STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745057	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuskegee Airmen Texas State Veterans Home	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to remove previously applied Rivastigmine Patches for Resident #1 as ordered by the physician.This failure could place residents at risk for medication duplication, adverse drug reactions, and potential side effects. Findings included:Record review of Resident #1's Face Sheet, dated 02/05/26, reflected the resident was an [AGE] year-old male admitted on [DATE]. Record review of Resident #1's Quarterly MDS Assessment, dated 01/23/26, reflected the resident had diagnoses of Alzheimer's Disease (progressive brain disorder that causes memory loss and confusion), PTSD (mental health condition caused by experiencing or witnessing a traumatic event), and Gastro-esophageal reflux disease (condition where stomach acid flows back into esophagus). The MDS also reflected a BIMS score of 5, indicating severe cognitive impairment. Record review of Resident #1's Care Plan, undated, reflected the resident was at risk for adverse side effects related to medications with a goal that Resident #1 would be free of side effects related to psychoactive medications. The care plan also reflected Resident #1 had an ADL self-care performance deficit related to Alzheimer's and disease related medications. Further record review reflected Resident #1 had impaired cognitive function or impaired thought processes related to Alzheimer's with an intervention to administer medications as ordered and monitor for/document side effects and effectiveness. Record review of Resident #1's Physician Orders, dated 02/05/26, reflected the following order, Exelon Transdermal Patch 24 hour 9.5MG/24HR (Rivastigmine) Apply 1 patch transdermally [on the skin] one time a day. and remove per schedule. Record review of Resident #1's MAR, dated 02/2026, reflected the Rivastigmine patch (Medication used to help improve memory and thinking in people with dementia) was to be removed daily at 8:59 a.m. and applied daily at 9:00 a.m Record review of Resident #1's MAR further reflected on 02/04/26 the patch was removed at 8:13 a.m. from the right scapula and a new patch was applied at 8:13 a.m. to the left scapula by MA B. This MAR reflected no Rivastigmine patch applications documented to Resident #1's left arm. During an observation on 02/05/26 at 9:29 a.m. LVN A applied Resident #1's Rivastigmine 9.5 mg patch. LVN A performed hand hygiene prior to entering room, applied clean gloves and assisted Resident #1 with removing his jacket. LVN A performed a skin assessment, and a Rivastigmine patch was located on the back of Resident #1's upper left arm. Observation revealed the date on the patch appeared smeared and was illegible. LVN A then located a second Rivastigmine patch on Resident #1's left scapula dated 2/4. LVN A removed both patches and applied a new Rivastigmine patch to Resident #1's right upper arm. LVN A removed gloves and performed hand hygiene prior to exiting the room. During an observation and an attempted interview on 02/05/26 at 9:40 a.m., Resident #1 was in the common area in his wheelchair. Resident #1 was a poor historian and unable to answer questions. (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 - Few	The resident did not appear to be in any distress.During an interview on 02/05/26 at 10:07 a.m. LVN A confirmed she found two Rivastigmine patches on Resident #1 at the same time. She stated one patch was located on the back of his shoulder and the other on his upper arm. She stated the patch on the Resident #1's left shoulder was dated 02/04/26, while the date on the patch on his arm was illegible. LVN A stated there was not supposed to be two patches on Resident #1 at the same time and there was an order to remove the old patch prior to applying the new one. LVN A also stated the staff documented where the old patch was removed and where the new patch was placed. LVN A stated she did not routinely administer medications and was unsure why two patches were present or how long the medication was there. She stated she did not apply the patch on 02/04/26 and stated she routinely removed the resident's shirt to ensure any old patch was removed. LVN A stated the risk of not removing old patches could have resulted in excessive medication. During an interview on 02/05/26 at 12:55 p.m., MA B revealed she applied the Rivastigmine patch to Resident #1 on 02/04/26. MA B stated she removed the patch dated 02/03/26, which was located on the resident's right scapula (shoulder blade). MA B stated she recalled applying the new patch to Resident #1's left scapula. MA B stated she did not recall seeing a Rivastigmine patch on his left arm but stated she could have missed it. MA B stated she was unsure how long the Rivastigmine patch was in place. MA B stated the risk of a resident having two patches on at the same time was overmedication. During an interview on 02/05/26 at 4:59 p.m., the ADON revealed she expected staff to remove any old medication patches prior to applying a new patch. The ADON stated all medications were to be administered according to physician orders and pharmacy instructions. She stated with the Rivastigmine patch, there was only supposed to be one patch applied at a time, unless otherwise specified by the orders. The ADON stated the computer orders had a schedule, and staff were expected to document removal time, application time, and patch location with each administration, and she expected staff to follow that system. The ADON stated the facility was going to begin implementing a paper log for all patches to assist staff in tracking patch removal and application. She stated in-services were initiated (02/05/26) on medication patches. The ADON stated the risk of not removing the old patch from a resident was that residents could receive more medication than ordered, but she was unsure of the specific side effects associated with Rivastigmine. During an interview on 02/05/26 at 5:17 p.m., the Medical Director revealed he always expected staff to remove old medication patches prior to applying a new patch. He stated the staff should have known to remove the old patches, unless the order specified two patches. He stated potential side effects of not removing old Rivastigmine patches included headache, upset stomach, and in rare cases, bradycardia (low heart rate), or seizures. During an interview on 02/05/26 at 5:39 p.m., the Interim DON stated she expected staff to check to make sure the old patch was removed prior to applying a new patch. The Interim DON stated there was removal and applying orders in the computer system that she expected staff to follow and document. The Interim DON stated the risk of not removing old patches could cause potential side effects, but was unable to specify the side effects. Record review of the facility's policy titled, Medication Administration, dated revised 07/01/25, reflected the following: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 10. Ensure that the six rights of medication administration are following a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation 11. Review MAR to identify medication to be administered.16. Administer medication as ordered in accordance with manufacturer specifications.