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	02/11/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to immediately report allegations that involved injuries of unknown source to HHSC for 1 of 4 residents (Resident #1) reviewed for reportable incidents of abuse and neglect.The facility failed to report an injury of unknown origin to HHSC when Resident #1's sustained a bruise of unknown origin to his right eye area on 02/05/2026.This failure could place residents at risk for abuse and neglect. Findings included:Record review of Resident #1's quarterly MDS dated [DATE] reflected he was an [AGE] year-old male admitted on [DATE]. The resident's diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age that affects memory, thinking, and behavior); obstructive sleep apnea (a condition in which breathing stops involuntarily for brief periods of time during sleep), depression (mood disorder); and vertigo (a sensation that the environment is spinning in circles). Section C. cognitive patterns reflected a BIMS score of 02, indicating he was severely impaired cognitively. Section D. Mood indicated he had feelings of being down and depressed, or hopeless for 2 to 6 days. Section GG Functional Status indicated Resident #1 required partial to moderate assistance for lying to sitting on the bed, sit to stand, chair to bed transfer and toilet transfer, supervision and touching for walking, and he used a walker or manual wheelchair for mobility. The MDS reflected that the resident had no falls, but he had a history of falls and used a walker as an adaptive device for mobility. Record review of Resident #1's care plan dated 11/07/2025 reflected the following care areas: * Cognitively impaired and had impaired thought processes r/t diagnosis of Alzheimer's. *An elopement risk and at risk for falls.resident had an actual fall on 11/17/2025 no injury, delayed bruising with noted interventions for no apartment acute injury, determine and address causative factors of the fall. Monitor/document/report PRN X 72 hours to MD for s/sx : pain, bruises, change in mental status, new onset, confusion, sleepiness, abilities to maintain posture agitation.PT consult or strength and mobility, staff to increase monitoring for safety. *Black eye., resident had a fall on 11/12/2025 resulting in bruising to his right eye. Risk for falls, dependent on staff for meeting his needs. r/t cognitive deficits, communication problems r/t hearing.* Moderate risk for falls r/t confusion, gait, and balance problems . follow facility protocol for falls, ensure call light is within reach, educate and encourage residents to call for help. *Impaired visual function r/t impaired vision in right eye d/t macular degeneration (loss of central vision.), Glaucoma (eye disease leading permanent vision loss.), other peripheral vertigo (spinning caused by nerve dysfunction.)Record review of Resident #1's facility incident report dated 02/06/2026 at 5:00 AM by RN-T reflected 2026 a morning nurse called this nurse at the dining table where the resident was sitting and showed a light bruise to right eye, resident is alert and denies pain but said that he can feel it when nurse touching the affected area. BS stable and no signs of change of LOC noted. Assessed for other injury, none noted. Incontinent care provided. Monitored for any changes. RN supervisor, Administrator and POA care (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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified. POA said to notify her for any changes. Bruise measures 3 cm X 3.5 cm is very faint in color and kin is intact. Resident was unable to give a description. Immediate action take Assessed for injury.unable to give description. was incident witnessed: no.type of injury bruise. Level of pain 0.mental status confused.no injuries observed post incident. Predisposing physiological factors confused. Predisposing situation factors.ambulating without assist and wanderer. Statements were provided. (list in record review). ADON incident note dated 02/06/2026 IDG discussion related to bruise to right eye area. Patient is ambulatory with walker. Head to toe assessment completed. No other injuries noted. He denied pain. Interventions staff educated to monitor patient for safety to avoid skin tears. Facility does not suspect abuse, neglect and exploitation. DON incident note dated 02/09/2026 reflected resident noted to have no pain to eyebrow area, bruising noted to be to eye as a result of gravity and resolving.Record review of Resident #1 photo taken by RN-T and time stamped 02/06/2026 at 5:41 AM. The photo revealed Resident #1 lying on the left side of his face in the bed with his eyes closed. Purple bruising was observed on his upper eyelid and above the eyebrow. eyebrow X2 (purple). Red bruising was observed on crease of eyelid and underneath, lacrimal gland (upper outer part of eye), upper eye lid, meibomian gland (upper and lower eyelid).Record review of Resident #1's Nursing Progress Note dated 02/05/2026 at 6:08 AM written by RN-T reflected on 02/05/2026 a morning nurse called this nurse at the dining table where the resident was sitting and showed a light bruise to right eye, resident is alert and denies pain but said that he can feel it when nurse touching the affected area. BS stable and no signs of change of LOC noted. Assessed for other injury, none noted. Incontinent care provided. Monitored for any changes. RN supervisor, Administrator and POA care notified.Record review of Resident #1's Nursing Progress Note dated 02/06/2026 at 6:12 AM, written by LVN H Resident noted with R eye discoloration. Admin and [family] notified. No distress noted at this time.Record review of Resident #1's Nursing Progress Note dated 02/06/2026 at 7:41 AM written by DON reflected Area to right eye measures 3.0cm x 3.5, light bruise noted, denies pain, when asked what happened, he states that he rolled over and felt it burn, upon assessment, resident's bed side chest was right next to his bed and corner of chest approximates to bed, potentially causing bruising as area appears to have been a [NAME] bump, skin is intact with no open areas, bed pulled away from his bed-side dresser, no changes in condition noted as he remains at baseline, laughing at breakfast table and enjoying breakfast at this time.Record review of Resident #1's Nursing Progress Note dated 2/7/2026 6:28 PM by written LVN P reflected F/u R eye discoloration, healing, no pain or discomfort noted.Record review of Resident #1's Nursing Progress Note dated 02/07/2026 6:30 PM written by LVN-P reflected VSS, and neuros WNL. Record review of Resident #1's Nursing Progress Note dated 02/10/2026 8:20 AM written by DON reflected Resident sitting up in chair with no distress noted, denies pain to right eye, skin warm and intact with healing and resolving of bruising noted, delayed residual bruising from gravity noted to be moving to side of face and eye area, no changes in psychosocial behavior, resident continues to laugh and have great sense of humor noted.Record review of Resident #1's Nursing Progress Note dated 02/10/2026 9:17 AM by written LVN C reflected Discoloration to the right eye remains. [resident #1] continue to deny pain upon palpation or touch. We will continue to monitor.Record review of the facility staff statements dated 02/06/2026 provided by the Administrator via email on 02/11/2026 at 5:48 PM. revealed the following:* CNA-B written statement reflected the incident date 02/06/2026 and date of statement 2/6/2026 at 4:30 PM reflected I noticed R eye bruise this morning on rounds. CNA-B's statement provided no additional information describing the bruise or reporting the bruise. if the nurse was notified of the bruise.* LVN-P's written statement reflected the incident date 02/05/2026 and time of event 6:00 PM morning nurse pointed out possible bruising (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(discoloration) to [Resident 1's] right eyebrow during staff changes. Area looked pinkish purple this morning.* RN-T's written statement reflected the incident date 02/05/2026 and the time of event 6:00 PM I was called at the dining by morning nurse and showed resident right eye bruising and discoloration. The statement revealed no additional information.* CNA-J's written statement reflected the incident date 02/06/2026 and the time of the event 6:00 PM reflected I recognized that he had a brise on his right eye. CNA-J's statement had no additional information describing the bruise or reporting the bruise. if the nurse was notified of the bruise. During an observation and interview with Resident # 1 on 02/10/2026 at 1:10 PM he was observed with a bruising on the corner and undereye of his right eye with colors (purple, green, blue, and yellow.) Surveyor attempted to interview the resident regarding the injury; he was unable to communicate how he obtained the injury.During an interview on 02/10/2026 at 10:00 AM with the Administrator, she stated that she was notified by LVN-T on 02/06/2026 at 6:30 AM of the fall. She notified the DON, and the resident was assessed upon arrival that morning. Administrator stated that she did not report the incident to HHS because it did not meet criteria. During an interview on 02/11/2026 at 3:55 PM the Administrator stated the provider letter clearly stated that it had to meet all 3 criteria for reporting abuse and neglect to HHS. Administrator said the criteria included Injury of unknown origin, if injury was not witnesses, and if the patient cannot report the incident, and suspicious. During an interview on 02/10/2026 at 10:30 AM with the DON, she was involved in the investigation of Resident #1's fall. She stated he told her that he had fallen . She conducted an observation and incident report regarding the incident. DON stated that the resident was observed with a pink mark on his eye that was consistent with him falling and hitting the corner of the nightstand. The DON said her Investigation findings concluded Resident #1 had his CPAP mask on his face, and as he was falling, he hit his eye on the corner of the nightstand. He was assessed and treated. The Bruising progressed to the side and undereye with increased bruising. She notified the FM and MD. She stated the fall did not warrant an ER visit for treatment. He was monitored, supervised, and assessed by the staff 72 hours and there were not any neurological changes. She stated that all documentation and assessments were in the EMR. During an interview with LVN C on 02/10/2026 at 1:00 PM, she stated that she was on duty from 6:00 AM-6:00 PM 02/06/2026. She was notified by the oncoming nurse LVN T that she observed a bruise to Resident #1's right eye. LVN-C stated that both nurses learned of his injury at that time. She said resident's eye was observed lightly discolored and had transformed to purple with visible marks and bruises thereafter the incident. LVN-C does not know how the injury occurred. LVN-C denied resident falls and altercations during her shift. LVN-C said LVN-T did not report any injuries from the previous shift. LVN-C said the CNA reported no injuries, bruises, or skin issues during incontinent care. LVN-C did not observe injury to right eye during her care rounds, but stated the resident wore a baseball cap all the time and may have covered the injury. During an Interview on 02/11/2026 at 3:30 PM with RN-R, she stated that all staff were notified of the resident's injury to his right eye that has increased in discoloration to a black eye. LVN-R said due to Resident #1's impaired cognition, he would not report how he obtained the injury. She stated interventions included lowering his bed and monitoring for changes neurologically. During an Interview on 02/11/2026 at 3:40 PM with ADON, she stated that she was not notified of the injury by staff. ADON said the resident could not communicate how he obtained the injury to his eye. She stated that interventions were to lower his bed and continue monitoring residents for changes in neurological status and supervision. ADON expected the staff to supervise and monitor residents during their shift to prevent unknown injuries or falls from occurring. ADON expected the nursing staff to report all unwitnessed injuries immediately for leadership and MD notifications, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further assessments, and investigations. She does not know how the resident obtained the injury.During an Interview on 02/11/2026 at 3:46 PM with the DON she stated interventions included moving the resident's nightstand away from the bed when the resident was in bed. The DON said that their quality improvement incident note provided information about the incident and staff statements. During an interview on 02/11/2026 at 4:05 PM with LVN T, she stated she observe Resident #1 with a light pink bruise near his eyebrow and undereye. She said that the bruise progressed in color during the day. She then reported the incident to the Administrator, completed the incident report, and sent a text message per the Administrator request of the resident's eye. (She provided surveyor with the photo.) LVN-T notified LVN-S of the injury at 6:00 PM on 02/06/2026. Resident denied pain until the nurse touched the area to investigate and assess. She stated it appeared that he had fallen. She believed the resident may have fallen out of bed overnight injuring his eye, and as the day progressed the injury worsened. Resident was unable to provide details of what occurred. Resident #1 the resident received CPAP treatment every night at bedtime.A phone interview was attempted on 02/17/2026 at 4:51 PM with CNA B, and a voicemail message was left requesting a return call. During a phone interview on 02/17/2026 at 4:53 PM with CNA-E, CNA E stated he was working the 10:00 PM to 6:00 AM shift. He was not working directly with Resident #1. CNA-E said he was assisting another aide (name unknown) with incontinent care, and they observed a mark on Resident #1's undereye. CNA-E said he was unable to identify the mark as a bruise, skin infection, skin tear, or injury. He did not observe a fall during his shift and stated the incident occurred prior to him starting his overnight shift. He stated the nurse RN-T was notified by the other aide (name unknown). He stated LVN-T reported the incident the next day to Administrator before leaving the 6:00 AM shift. CNA-E stated that the Administrator requested staff statements about the resident bruise. The DON provided in-service education to the staff on abuse and neglect procedures.The following information was requested on 02/10/2026 at 10:00 AM from the DON and Administrator to complete the investigation for Resident #1: EMR access, incident and accident reports, abuse and neglect policies, unknown injuries. Staff education and all supporting information and documentation completed by the facility. Record review of the facility's policy dated 10/2022 titled Abuse, reflected in part the following: it was the responsibility of all staff.Purpose to identify, prohibit, and prevent resident abuse. Injury of unknown origin: an injury should be classified as an injury of unknown origin when all of the following criteria are men. The source of the injury was not observed by any person: and the source of the injury could not be explained by the resident.The injury is suspicious because of the extent of the injury or the location of the injury (the injury is located in an area not generally vulnerable to trauma) or the number of injuries at one particular point in time or the incidence of injuries over time.Any allegation of abuse will be immediately reported to the facility Administrator. The facility will designate an Abuse Prevention coordinator who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency, law enforcement, and other officials in accordance with state law.

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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 interviews and reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 3 residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1's CPAP treatments were coded in his MDS dated [DATE]. This failure could result in Resident missing essential treatment treatments and interventions for care. Findings included: During an observation and interview with Resident # 1 on 02/10/2026 at 1:10 PM his CPAP mask was on his nightstand. Resident #1 was observed in the main resident area of memory care attending activities. Resident # was not interviewed about CPAP treatments and care tasks, due to severe cognitive impairment. Record review of Resident #1's face sheet dated 2/10/2026 reflected he was an [AGE] year-old male admitted on [DATE]. DX: Alzheimer's (severe cognitive decline.) Sleep Apnea (serious sleep disorder), Depression (mood disorder), Obstructive sleep apnea (serious sleep disorder causing changes in blood oxygen levels), and vertigo (motion of spinning). Record review of Resident #1's quarterly MDS dated [DATE] reflected he was an [AGE] year-old male admitted on [DATE]. The resident's diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age that affects memory, thinking, and behavior); obstructive sleep apnea (a condition in which breathing stops involuntarily for brief periods of time during sleep), depression (mood disorder); and vertigo (a sensation that the environment is spinning in circles). Section C. cognitive patterns reflected a BIMS score of 02, indicating he was severely impaired cognitively. Section D. Mood indicated he had feelings of being down and depressed, or hopeless for 2 to 6 days. Section GG Functional Status indicated Resident #1 required partial to moderate assistance for lying to sitting on the bed, sit to stand, chair to bed transfer and toilet transfer, supervision and touching for walking, and he used a walker or manual wheelchair for mobility. The MDS reflected that the resident had no falls, but he had a history of falls and used a walker as an adaptive device for mobility. Section N addressed medications prescribed for anxiety, depression, pain, and fluid reduction. Section O Special treatments, procedures and programs did not indicate the resident treatments for Non-invasive Mechanical Ventilator, did not address Resident #1's use of CPAP machine. Record review of Resident #1's care plan dated 02/03/2026 reflected he was cognitively impaired and had impaired thought processes r/t diagnosis of Alzheimer's. Risk for falls, dependent on staff for meeting his needs. r/t cognitive deficits, communication problems r/t hearing. Record review of Resident #1's MD orders dated 08/07/2025 reflected 1. Wipe masks, nasal pillows, daily with damp cloth. 2 empty humidifier chambers, 3. Fill humidifier with warm soapy water, shake well. 4. Rinse and air dry. During an interview with the MDSC on 02/10/2026 at 2:00 PM, she stated that Section O Special Treatments, Procedures, and Programs would not be coded if the resident had not used the CPAP machine during the 7 days look back period. MDSC said failing to code the resident's treatment could place the resident at risk of missing treatments ordered by the physician. During an interview on 02/10/2026 at 5:00 PM with the FM, she stated that the resident was administered CPAP treatment daily at bedtime since admitting 08/07/2025.During an Interview on 02/11/2026 at 3:30 PM with RN-R, she stated that Resident #1 was administered CPAP at bedtime every night. During an Interview on 02/11/2026 at 3:46 PM with the DON said it was her expectation that the MDS staff address all the residents' care and treatment based on the MD orders of administration and documented. During an interview on 02/11/2026 at 3:55 PM the Administrator revealed it was her expectation for the staff to code resident treatments accurately on the assessments. She stated that she was not aware of the risk to the residents if the treatment was not coded. During an interview on 02/11/2026 at 4:05 PM with LVN T, she stated that the resident received CPAP treatment every night at bedtime.The surveyor requested (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policies for MDS assessments on 02/10/2026 at 10: 00 AM, 10:15 AM, 1:00 PM, and 4:00 PM from the DON and Administrator via email and verbally. The surveyor requested MDS policies from the DON and Administrator on 02/11/2026 at 1:00 PM, and again at 3:00 PM. The policy was not provided prior to exit.

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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 reviews, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included describing the services to be furnished to attain or maintain measurable objectives to meet the resident's highest practicable physical, mental, and psychosocial well-being, for 1 of 6 residents (Resident #1) reviewed for care plans.Resident #1's, care plan dated 02/03/2026 did not address his CPAP treatment for obstructive sleep apnea. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. Findings included:Record review of Resident #1's quarterly MDS dated [DATE] reflected he was an [AGE] year-old male admitted on [DATE]. The resident's diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age that affects memory, thinking, and behavior); obstructive sleep apnea (a condition in which breathing stops involuntarily for brief periods of time during sleep), depression (mood disorder); and vertigo (a sensation that the environment is spinning in circles). Section C. cognitive patterns reflected a BIMS score of 02, indicating he was severely impaired cognitively. Section D. Mood indicated he had feelings of being down and depressed, or hopeless for 2 to 6 days. Section GG Functional Status indicated Resident #1 required partial to moderate assistance for lying to sitting on the bed, sit to stand, chair to bed transfer and toilet transfer, supervision and touching for walking, and he used a walker or manual wheelchair for mobility. The MDS reflected that the resident had no falls, but he had a history of falls and used a walker as an adaptive device for mobility. Record review of Resident #1's care plan dated 02/03/2026 reflected he was cognitively impaired and had impaired thought processes r/t diagnosis of Alzheimer's. Care plan did not address Resident #1's CPAP treatments per MD orders 08/07/2025 and 02/10/2026.During an observation and interview with Resident # 1 on 02/10/2026 at 1:10 PM his CPAP was on his nightstand. Resident #1 was observed in the main resident area of memory care attending activities. Resident #1 was not interviewed about CPAP treatments and care tasks, due to severe cognitive impairment. Record review of Resident #1's MD orders dated 08/07/2025 reflected 1. Wipe masks, nasal pillows, daily with damp cloth. 2 empty humidifier chambers, 3. Fill humidifier with warm soapy water, shake well. 4. Rinse, and air dry. MD order dated 02/10/2026 at 3:35 PM MD J reflected an order Resident utilizes a CPAP at night with settings of 8.0cm for H2O CPAP at bedtime for sleep apnea-obstructive sleep apnea.During an interview with the MDSC on 02/10/.2026 at 2:00 PM, she stated that the MDS would guide the care goals and treatments for the residents' needs. She was unable to answer if Resident #1's care plan addressed his CPAP use at the time of the interview. MDSC said during her assessment she will review the TAR for current treatments during the 7-day look back period and code the MDS. MDSC said if the resident's CPAP was left off the TAR, she would not have addressed the treatment. During an interview with LVN S on 02/10/2026 at 1:00 PM, she stated that Resident #1 received CPAP treatments for obstructive sleep apnea at night. She reported that residents are provided with an order. She stated the care plan addressed resident care and treatment. During an Interview on 02/11/2026 at 3:30 PM with RN-R, she stated that Resident #1 received CPAP treatments for obstructive sleep apnea. LVN-R reviewed the resident orders and care plan during the interview with the surveyor. LVN-R was not aware that Resident #1's CPAP treatments were not addressed in his care plan. LVN-R stated that the resident was at risk of missing care and treatment if it was not documented in the care plan. During an Interview on 02/11/2026 at 3:46 PM with the DON, she stated it was her expectation that the care plans addressed the residents' current treatments of CPAP. She stated it was ADON's responsibility to ensure that all care plans reflected resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. She stated all the residents' care and treatment based on the MD orders of administration and documented. During an interview on 02/11/2026 at 3:55 PM the Administrator revealed she expected nursing staff to ensure care plans were consistent with residents' care and treatments provided. She stated that she was not aware of the risk to the residents. During an interview on 02/11/2026 at 4:05 PM with LVN T, she stated that Resident #1 received CPAP treatments every night at bedtime for obstructive sleep apnea. She was not aware that the CPAP treatments were not addressed in the care plan. She said the risk to the resident's care plan being inaccurate could result in the resident missing treatment, illness, and other health concerns. Record review of facility policy titled Clinical Services: Care Plans and Case Management dated November 2017 reflected Purpose: to develop an interdisciplinary resident centered comprehensive care plan to meet the individual needs of each resident.An interdisciplinary team develops and maintains a comprehensive care plan for each resident.Designed to identify care needs that include history, risk factors, measurable goals and outcomes, and approaches to meet resident goals.the comprehensive care plan is developed 7 days after the completion of the MDS assessment.care plans are revised as changes are indicated.review of the care plan is made with each comprehensive and quarterly assessment

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that at resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan for 1 of 4 residents (Resident #1) reviewed for physician orders.The facility failed to ensure there were physician orders for Resident #1's use of a CPAP machine, which is non-invasive ventilation machine that involved the administration of air usually through the nose by an external device at a predetermined level of pressure, that was provided by the nursing staff daily. This failure placed residents at risk of not receiving adequate respiratory care. Findings included:Record review of Resident #1's quarterly MDS dated [DATE] reflected he was an [AGE] year-old male admitted on [DATE]. The resident's diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age that affects memory, thinking, and behavior); obstructive sleep apnea (a condition in which breathing stops involuntarily for brief periods of time during sleep), depression (mood disorder); and vertigo (a sensation that the environment is spinning in circles). Section C. cognitive patterns reflected a BIMS score of 02, indicating he was severely impaired cognitively. Section D. Mood indicated he had feelings of being down and depressed, or hopeless for 2 to 6 days. Section GG Functional Status indicated Resident #1 required partial to moderate assistance for lying to sitting on the bed, sit to stand, chair to bed transfer and toilet transfer, supervision and touching for walking, and he used a walker or manual wheelchair for mobility. The MDS reflected that the resident had no falls, but he had a history of falls and used a walker as an adaptive device for mobility. Section N addressed medications prescribed for anxiety, depression, pain, and fluid reduction. Section O Special treatments, procedures and programs did not indicate the resident treatments for Non-invasive Mechanical Ventilator, did not address Resident #1's use of CPAP machine. Record review of Resident #1's care plan dated 02/03/2026 reflected he was cognitively impaired and had impaired thought processes r/t diagnosis of Alzheimer's. Risk for falls, dependent on staff for meeting his needs. r/t cognitive deficits, communication problems r/t hearing. Care plan did not address Resident #1's CPAP treatments per MD orders 08/07/2025 and 02/10/2026.Record review of Resident #1's MD orders dated 08/07/2025 reflected 1. Wipe masks, nasal pillows, daily with damp cloth. 2 empty humidifier chambers, 3. Fill humidifier with warm soapy water, shake well. 4. Rinse, and air dry.Record review of Residents #1 orders (after surveyor intervention) the DON obtained a physician order on 02/10/2026 at 3:35 PM from MD J reflecting Resident #1 utilizes a CPAP at night with settings of 8.0 cm for H2O CPAP at bedtime for sleep apnea- obstructive sleep apnea.During an observation and interview on 02/10/2026 at 1:10 PM his CPAP was on his nightstand. Resident #1 was not interviewed about CPAP treatments and care tasks, due to severe cognitive impairment. During an interview with LVN C on 02/10/2026 at 1:00 PM, she stated that Resident #1 received CPAP treatments for obstructive sleep apnea at night. She reported that residents are provided with an order. During an interview on 02/11/2026 at 3:30 PM with RN-R, she stated that Resident #1 received CPAP treatments for obstructive sleep apnea. She reported no concerns with administration and use daily. LVN-R reviewed the resident orders with the surveyor and stated that he had orders for CPAP cleaning. She could not recall if he had an order for CPAP prior to 02/11/2026. During an interview on 02/11/2026 at 3:40 PM with ADON, she stated that it was the nursing staff responsibility to ensure that MD orders were added to the EMR. She was not aware that Resident #1 did not have an order for CPAP treatments. She stated failing to have an MD order could place the resident at risk of not receiving treatment. The facility did not provide policy for MD orders and respiratory therapies.