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 03/18/2026

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 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** Based on observation, interview and record review, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systemically organized in accordance with accepted professional standards for 1 of 6 residents (Resident #1) reviewed for medical records.The facility failed to ensure Resident #1's medical record included documentation reflecting the resident had received showers/baths in February and March of 2026.The failure placed residents at risk of not having continuity of care.Findings included: Record review of Resident #1's admission MDS assessment dated [DATE], reflected the resident was a [AGE] year-old male who was admitted on [DATE]. His diagnoses included Parkinsonism (any disorder manifesting symptoms of Parkinson's disease or any such symptom complex occurring secondarily to another disorder), chronic ischemic heart disease (heart damage caused by poor blood flow to the heart), chronic respiratory failure (not enough oxygen travels from the lungs into the blood), anxiety disorder (excessive worry and feelings of fear), post-traumatic stress disorder (mental health condition triggered by trauma), and heart disease. The MDS reflected Resident #1's cognition was intact with a BIMS score of 13. The MDS Assessment Section GG - Functional Abilities for Shower/Bath Self was coded as Not applicable - (Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury). Further review reflected Resident #1 needed substantial/maximal assistance from staff in regard to personal hygiene. Record review of Resident #1's care plan, dated 01/15/26, reflected [Resident #1] has an ADL self-care performance deficit [related to] Parkinsonism and Impaired balance. Goal: [Resident #1] will maintain current level of function through the review date. Interventions: BATHING/SHOWERING: The resident requires (assistance) by (1) staff with (bathing/showering) and as necessary.Record review of Resident #1's ADL Record for February 2026 and March 2026 in the section titled Shower/Bed Bath reflected the following: Did the resident received a shower?, and No was marked indicating no showers were provided. There was no documentation in the ADL Record or the resident's clinical record reflecting the resident had refused to be bathed. Record review of the facility's shower binder which contained Skin monitoring: Comprehensive CNA Shower Review sheets reflected Resident #1 only had 1 shower sheet for 01/17/26, which indicated he had refused a shower.Observation on 03/18/26 at 9:55 AM revealed Resident #1 asleep while sitting in his wheelchair. Resident #1 appeared clean and well-groomed. Several attempts were made to interview resident, but he continued to sleep. Interview on 03/18/26 at 11:00 AM, Resident #1's family member, Family Member A, revealed concerns about Resident #1's hygiene and showers. Family Member A stated that Resident #1 was last seen on 03/15/26 by family, and the resident had food all over his mouth and face, crust on his eyes, and fingernails were long with a substance built-up underneath the nails. Family Member A stated that they had requested for Resident #1's fingernails to be cut and cleaned on 03/15/26. Family Member A stated that Resident #1 appeared like he had not received a shower in a very long time. Family Member A stated that Resident #1 was unable to say when he had been provided with showers. Interview on 03/18/26 at 12:15 PM, Resident #1 stated he was provided with showers, but he could (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not recall how often or when the last time he received one. Interview on 03/18/26 at 1:22 PM, LVN A revealed Resident #1's shower days were Mondays, Wednesdays and Fridays during the evening shift. She stated when CNAs showered residents they documented in the resident's the electronic health record and on the shower sheets. LVN A reviewed Resident #1's electronic health record and stated it was documented No which meant that shower/bed bath had not been provided; however, the documentation was during the morning shift. She stated she reviewed the documentation for the evening shift and there was no documentation showing Resident #1 had received any showers/bed baths. She stated in the system it showed that Resident #1's showers were scheduled for Mondays, Wednesdays, and Fridays during the morning shift but whoever put it in the system did it incorrectly. She stated Resident #1 was in a B bed and B bed residents received showers during the evening shift. She stated no one had mentioned or noticed that in the system his showers were inputted incorrectly. LVN A stated there were no shower sheets for Resident # 1, which she was not aware of. LVN A stated due to the lack of documentation they would not know if Resident #1 received any showers/bed baths. She stated the potential risk of not receiving any showers was that it could lead to infections. Interview on 03/18/26 at 1:36 PM, CNA B revealed she was the CNA assigned to Resident #1. She stated she had not provided any showers to Resident #1 during the morning shift due to resident being in a B bed. She stated residents in B beds received their showers during the evening shift. Interview on 03/18/26 at 2:11 PM, LVN C revealed Resident #1 received showers during the evening shift. She stated Resident #1's shower days were Mondays, Wednesdays, and Fridays. She stated she had witnessed CNA D provide Resident #1 with a bed bath about a month or two ago. She stated CNAs documented in the electronic health record and completed shower sheets. She stated she could not recall getting any shower sheets for Resident #1. LVN C stated she was not aware Resident #1's bed baths were not being documented in electronic health record. She stated the expectation was for CNAs to provide showers/bed bath to the residents, document that it was provided, and complete shower sheets. She stated if it was not documented then it was not done. She stated if showers were not provided to residents, it could lead to infection.Interview on 03/18/26 at 3:21 PM, CNA D revealed she had worked with Resident #1 before, but it had been a while since she last worked with him. She stated Resident #1's shower days were Tuesdays, Thursdays, and Saturdays during the evening shift. She stated it had been a couple of months since she had provided him with a shower. She stated showers/bed baths were documented in electronic health record and shower sheets. CNA D reviewed Resident #1's electronic health record and stated in the system his showers were put in on the wrong shift. CNA D stated she would not be able to know when the last time Resident #1 received a shower without any documentation. She stated the potential risk of not receiving any showers was that it could lead to dry skin. Interview on 03/18/26 at 4:22 PM, the ADON revealed Resident #1's shower days were Mondays, Wednesdays and Fridays during the 2:00 PM-10:00 PM shift. She stated Resident #1 received bed baths. The ADON stated that when residents receive a shower or bed bath, the CNAs documented it in electronic health record and completed a shower sheet. She stated she was not aware there were no shower sheets for Resident #1 or documentation of his bed baths. She stated she would have to verify with her staff whether Resident #1 received a shower. She stated the nurses were responsible for following up to ensure showers or bed baths were being provided and had to sign the shower sheets. She stated there was no potential risk to Resident #1 if showers were not being provided, because staff were checking on him daily. Interview on 03/18/26 at 4:44 PM, CNA E revealed he had been providing Resident #1 with his bed baths. He stated he should have been documenting the bed baths in the resident's electronic health record and on the shower sheets. He stated he had not completed the shower sheets because he did not know where they were located. He stated shower sheets needed to be completed because the sheet had the things that needed to be reported, like any skin abnormalities. Interview on 03/18/26 at 5:46 PM, the Interim DON revealed she was notified Resident #1's electronic health record documentation was inputted incorrectly. She stated in the system it indicated Resident #1's showers (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to be provided during the morning shift; however, his showers were supposed to be provided during the second shift. She stated she was not aware shower sheets were not being completed. She stated if it was not documented it did not happen. She stated she expected showers to be completed on the residents' shower days, and staff were supposed to fill out the shower sheets and provide them to the nurses, which the nurses must sign to verify that the shower was completed. She stated the potential risk of not receiving any showers was that it could lead to dry skin.Interview on 03/18/26 at 6:13 PM, the Administrator revealed her expectation was for staff to be documenting showers/bed bath in the resident's electronic health record. She stated from what staff told her, Resident #1's showers were populating on the wrong shift. She stated Resident #1's showers was populating on the 6:00 AM-2:00 PM shift instead of 2:00 PM-10:00 PM shift. She stated Resident #1's shower days were supposed to be Mondays, Wednesdays, and Fridays on the 2:00 PM-10:00 PM shift. She stated staff should be completing shower sheets. She stated she was not aware the shower sheets were not being completed. She stated if it was not documented then it did not happen. Record review of the facility's Bath (Bed) policy, dated 09/2/2025 reflected the following: Bed baths will be provided regularly or as indicated. 21. Complete personal care record.