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	04/23/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 2 residents (Resident #1) reviewed for ADL care .The facility failed to provide incontinence care to Residents #1 as needed.This failure could place residents at risk for loss of dignity, infections and a decreased quality of life.Findings include:Record review of Resident #1's quarterly MDS Assessment, dated 03/27/26, reflected a [AGE] year-old male who was admitted to the facility 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), respiratory failure (not enough oxygen travels from the lungs into the blood), anxiety disorder (excessive worry and feelings of fear) and post-traumatic stress disorder (mental health condition triggered by trauma). Resident #1's cognition was severely impaired with a BIMS score of 7, and the resident was dependent upon staff for toileting 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: Toilet use. The resident requires (assistance) by (2) staff for toileting.During an observation and interview on 04/23/26 at 9:55 AM, revealed Resident #1 was in his room in his bed. He stated his brief was changed, but he could not recall when it was last changed. No odor. He was noted wet while performing skin assessment.During an observation on 04/23/26 at 11:18 PM, CNA B and RN C went to Resident #1's room to conduct a skin assessment and to provide the resident with incontinence care. Upon entering the room, they explained the procedure to Resident #1. CNA B and RN C put on PPE and gathered their supplies together. They then went to the resident's bedside. Without performing hand hygiene, CNA B put on gloves and unfastened Resident #1's brief. Resident #1 was wearing two briefs and was heavily soaked in urine with some redness in her perineal area (the area between the genitals and anus).During an interview on 04/23/26 at 11:56 AM, CNA D revealed she was the one assigned to Resident #1. CNA D stated she changed the resident after breakfast. She stated she was the one who applied two briefs on Resident #1. She stated she applied one brief to act as a pad because Resident #1 wet his briefs a lot, and she wanted to prevent him from soiling his clothes. She stated she was aware they were not supposed to double the briefs on residents. She stated the risk of doubling the briefs would be the resident having skin breakdown. She stated she had done training on not putting two briefs on residents and rounding every two hours. She stated she last did her rounds at 9:00 AM and had no reason why she had not changed Resident #1.During an interview on 04/23/26 at 12:18 PM, CNA B revealed she was not assigned to Resident #1. She stated she was just called to help with the skin assessment. She stated she was not the aide who put two briefs on Resident #1. She stated she was aware they were not supposed to double the briefs on residents. She stated the risk of doubling briefs was that it could cause skin breakdown. CNA B stated she had done training on not putting two briefs on residents, but she could not recall when.During an interview on 04/23/26 at 2:55 PM, RN C revealed she was the treatment nurse. She (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was performing Resident #1's skin assessment, and when CNA B unfastened the resident's brief, she saw Resident #1 had two briefs. She stated she was aware Residnet#1 was not supposed to have double briefs, and she expected the staff to change him more frequently and let the management know. She stated the risk of doubling the briefs was it could cause skin breakdown. She stated she had done training and re-educated staff on incontinence care, but she could not recall when and whether CNA B and CNA D were in attendance. Resident was observed to have some redness on his peri area.During an interview on 04/23/26 at 4:23 PM, the ADON revealed her expectation was the staff performed rounds every two hours and as needed. She stated the nurses were responsible for monitoring the CNAs during their shifts. She stated staff should not double the briefs on residents. She stated the risk of not performing rounds every two hours and doubling briefs was it could lead to skin issues and infections.During an interview on 04/23/26 at 4:43 PM, the DON stated she expected staff to perform rounds every two hours and as needed for residents, who wet heavily.Residnet #1 was not identified as one that wet heavily on his care plan. She stated the nurses were responsible for monitoring the CNAs during their shifts. She stated staff should not double the briefs on residents. She stated the risk of not performing every two hours rounds and doubling the briefs was it could lead to skin issues and infections. The DON stated she had done training with staff on providing incontinence care every two hours and not putting two briefs on the residents. The DON provided these in-service training records. They were not interviewed.Record review of the facility's training records revealed the facility did in-service training on toileting, changing and checking patients every two hours and as needed, and handwashing techniques on 02/25/26. The training record revealed CNA D was not in attendance.Record review of the facility's Incontinent/Perineal Care (Male) policy, revised 09/02/25, reflected the following: . To promote cleanliness and prevent infection and skin irritation. Apply brief/pull-up as indicated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable and to prevent the development and transmission of communicable diseases and infection for 2 of 2 residents (Residents #1 and #2) reviewed for infection control.1. CNA B and CNA D failed to perform hand hygiene while providing incontinence care to Residents #1 and #2.2. RN C failed to perform hand hygiene and change her gloves when she performed a skin assessment on Resident #2. These failures could place residents at risk for worsening conditions and cross-contamination. Findings include:1. Record review of Resident #1's quarterly MDS Assessment, dated 3/27/26, reflected a [AGE] year-old male who was admitted to the facility 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), respiratory failure (not enough oxygen travels from the lungs into the blood), anxiety disorder (excessive worry and feelings of fear) and post-traumatic stress disorder (mental health condition triggered by trauma).] Resident #1's cognition was severely impaired with a BIMS score of 7, and the resident was dependent upon staff for toilet 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: Toilet use. The resident requires (assistance) by (2) staff for toileting.During an observation on 04/23/26 at 11:18 AM, CNA B and RN C provided Resident #1 with incontinence care. CNA B and RN C were observed putting on personal protective equipment before they washed their hands. CNA B explained the procedure to Resident #1, she positioned the resident, unfastened the resident's brief, and proceeded to cleanse Resident #1. Resident #1 had two briefs and was heavily soaked in urine with some redness on the resident's perineal area (area between the genitals and anus). She cleansed the resident's abdominal folds and penis in a clockwise direction. RN C performed a skin assessment on the resident, which included assessing the resident's head, face, under arms, abdomen and legs. They then positioned the resident on his side and cleansed his bottom area wiping from the inside to the outside. Without performing hand hygiene or changing her gloves, CNA B put a clean brief on Resident #1. RN C completed the skin assessment and left the resident comfortable with the bed in a low position with his call light within reach. CNA B was observed leaving the room after removing gloves and gown without washing hands and walked down the hall with the trash. RN C was left in the room she removed her gloves and washed her hands.2. Record review of Resident #2's comprehensive MDS Assessment, dated 02/9/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnosis included hemiplegia following cerebral infarct affecting the left nondominant side (a severe form of stroke-induced paralysis affecting the entire left side of the body). Resident #2's cognition was severely impaired with a BIMS score of 1, and the resident was dependent upon staff for toilet hygiene. Record review of Resident #2's care plan, dated 03/12/26, reflected [Resident #2] has an ADL self-care performance deficit [related to] dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Goal: [Resident #2] will maintain current level of function through the review date. Interventions: Toilet use. The resident requires (assistance) by (1) staff for toileting.During an observation on 04/23/26 at 11:10 AM, CNA D provided Resident #2 with incontinence care. CNA D put on gloves before washing her hands. After explaining the procedure to Resident #2, CNA D positioned the resident, unfastened the resident's brief, and proceeded to cleanse Resident #2. She cleansed the resident's abdominal folds and penis in a clockwise direction. CNA D turned Resident #1 and positioned the resident on his side and cleansed his bottom area wiping from the inside to the outside. Resident #2's brief soaked with urine. Without (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing hand hygiene or changing her gloves, CNA D put a clean brief on the resident and left the resident comfortable with the resident's bed in the low position and the call light within the resident's reach. CNA D then left the resident's room after removing her gloves without washing hands, and she walked down the hall with the trash.During an interview on 04/23/26 at 11:56 AM, CNA D revealed she did not perform hand hygiene before, during, and after Resident #2's incontinence care. CNA D stated she was expected to wash her hands before and in between care, if her gloves were soiled, when moving from dirty to clean, and after care. She stated she forgot. CNA D stated she was supposed to complete hand hygiene and change gloves during incontinence care to prevent cross contamination. She stated failure to wash hands after or before contact with resident, and after removing gloves could lead to cross contamination. She stated she had done training on handwashing, but she could not recall when.During an interview on 04/23/26 at 12:18 PM, CNA B revealed she knew she was supposed to perform hand hygiene before contact with Resident #1, between the care, when gloves were soiled with body fluid, and with each removal of gloves. She stated she forgot. She stated failure to perform hand hygiene before contact, between care, and after removal of gloves could lead to contamination and spread of infection. She stated she did training on hand washing and infection control, but she could not remember when.During an interview on 04/23/26 at 2:55 PM, RN C revealed she was the treatment nurse. She stated she knew she was supposed to perform hand hygiene before contact with Resident #1 and between care. She stated she knew better, but she forgot. She stated failure to perform hand hygiene before contact, between care, and after removal of gloves could lead to contamination and spread of infection. During an interview on 04/23/26 at 4:43 PM, the DON revealed her expectation was for staff to perform hand hygiene before contact with residents, between care, when gloves were soiled, and when they changed gloves. She stated failure to perform hand hygiene before contact, between care, and change of gloves could lead to cross contamination and spread of infection. She stated she had training on infection control with staff.Record review of the facility's Hand Hygiene policy, dated February 2020, reflected, .It is the policy of this facility that staff will perform hand Hygiene and aide in the prevention of the transmission of infections '