular and often rapid heartbeat); type 2 diabetes mellitus without complications; heart failure; and major depressive disorder, recurrent. A record review of the Resident #1's Quarterly MDS dated [DATE] indicated Resident #1 had a BIMS of 4, which indicated severely impaired cognition. The MDS indicated Resident #1 exhibited physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others), and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) every 1 to 3 days. A record review of a progress note for Resident #1 dated 05/23/2026 at 11:15 AM indicated Resident #1 told Resident #2 to get the [f-word] away from me and hit Resident #2 in the left jaw. The progress note indicated Resident #1 was transferred to the hospital following the incident. A record review of an incident/accident report dated 05/23/2026 at 11:15 AM indicated Resident #1 was sent to the emergency department for evaluation due to aggression, Resident #1 was be placed on one-to-one observation for safety, and behavior monitoring was in place for aggression. A progress note dated 05/23/2026 at 11:07 PM indicated Resident #1 returned from the hospital to the facility. A record review of Resident #1's psychiatric subsequent assessment dated [DATE] indicated an increase in Depakote Sprinkle 250 milligrams twice a day (a mood stabilizer that can reduce symptoms like agitation, impulsivity, aggression, and mood swings) from and a new prescription of Sertraline 150 milligrams once daily (an antidepressant that can improve mood and alleviate symptoms of depression and anxiety). Resident #1 was also prescribed Memantine 10 milligrams twice a day (a medication used to help manage symptoms of Alzheimer's disease including memory loss, confusion, and difficulties with daily activities) and Melatonin 5 mg every night at bedtime (a hormone that regulates and supports sleep). A record review of a progress note for Resident #1 dated 06/01/2026 at 7:40 PM indicated Resident #1 was observed by CNA B hitting Resident #2 in the face with his hands. The progress note indicated Resident #1 was transferred from the facility to the hospital on [DATE]. 2. A record review of a face sheet dated 06/10/2026 indicated Resident #2 was an [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had diagnoses which included Alzheimer's disease, unspecified (a neurodegenerative disease that primarily affects memory, thinking, and behavior) and unspecified dementia, moderate, with other behavioral disturbance (a decline in cognitive abilities that affects memory, thinking, reasoning, and behavior). A record review of Resident #2's most recent Quarterly MDS dated [DATE] indicated Resident #2 had a BIMS of 3, which indicated severe cognitive impairment. The MDS indicated Resident #2 had not exhibited physical or verbal behavioral symptoms directed at others or other behavioral symptoms not directed at others. A record review of a progress note for Resident #2 dated 05/23/2026 at 11:20 AM indicated Resident #2 was assessed for injuries (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and pain and none was noted. The progress note indicated Resident #2 was assessed by emergency services and that Resident #2's family declined for him to be taken to the hospital for evaluation. A record review of a progress note for Resident #2 dated 06/01/2026 at 7:26 PM indicated Resident #1 hit Resident #2 in the face with his hands. The progress note indicated Residents #1 and #2 were separated by CNA C and Resident #2 was assessed and did not have any distress, skin issues, or pain. During an interview on 06/10/2026 at 9:13 AM, ADON D stated Resident #2 was outgoing and Resident #1 preferred space, so after the altercation on 05/23/2026 Resident #1 was placed on one-to-one supervision. ADON D stated when the altercation on 06/01/2026 occurred CNA A had stepped away briefly. ADON D stated there was no way to know but, had CNA A not stepped away the altercation might not have happened. ADON D stated there had been no incidents of aggression when Resident #1 was being supervised consistently. ADON D stated she did not expect staff assigned to one-to-one supervision to step away from the resident being supervised. During an interview on 06/10/2026 at 10:35 AM, CNA A stated she was assigned to the one-to-one supervision with Resident #1 on 06/01/2026. CNA A stated Resident #1 had walked outdoors, and she stayed indoors and watched him through the window. CNA A stated Resident #1 had been agitated the day of 06/01/2026 prior to the altercation. CNA A stated she stepped away for a couple of minutes to assist with another resident who had entered the wrong room. CNA A stated that while she was assisting the other resident, CNA C ran outside and stated Resident #1 had hit Resident #2. CNA A stated she had received training for one-to-one supervision and the training indicated to be within the line of sight of the resident being supervised. CNA A stated if she could go back, she would have done it differently and hollered at another staff member to go help with the other resident so she could keep Resident #1 in her line of sight. During an interview on 06/10/2026 at 10:45 AM, the Regional Director of Clinical Operations stated there was no facility policy regarding one-to-one supervision and she was unsure if staff had been trained on expectations for one-to-one supervision. During an interview on 06/10/2026 at 12:34 PM, CNA B stated she had been in-serviced on one-to-one supervision a little over a month ago. CNA B stated she did not believe it would be okay to be indoors while the resident on supervision was outdoors. CNA B stated that an in-service on one-to-one supervision was sent out to be completed by staff at 11:09 AM on the morning of 06/10/2026. During an observation on 06/10/2026 at 12:50 PM, Resident #2 appeared clean, did not have any bruising or redness to the skin, and did not appear afraid. An interview was attempted with Resident #2, though he was unable to appropriately respond to questions asked and would respond with everything is good. During an interview on 06/10/2026 at 1:14 PM, the DON stated she prefaced staff with the meaning of one-to-one supervision depending on why the resident was on it. The DON stated she expected staff to make sure if Resident #1 showed signs of anxiety or irritation they would be there to intervene, staying within his line of sight. The DON stated she did an in-service with CNA A on one-to-one supervision. The DON stated her expectation was that Resident #1 would have remained in the line of sight of CNA A and her preference was that CNA A would have been outdoors with him. The DON stated the moment Resident #2 went outside with Resident #1 she should have gone out there as well, but she did not see this happen because Resident #1 was no longer in her line of sight when she was assisting the other resident. During an interview on 06/10/2026 at 1:19 PM, CNA C stated Resident #1 was on one-to-one supervision on 06/01/2026. CNA C stated he was in the kitchen washing dishes and could see outdoors from the window. CNA C stated he looked up and saw Resident #1 throw a closed fist open swing and hit Resident #2 twice on one side of the face and once on the other. CNA C stated he was unsure if those were the only times Resident #1 had hit Resident #2 during that altercation as there was nobody watching them. CNA C stated at the time of the altercation, CNA A was redirecting another resident. CNA C stated he had not been in-serviced on one-to-one supervision, and he believed one-to-one supervision to mean keeping eyes on the resident being supervised at all times. CNA C stated he did not think it was okay for CNA A to be indoors while Resident #1 was outdoors, but he could understand due to the temperature outdoors being warm. CNA (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C stated there was an indoor den room near the patio where he believed it to be okay to sit and watch a resident on the patio if the supervised resident were outdoors alone. CNA C then stated if an event were to occur, he would lose line of sight with the resident being supervised going around the corner to the door leading outside. During an interview on 06/10/2026 at 2:50 PM, the Regional Director of Clinical Operations stated she could not find any prior in-services on one-to-one supervision. An observation on 06/11/2026 at 9:04 AM revealed that the outdoors patio could be seen from the window of the den, however, to get outdoors there was a corner that would disrupt the line of sight. During an interview on 06/11/2026 at 9:48 AM, the Regional Director of Clinical Operations stated the CNA assigned to the shift was responsible for providing Resident #1 supervision on 06/01/2026. The Regional Director of Clinical Operations stated her expectations of the assigned staff when providing one-to-one supervision was to ensure they were monitoring the residents behavior. The Regional Director of Clinical Operations stated she did not believe that not providing proper one-to-one supervision had a negative impact on Resident #2 as he did not recall the incident and there was no bruising or injury. The Regional Director of Clinical Operations stated there was a difference in being punched and being hit with a weak man. The Regional Director of Clinical Operations stated staff were aware of the expectation of keeping residents on one-to-one supervision within their line of sight. The Regional Director of Clinical Operations stated she was not overseeing staff at all times and could not be there every shift to know where they were. A record review of an in-service dated 06/01/2026 signed only by CNA A indicated the following: Topic: Staff assigned to 1:1 supervision are expected to remain at the resident's bedside or within direct line of sight at all times. Continuous monitoring must be provided to ensure the resident's safety. A record review of an Employee Counseling Form dated 06/01/2026 signed by CNA A indicated the following: Performance ExpectationsStaff assigned to one on one supervision are expected to remain with the resident at all times and provide continuous monitoring to ensure the safety of the resident and others. Failure to do so places residents at risk for injury and is inconsistent with facility expectations and standards of care.