

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/23/2026
NAME OF PROVIDER OR SUPPLIER Tuskegee Airmen Texas State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 2 Residents (Resident #1) reviewed for essential equipment. The facility failed to ensure Resident #1's WanderGuard device (wander management bracelet) was functioning on all sensors of the four exit doors on the Delta pod. This failure could place residents at risk for elopement and injury. Findings included:Record review of Resident #1's Quarterly MDS, dated [DATE], reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnoses included Non-Alzheimer's Dementia (brain disease that alters brain function and causes a cognitive decline) and aphasia (brain related condition that makes it hard to speak and understand others). Resident #1's BIMS score was blank and staff assessment for Mental Status reflected Resident #1 had a short- and long-term memory problem and cognitive skills for daily decision making were severely impaired. Resident #1 had not exhibited any wandering behaviors. Record review of Resident #1's care plan, dated 02/05/2026, reflected Interdisciplinary team determined the resident to be an Elopement risk due to 7 yes responses from Elopement Eval. and increased wandering behaviors. Wander guard - Apply Security Bracelet (TekTone) for safety. Check placement (back of wheelchair) every shift.Record review of Resident #1's physician orders reflected the following: - Apply Security Bracelet/WanderGuard for safety. Check placement (back of wheelchair) every shift - start date 07/07/2026.- Check WanderGuard device (back of wheelchair) every shift to ensure placement and the red light is visible. If missing or red light is not visible, replace WanderGuard - start date 07/07/2026.Record review of incident and accident log, from 06/23/26 to 07/23/26, reflected no elopements. Observation and interview on 07/23/2026 at 3:00 PM, Resident #1 was sitting up in his wheelchair near the TV. Resident #1 was not able to answer any questions. CNA A showed Resident #1's security bracelet and the blinking red light that indicated it was functioning. CNA A then brought the bracelet by the door to the enclosed patio and stated the keypad should change color, and an alarm would sound if the door opened, however no light came on the keypad, and the alarm did not sound when the door opened. CNA A then went to the other door side door and the keypad lit up and alarm sounded when she opened the door.No residents were observed going into the enclosed patio. Observation on 07/23/26 at 3:31 PM, LVN B took another resident that was wearing a security bracelet near the same patio exit door and the keypad lit up and the door alarm sounded when opened. Interview on 07/23/2026 at 3:18 PM, LVN B stated an alarm would sound any time a resident with a WanderGuard security bracelet would try to go out an exit door on the pod. LVN B stated nurses checked the bracelets every shift to ensure they were functioning, and if they were not, they were to immediately report to their supervisor. Interview on 07/23/2026 at 3:51 PM, Social Worker C stated Nursing was responsible to check placement of the bracelet on residents who wore them. She stated Maintenance, the DON and Administrator received a (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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification if a bracelet had a low battery. The Social Worker stated if a resident [with a WanderGuard] passed by a door it would trigger the sensor, and if the door opened an alarm would sound and a notification of where it was going off would be sent. Observation and interview on 07/23/26 at 4:11 PM, revealed the Maintenance Director checked the patio door keypad and the alarm with an extra tag (security bracelet). He then tested Resident #1's bracelet on the patio exit door and stated the keypad stayed green and the alarm did not sound when the door opened. He stated he could not give a solid answer to why Resident #1's bracelet was not working. He stated he tested the functioning of the doors weekly and used a different handheld device. He did not answer when asked if there was a risk to residents by not checking the actual security bracelets worn by resident's and the door sensors. Interview on 07/23/2026 at 4:58 PM, the DON stated there had not been any recent elopements and nursing staff checked placement of the WanderGuards. She stated they would make sure the bracelet was not too tight, and if the red light was blinking. The DON stated nursing staff checked it daily and management checked it weekly. She stated it did not keep a log and was not able to provide when the last time Resident #1's bracelet was checked against the door sensors. She stated it was important to ensure the system was functioning for the residents' safety. Interview on 07/23/2026 at 5:29 PM, the Administrator stated they had no elopements since their self-report [in March 2026]. She said doors were tested weekly and the WanderGuards had the ability to tell them when it had a low battery. She stated she was told it was not working properly, so she went and tried it on the patio door, and the keypad did not light up. She tried a second time, and it did light up. She said it was working on the other three doors. The Administrator stated they replaced Resident #1's bracelet and did not know what was wrong with it. She said the bracelets got checked for placement, that the light was on daily and the doors were tested weekly, but they were not checking every single door with each bracelet. She stated it was important to test the WanderGuard system to minimize the risk of elopement. Record review of the facility's Physical Environment: Electrical Equipment policy, dated 2026, reflected in part: The facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition. Policy Explanation and Compliance Guidelines: 1. The Maintenance Director shall maintain schedules for routine inspection and maintenance of all mechanical, electrical, and patient care equipment. 4. Essential equipment shall be repaired or replaced as soon as practicable. a. Patient care-related electrical equipment.		