

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

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No. 0938-0391

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 07/09/2026
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident was not given a psychotropic drug unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #3) reviewed for unnecessary medications, in that: The facility failed to ensure Resident #3 was prescribed a psychotropic drug for anxiety no longer than 14 days PRN. Resident #3 was ordered PRN Lorazepam (a benzodiazepine medication used primarily to treat anxiety disorders and severe agitation) on 06/03/26 without a stop date. This deficient practice could place residents at risk of receiving unnecessary psychotropic medications. Findings included: Review of Resident #3's Quarterly MDS Assessment, dated 04/02/26, reflected he was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had a BIMS score of 14 indicating he had no cognitive impairment. His active diagnoses included Parkinson's Disease (a progressive neurological disorder that primarily affects movement) and anxiety disorder (excessive and persistent fears or worries that interfere with daily life). Review of Resident #3's care plan reflected the following: Focus: [Resident #3] is receiving hospice care services through [Hospice Company]. DX- End Stage Parkinson's. Interventions: coordinate care with Hospice Team. Review of Resident #3's Order Summary Report, dated 07/08/26, reflected the following: Admit to hospice with an order date of 06/03/26 Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for Anxiety with an active date of 06/03/26 Review of Resident #3's June 2026 Medication Administration Record reflected he received the ordered Ativan on the following dates and times: 6/10/26 at 6:40 AM and 6:01 PM, 06/22/26 at 12:42 PM, 06/28/26 at 3:31 AM, and 06/30/26 at 4:42 PM. Review of Resident #3's July 2026 Medication Administration Record reflected he did not receive any Ativan. Observation and interview on 07/09/26 at 9:45 AM, Resident #3 was in his room resting in bed watching TV. Resident #3 said he was not feeling well today and was not doing good. Resident #3 said he had not been anxious in a while and knew to ask for his medication to help him if he needed it. Resident #3 said he had not needed his anxiety medication in a while but was not sure when he last needed the medication. Interview on 07/09/26 at 9:48 AM, LVN D said Resident #3 was placed on hospice services about a month ago or so. LVN D said Resident #3 sometimes hallucinated and showed anxious behaviors and would be given his PRN anti-anxiety medication to help him calm down. LVN D said Resident #3 knew how to ask for his medication if he felt anxious and needed it but he had been doing better lately. LVN D said Resident #3 had not needed his anti-anxiety medication in a while. LVN D said she reviewed Resident #3's orders for his Ativan and it did not have a 14-day stop date for it. LVN D said Resident #3's ordered Ativan should have a 14-day stop date since it had something to do with behaviors. LVN D said the doctor usually gave the order for a 14-day stop date but staff could add it after asking the (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor about it. LVN D said if Resident #3's ordered Ativan did not have 14-day stop date he could have an adverse reaction but she was not sure what that could be. Interview on the phone on 07/09/26 at 9:58 AM, LVN E said she had added Resident #3's as needed Ativan order to his chart. LVN E said the doctor did not give a stop date which normally would have been included with an order like this. LVN E said she was not sure if this situation would apply to a resident on hospice services, which Resident #3 was receiving. LVN E said Resident #3 did get anxious sometimes and would request the ordered Ativan sometimes but he has not recently needed any of this medication. LVN E said the 14-day stop date should have been included with the order and she should have added it to the order but she was not sure what could happen without it. Interview on 07/09/26 at 10:26 AM, the Unit Manager who said Resident #3 should have a 14-day stop date on his ordered Ativan. The Unit Manager said the Pharmacy Nurse who was onsite would have been the one to review Resident #3's orders and make sure the 14-day stop date was included with the order. The Unit Manager said Resident #3 started on hospice services about a month ago and that was where the order came from. The Unit Manager said the nurse who took the order from hospice should have included the 14-day stop date because the resident may not need to be on it for a long time. Interview on 07/09/26 at 10:38 AM, the Pharmacy Nurse said Resident #3 was on hospice services and she understood from hospice that residents on an anti-anxiety medication that was as needed did not require a stop date. The Pharmacy Nurse said normally any anti-anxiety medication that was ordered for as needed required a 14-day stop date for it. The Pharmacy Nurse said she reviewed resident's orders every day and because she thought since the resident was on hospice it was not a requirement for him. The Pharmacy Nurse said ultimately she was responsible for making sure Resident #3's ordered Ativan included a 14-day stop date. The Pharmacy Nurse said if the medication did not include the 14-day stop date he could have adverse reactions but did not specify what they could be. Interview on 07/09/26 at 11:50 AM, the DON said Resident #3 was on hospice services and she understood that meant his ordered Ativan did not need at 14-day stop date. The DON said the Pharmacy Nurse would have been responsible for ensuring the 14-day stop date was included in Resident #3's Ativan order. The DON said there was no risk the 14-day stop date was not included for Resident #3's ordered Ativan because staff were constantly assessing him if he had any sort of effects from his medications. Review of the facility's undated policy titled Use of Psychotropic Medication(s) reflected: 16. Psychotropic medication used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted: a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or the prescriber for the rationale for the extended period and indicate a specific duration.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident (Resident #109) reviewed for intravenous fluids. The facility failed to change and maintain the integrity of the dressing on Resident #109's Central Venous Catheter (an indwelling device inserted into a large, central vein that sends medicines and other treatments into a large vein in the middle of your chest) per professional standards. These failures could place residents at risk for infections and cross-contamination. Findings include: Record review of Resident #109's quarterly MDS Assessment, dated 06/24/26, revealed an [AGE] year-old male who admitted to the facility on [DATE] and reentry on 06/17/26. Resident #109 had diagnoses which included chronic venous hypertension with ulcer of right lower extremity (damaged vein valves cause blood to pool in the lower leg, forcing fluid into the tissue), lymphedema (chronic condition that causes swelling), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), hypertension (high blood pressure), and heart failure. The MDS reflected that the resident's cognition was intact with a BIMS score of 14. The MDS did not address the use of antibiotics or central line. Record review of Resident #109's care plan, revised 07/06/26, revealed Focus: [Resident #109] has potential/actual impairment to skin integrity of the (BLE) r/t lymphedema, not elsewhere classified, cellulitis of unspecified part of limb. Non pressure ulcer right calf to subcutaneous layer, cellulitis of right lower extremity. Goal: He will maintain or develop clean and intact skin by the review date. Intervention: Monitor for side effects of the antibiotics and over-the-counter pain medications: gastric distress, rash, or allergic reactions which could exacerbate skin injury. Care plan did not address the central line. Record review of Resident #109's active physician order, dated 07/08/26, revealed the following orders: CefTRIAXone Sodium Solution Reconstituted 2 GM Use 2 gram intravenously every 24 hours for Wound infection related to Chronic venous hypertension with ulcer of right lower extremity. Order date 07/01/26 - Start Date 07/01/26 - End date 07/16/26. Change dressing to PICC line weekly - Weekly every 7 day(s) for PICC Line - Order date 07/02/26 - Start date 07/02/26. Change dressing to Central Venous Catheter weekly using sterile technique. every day shift every Tue for Central Venous Catheter - Order date: 07/01/26 - Start Date 07/07/26. Record review of Resident #109's July [DATE] revealed the following: Change dressing to PICC line weekly - Weekly every 7 day(s) for PICC Line -Start Date- 07/02/2026 1200. It was documented CVC dressing was changed on 07/02/26 by RN B. Change dressing to Central Venous Catheter weekly using sterile technique. every day shift every Tue for Central Venous Catheter -Start Date- 07/07/2026 0700. It was documented CVC dressing was changed on 07/07/26 by RN B. During an observation and interview on 07/08/26 at 11:26 a.m., revealed Resident #109 was in his room. Resident #109 stated he was doing well. Resident #109 had a central venous catheter on his upper right chest, and the dressing had a date of 06/30/26. Resident #109 stated his catheter was placed on 06/30/26, and his dressing had not been changed since then. The resident denied any pain or discomfort. During an interview on 07/08/26 at 11:30 a.m., LVN A stated she was the nurse assigned to Resident #109. She stated Resident #109 was receiving antibiotics via central line. She stated Resident #109 had orders for antibiotics and flushing. LVN A reviewed Resident #109's orders and stated he had an order for dressing change every 7 days. LVN A reviewed Resident #109's July MAR and stated it was documented the resident's central line dressing was changed on 07/07/26. LVN A entered Resident (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#109's room, observed the central line dressing and stated the dressing was dated 06/30/26. She stated the nurse assigned to Resident #109 yesterday (07/07/26) failed to change the dressing and documented something that was not done. She stated she was not aware it was not done. LNV A stated the assigned nurses were responsible for changing the dressings. She stated the potential risk of not following physician orders was it could lead to infection. Interview on 07/08/26 at 2:53 p.m. via phone, RN B stated he was the assigned nurse for Resident #109 yesterday (07/07/26) and 07/02/26. He stated Resident #109 was receiving IV antibiotics. He stated the central line dressing had to be changed weekly. He stated he had not changed Resident #109's dressing yesterday (07/07/26) or on 07/02/26, he stated he only flushed the IV. RN B stated when he flushed the IV he did not pay attention to the dressing. He stated he was not aware the dressing had not been changed. RN B stated the night nurse was responsible for administering the IV antibiotics and changing the dressing. RN B stated he did not pay attention when documenting, he stated it was a mistake. He stated he thought the nurse changed the dressing and made the mistake of documenting on the resident's MAR. He stated he does not recall documenting anything. He stated the potential risk of not changing the central line dressing could lead to an infection. Interview on 07/09/26 at 12:16 p.m., the ADON stated the expectation for resident receiving antibiotics the nurses must follow physician orders, check site, flush, and change central line dressing every 7 days. She stated the charge nurse assigned to the resident was responsible for changing the dressings on IVs. The ADON stated if the nurse was unable to change the IV dressings, the nurse must notify the Unit Supervisor, ADON or DON. She stated the potential risk of not changing the IV dressings could lead to an infection. Interview on 07/09/26 at 12:28 p.m., the DON stated the expectation for residents receiving antibiotics the nurses must change the central line dressing weekly, using a sterile technique. If nurse not able to change the central line dressing, the nurse must notify management. The DON stated the nurses were responsible for changing central dressing. She stated the Unit Manager, ADON and herself were responsible for overseeing to ensure central line dressing were being changed. The DON stated they have in-service the nurses and nurses' complete yearly trainings on PICC lines; however, she could not recall when the last time it had been done. She stated the potential risk of not changing the dressing could lead to skin irritation. Record review of facility Mid-line, PICC Catheter Dressing Change dated 09/2012, reflected the following: . The initial dressing change must be done 24 hours post insertion of catheter, dressing changes will then be performed one time per week and as needed whenever the integrity of the dressing is compromised.		

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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 ensure the clinical records were maintained in accordance with accepted professional standards and practices and were complete and accurately documented for 1 of 6 residents (Resident #109) records reviewed for treatment documentation. RN B inaccurately documented that Resident #109's Central Venous Catheter (an indwelling device inserted into a large, central vein that sends medicines and other treatments into a large vein in the middle of your chest) dressing was changed on 07/02/26 and 07/07/26 when it was not. These failures could affect the residents' medical record not being an accurate representation of the resident's medical condition or medical needs. Findings included: Record review of Resident #109's quarterly MDS Assessment, dated 06/24/26, revealed an [AGE] year-old male who admitted to the facility on [DATE] and reentry on 06/17/26. Resident #109 had diagnoses which included chronic venous hypertension with ulcer of right lower extremity (damaged vein valves cause blood to pool in the lower leg, forcing fluid into the tissue), lymphedema (chronic condition that causes swelling), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body), hypertension (high blood pressure), and heart failure. The MDS reflected that the resident's cognition was intact with a BIMS score of 14. The MDS did not address the use of antibiotics or central line. Record review of Resident #109's care plan, revised 07/06/26, revealed Focus: [Resident #109] has potential/actual impairment to skin integrity of the (BLE) r/t lymphedema, not elsewhere classified, cellulitis of unspecified part of limb. Non pressure ulcer right calf to subcutaneous layer, cellulitis of right lower extremity. Goal: He will maintain or develop clean and intact skin by the review date. Intervention: Monitor for side effects of the antibiotics and over-the-counter pain medications: gastric distress, rash, or allergic reactions which could exacerbate skin injury. Care plan did not address the central line. Record review of Resident #109's active physician order, dated 07/08/26, revealed the following orders: CefTRIAXone Sodium Solution Reconstituted 2 GM Use 2 gram intravenously every 24 hours for Wound infection related to Chronic venous hypertension with ulcer of right lower extremity. Order date 07/01/26 - Start Date 07/01/26 - End date 07/16/26. Change dressing to PICC line weekly - Weekly every 7 day(s) for PICC Line - Order date 07/02/26 - Start date 07/02/26. Change dressing to Central Venous Catheter weekly using sterile technique. every day shift every Tue for Central Venous Catheter - Order date: 07/01/26 - Start Date 07/07/26. Record review of Resident #109's July [DATE] revealed the following: Change dressing to PICC line weekly - Weekly every 7 day(s) for PICC Line -Start Date- 07/02/2026 1200. It was documented CVC dressing was changed on 07/02/26 by RN B. Change dressing to Central Venous Catheter weekly using sterile technique. every day shift every Tue for Central Venous Catheter -Start Date- 07/07/2026 0700. It was documented CVC dressing was changed on 07/07/26 by RN B. During an observation and interview on 07/08/26 at 11:26 a.m., revealed Resident #109 was in his room. Resident #109 stated he was doing well. Resident #109 had a central venous catheter on his upper right chest, and the dressing had a date of 06/30/26. Resident #109 stated his catheter was placed on 06/30/26, and his dressing had not been changed since then. The resident denied any pain or discomfort. During an interview on 07/08/26 at 11:30 a.m., LVN A stated she was the nurse assigned to Resident #109. She stated Resident #109 was receiving antibiotics via central line. She stated Resident #109 had orders for antibiotics and flushing. LVN A reviewed Resident #109 orders and stated Resident #109 had an order for dressing change every 7 days. LVN A reviewed Resident #109's July MAR and stated it was (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented resident's central line dressing was changed on 07/07/26. LVN A entered Resident #109 room, observed Resident #109's central line dressing and stated the dressing was dated 06/30/26. She stated the nurse assigned to Resident #109 yesterday (07/07/26) failed to change the dressing and documented something that was not done. She stated she was not aware it was not done. LNV A stated the assigned nurses were responsible for changing the dressings. She stated the potential risk of inaccurate documentation is the inability to know whether the treatment was completed. Interview on 07/08/26 at 2:53 p.m. via phone, RN B stated he was the assigned nurse for Resident #109 yesterday (07/07/26) and 07/02/26. He stated Resident #109 was receiving IV antibiotics. He stated the central line dressing had to be changed weekly. He stated he had not changed Resident #109's dressing yesterday (07/07/26) or on 07/02/26, he stated he only flushed the IV. RN B stated when he flushed the IV he did not pay attention to the dressing. He stated he was not aware the dressing had not been changed. RN B stated the night nurse was responsible for administering the IV antibiotics and changing the dressing. RN B stated he did not pay attention when documenting, he stated it was a mistake. He stated he thought the other nurse changed the dressing and he made the mistake of documenting on the resident's MAR. He stated does not recall documenting anything. RN B stated accurate documentation was important so that other nurses know what treatment had been completed. Interview on 07/09/26 at 12:16 p.m., the ADON stated nurses were responsible for documenting each treatment after completion. If treatment was not completed, nurses were still responsible for documenting that the treatment was not completed. ADON stated the potential risk of inaccurate documentation would be a med error. Interview on 07/09/26 at 12:28 p.m., the DON stated nurses were expected to document accurately, monitor any signs or symptoms. She stated the potential risk of incorrect documentation would be nurses unable to determine whether care was completed in a timely manner. Record review of facility Documentation in Medical Record undated, reflected the following: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of services, but no later than the shift in which the assessment, observation, or care service occurred.		