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	04/01/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 reviews the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #1) reviewed for accident and hazards. The facility failed to ensure Resident #1 received adequate supervision to prevent the resident from eloping from the facility through an ancillary door on the service hallway on 03/21/26 at approximately 3:30 PM. An Immediate Jeopardy (IJ) situation was identified on 03/31/26. While the IJ was removed on 04/01/26 the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate effectiveness of their corrective systems. This failure could place residents at risk of serious injury, harm or death. Findings included:Record review of Resident #1's quarterly MDS, dated [DATE], reflected a [AGE] year-old male, who admitted to the facility on [DATE]. The resident's active diagnoses included mild cognitive impairment of uncertain cause, heart failure, high blood pressure, and presence of pacemaker . The resident had severe cognitive impairment with a BIMS score of 4. The resident did not have any behavioral symptoms and had no wandering behavior during the assessment period. Resident #1 was able to walk independently, and he had had two or more falls without injury.Record review of Resident #1's care plan, dated 03/23/26, reflected that he was at risk for falls, and he was determined to be an elopement risk and had a Wander Guard bracelet applied on 12/23/25, with interventions of checking his bracelet every shift. Record review of Resident #1's Elopement Evaluations reflected: On 12/23/25 the resident exited the facility via the front door by following visitors through the door. A Wander Guard bracelet was applied to the resident's ankle. The resident was considered an elopement risk with 8 Yes responses. On 03/23/26 reflected the resident had exited the facility again via a side door. It was determined the resident was still a risk for elopement with 9 Yes answers and the safest option for the resident was to move him to the secured unit. Record review of the facility's incident report, dated 03/23/26, reflected Resident #1 eloped from the facility on 03/21/26 via a side door on the service hallway and was found at a clinic adjacent to the facility. Facility's video footage revealed the resident left the facility at 3:22 PM and was discovered in the parking lot at 3:26 PM. The resident reported to staff that he needed to go into town. The resident and no injury or ill effects, and was placed on 1:1 line of sight observation until the IDT team met on 3/23/26 and determined for the resident's safety he should be moved to the secured unit.Record review of Resident #1's progress notes, dated 03/21/26 at 4:21 PM, written by LVN-A reflected the following: At approximately 1530 [3:30 PM], patient [Resident #1] with a history of dementia left the facility without authorization and was later observed outside in the parking lot of the VA clinic. Patient was alert but confused, stating desire to go to town, with impaired safety awareness. Patient was able to be redirected without difficulty and escorted safely back to the facility. Assessment completed; no injuries noted, and vital signs were within normal range (BP 114/59, HR 80, Oˆ 93%). Patient was reoriented and provided reassurance. Staff notified, and elopement precautions reinforced, including increased monitoring. Administrator was contacted and stated patient should be placed on 1:1 observation. Social worker to be contacted regarding possible (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	relocation to a different unit, with follow-up planned for Monday. [Resident #1's Family Member] was contacted and updated on patient status; she expressed that she does not want the patient relocated at this time. Administrator to be updated regarding family's preference. Patient currently resting on unit; will continue close observation and update care plan as needed.Record review of written statement dated 03/27/26, by Housekeeper B reflected she and Housekeeper- C were in the breakroom getting ready to go on break when Housekeeper-C looked out the window and viewed Resident #1 walking across the parking lot. They exited the breakroom, turned off the door alarm, and notified the nurse the resident was outside the facility.During an observation on 03/31/26 at 1:25 PM of the door Resident #1 eloped through revealed it was labeled No Exit, had the Wander Guard system in place, and had a keypad in place. The door was able to be opened without a code, and without setting off an alarm. There was a similar door at the opposite end of the hallway that also did not alarm when opened. During an observation on 03/31/26 at 1:35 PM, the Director of Maintenance activated the WanderGuard alarm for the door Resident #1 used, which was an ancillary door on the service hallway. The alarm from the door was not audible on Alpha Pod, and staff did not appear aware of the alarm. At the nurse call system, a sound of ding dong was heard on the Alpha Pod which was the same sound as the call light activation alerts on the hall at the same call system.An interview attempt on 03/31/26 at 1:30 PM with Resident #1 was unsuccessful, he was not able to answer questions or follow the conversation. In an interview on 03/31/26 at 1:22 PM, LVN-A stated on 03/21/26 she was notified by the housekeeper that one of the residents was outside the facility in the parking lot. She stated when she caught up with the resident, she recognized it was Resident #1 and he was in the parking lot of the clinic adjacent to the facility. She stated Resident #1 walked with a walker and was known to wander between his unit and the front lobby. She assessed him and found no injury and then notified the appropriate people. Resident #1 was placed on 1:1 direct sight observation for the rest of her shift. In an interview on 03/31/26 at 1:40 PM, the Director of Maintenance stated high pitch alarm of the WanderGuard only sounded at the door it was activated at , all external doors have the system in place. On the individual pods the staff would have a ding dong sounding alert on their call light monitor with the location of the door that were activated. If the door activated was on one of the pods the staff of that pod would hear the high pitched alarm as well as the ding dong alert on the monitor. In an interview on 3/31/26 at 3:00 PM, Housekeeper C stated he was in the breakroom changing out a trash bag when he happened to look out the window and saw a resident with a walker in the back parking lot. He stated he did not know who the resident was, but knew he was one of their residents. He alerted Houskeeper- B and they went to Alpha pod to alert the staff. Housekeeper-B stated he did not hear the door alarm while in the breakroom, only when he got out into the hallway. Housekeeper-C put the code in to turn the alarm off, on the way to Alpha pod. During an observation on 3/31/26 from 3:30 - 3:40 PM revealed the Maintenance Worker tested the Wander Guard system at each external door and all alarms were working. The Maintenance Worker stated the alarm was not very loud . In an interview on 3/31/26 at 4:50 PM, the Administrator stated she was notified on a Saturday (3/21/26)that Resident #1 had eloped from the facility, he was spotted by a housekeeper, and returned to the unit with no injury. The resident was placed on 1:1 direct line of sight observation until the IDT team met on Monday (3/23/26) and determined the safest option for Resident #1 was to move him to the secured unit. The resident had not exhibited any exit seeking behaviors since being moved to the secured unit. During observations and interviews on 03/31/26 from 5:40 PM-5:54 PM, the Administrator and State Surveyor stood at the entrance of Alpha pod while the Director of Maintenance activated the Wander Guard alarm in the hallway, and the alarm was audible. While standing at the nurses' station the alarm was not audible but the ding dong alert could be heard on the call light monitor, with the door number displayed in red at the top of the monitor. LVN-A was sitting at the nurses' station documenting; she glanced at the monitor and returned to her computer. The Administrator asked LVN-A about the alert, LVN-A stated, It's not one of our doors, meaning it was not on their unit. Other staff on the unit were also not responding to the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	alert, were not checking their doors, and not checking their residents with Wander Guard bracelets. The Administrator and the State Surveyor moved to [NAME] pod, on the opposite side of the building, while the Director of Maintenance activated the Wander Guard alarm in the hallway again. The alarm was not audible at the nurses' station but the alert on the monitor was audible, and the door number was displayed on the monitor. Staff on the unit were not responding to the alert. The Administrator asked RN-D what she should do about the alert, RN-D stated, Cancel it. During an observation and interview on 3/31/26 at 6:10 PM on Alpha pod the call light for room [ROOM NUMBER] had been activated. The alert for a call light sounded the same as the alert for a door alarm. RN-E stated the two alarms sounded similar and the only way to know the difference would be to look at the monitor and see if it was a door or a room number displayed . Record review of the facility's policy Elopement, dated 08/26/25, reflected: .4. The facility has an ?eyes on policy' where residents are observed approximately every two hours, or more frequently if deemed necessary. 5. The facility completes a care plan on all residents who are at risk for elopement to communicate to staff the interventions they should attempt to prevent elopement from the facility.6. The facility has an elopement response plan to implement in the event of an elopement. Drills are performed as needed to evaluate and train staff based upon actions/reactions observed during the drill.This was determined to be an Immediate Jeopardy (IJ) on 03/31/26 at 5:30 PM. The Administrator was notified. The Administrator was provided with the IJ template on 03/31/26 at 5:35 PM. The following Plan of Removal submitted by the facility was accepted on 03/31/26 at 8:35 PM: All Veterans identified by IDT for the need of a wander guard bracelet are at risk from this alleged deficient practice. DON immediately in-serviced all staff currently On Shift on door alarm notification on call light system-which states Door Alarm, what it means, what to do when it goes off and to respond immediately; completed by 3/31/2026. Administrator checked all pods and confirmed staff were able to hear door alarm and sound sufficient. Completed on 3/31/2026. All staff not onsite to be in-serviced via electronic communication platform prior to their next scheduled shift by Administrator on 3/31/2026. All veterans that are considered at risk for elopement and wearing wander guard system bracelets are in elopement binder at each nurse's station. Completed by 3/31/2026 by Social Workers . Administrator or designee to do elopement drills utilizing wander guard system 4x per week x4 weeks on all shifts to ensure compliance and response. Ad Hoc QAPI to review plan (DON , Administrator, OSR , and Regional Support) completed by 3/31/2026 and will meet weekly X 4 weeks for effectiveness of plan. Formal QAPI to continue meeting monthly X3 months.Monitoring of the facility's implementation of their Plan of Removal included:During an observation on 04/01/26 from 9:30 AM-10:15 AM, the Director of Maintenance tested the Wander Guard system in the hallways of the facility. Staff from all areas of the facility responded to the door being tested. Staff were able to verbalize their responsibility in the event of an elopement which included searching the immediate area outside the door for a resident, calling a Code [NAME] over their radio, checking their residents on their units and performing a head count on their unit. A Second State Surveyor stood at the nurses' station and observed staff checking the monitor, identified a door in the hallway was alarming, and responded to the door. Observation on 04/01/26 at 3:15 PM revealed the alerts on the computer monitor at the nurses' station for a bed alarm and a door alarm were remarkably different sounding. Staff were aware the new sound was a door alarm that needed immediate attention . Staff were observed responding to the new alert sound. In an interview and observation on 04/01/26 at 10:20 AM, the Director of Maintenance observed the alerts for a call light and a door alarm sounding the same. He stated staff would not know the difference without looking at the monitor. He contacted their vendor via phone who stated he could change the door alert to sound significantly different than the call light alert. The change could be completed remotely and would be completed within a few hours . Interviews on 04/01/26 from 11:00 AM to 3:58 PM in person and via phone with staff (RN-F. RN-G, RN-H, CNA-I, CNA-J, CNA-K, CNA-L, CNA-M, CNA-N, LVN-O, LVN-P, LVN-Q, RN-R, CNA-S, CNA-T, CNA-U, CNA-V, CNA-W, CNA-X, CNA-Y, CNA-Z, RN-AA, Activity Assistant, Laundry Aide. Housekeeper-B, Housekeeper-C, LVN-A) revealed (continued on next page)

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