

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Tuskegee Airmen Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Joe B Rushing Road Fort Worth, TX 76119	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one of six residents (Resident #2) reviewed for abuse. The facility failed to ensure Resident #2 had the right to be free from abuse on 11/27/25, while on the memory care unit, Resident #1 punched Resident #2 in the face causing him to fall against the wall and then to the ground resulting in facial bleeding and a fractured hip. The noncompliance was identified as a past non-compliance. The Immediate Jeopardy (IJ) began on 11/27/25 and ended on 12/02/25 the facility had corrected the noncompliance before the investigation began. This failure placed residents at risk of harm and/or severe injury. Findings included: Record review of Resident #1's most recent Quarterly MDS Assessment, dated 09/25/25, reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had BIMS of 06 indicating moderate cognitive impairment. Diagnoses included Alzheimer's Disease (neurodegenerative disorder that leads to the gradual decline of cognitive functions), Non-Alzheimer's Dementia (various types of dementia). Resident #1's MDS indicated he had signs of verbal behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing) along with other behavioral symptoms not directed towards others (threatening others, screaming at others, cursing at others). Record review of Resident #1's undated care plan revealed [Resident #1] had Impaired thought processes related to Alzheimer's, Dementia. Goal: He will be able to answer simple questions with a yes/no response. Interventions included Approach calmly and warmly, Ask simple questions that require a yes or no answer, Call resident by name, Do not rush resident, explain all procedures to resident, introduce yourself when approaching resident, Meds as ordered, Provide choices when possible, Provide consistent routine of care as much as possible. The Care plan revealed: [Resident #1] was at risk for difficulty in psychosocial adjustment related to admission to facility. Veteran gets easily agitated. Goal: Resident #1 will not exhibit signs and symptoms of difficulties in psychosocial adjustment. Interventions included to encourage resident to read name tags if applicable. Introduce self upon each visit with resident. Introduce others who may have similar interests. Notify physician as needed. Observe for sign and symptoms of difficulties in psychosocial adjustment (decreased socialization, sad mood, verbalizes wants to go home). Orientate to facility. Provide 1:1 assistance with emotional adjustment. The Care plan revealed: [Resident #1] was at risk for exhibiting behavior problems- physical aggression towards peers/staff, agitated with staff/peers, hiding things due to fear of things being taken from him. Risk for self- isolating and paranoid behavior noted behavior refusing meds, agitation. Veteran had resident to resident incident 11/27/25, 11/28/25. Goal: he will accept reassurance and respond to interactions during periods of abnormal behaviors. Interventions included Approach resident warmly and positively at all times, Attempt to keep environment free of stress (loud noise, TV,) Consult with family as needed. Encourage family to limit the number of visitors who come to the facility at one time to decrease stimulation Interventions: redirect, reapproach, provide quiet environment, avoid crowds, noise cancelling headphones, play favorite music, talk to him about his daughters, use do you need to call family? Meds as ordered. [Resident #1] to be sent for eval and treatment at In-patient psychiatric unit if approaches unsuccessful and agitation/aggression continues. Notify MD as needed. Observe and document behavior as needed. Provide 1:1 sessions as needed. Provide for safety of resident during periods of combativeness. Provide quiet spaces when agitated as loud noise can be a trigger. Psych eval as needed. Triggers: echoes, sudden noises, loud noises, paranoia of personal space/items, others entering his space/room. The Care Plan revealed: [Resident #1] was at risk for psychosocial changes related to resident-to-resident incident. Goal: [Resident #1] he will have no psychosocial changes. Interventions included Medication as ordered. Notify physician as needed. Provide diversional activities if behaviors occur. Psychological consult as needed. The Care Plan revealed: [Resident #1] had a history of trauma that affects them negatively related to the military. Triggers include: echoes, sudden noises, loud noises, paranoia of personal space/items, others entering his space/room. He may display: suspicions, hiding items, fears things being taken away, verbal, and physical aggression, agitation, self-isolation, paranoia, refuse care or meds, collects/hides gait belts, makes false claims, throwing items, restlessness. Goal: Triggers that may cause re-traumatization will be minimized daily. Interventions included encourage relationships with family and friends that are supportive. Encourage resident to express feelings, concerns, thoughts in a safe space. Observe for signs and symptoms of depression, anxiety, sleep disturbances. Provide a quiet non-threatening environment with decreased stimulation as needed. Triggers:</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 residents (Resident #2) reviewed for supervision. The facility failed to provide adequate supervision to prevent a physical altercation when Resident #1, who was sitting at the dining room table eating and talking with LVN A, got up from the table. LVN A asked him where he was going and to have a seat, Resident #1 stated, I will be right back with you. He then walked up to Resident #2 and punched him in the face causing Resident #2 to fall against the wall and then to the ground, which resulted in Resident #2 sustaining facial bleeding and a fractured hip on 11/27/25. The noncompliance was identified as a past non-compliance. The Immediate Jeopardy (IJ) began on 11/27/25 and ended on 12/02/25 the facility had corrected the noncompliance before the investigation began. This failure placed residents at risk of harm and/or severe injury. Findings included:Record review of Resident #1's most recent Quarterly MDS Assessment, dated 09/25/25, reflected an [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had BIMS of 06 indicating moderate cognitive impairment. Diagnoses included Alzheimer's Disease (neurodegenerative disorder that leads to the gradual decline of cognitive functions), Non-Alzheimer's Dementia (various types of dementia). 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