STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675857	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William R Courtney Texas State Veterans Home	1424 Martin Luther King Jr LN Temple, TX 76504

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 (Residents #1 and #2) of 12 residents reviewed for resident to resident altercations. The facility failed to prevent Resident #2 from being abused when Resident #1 punched him and knocked him on the floor, resulting in pain. Staff failed to notify the ADM, who was the abuse coordinator of the incident. This failure resulted in an IJ being identified on 07/22/25. The IJ template was provided to the facility on [DATE] at 6:05 p.m. While the IJ was removed on 07/23/25, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk of abuse, neglect, change in condition, and receiving untimely care and services. Review of Resident #1's admission Record, dated 07/22/25, reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] and had an RP. Resident #1 had medical diagnoses including late onset Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), dementia (a general term for a decline in mental ability, severe enough to interfere with daily life), and unsteadiness on feet. Review of Resident #1's Quarterly MDS, dated [DATE], reflected he had a BIMS score of 4/15, which indicated he had severe cognitive impairment. Resident #1 also had a fluctuated presence of inattention and disorganized thinking behaviors. Resident #1 had no other noted behavior symptoms. Resident #1 also had no wandering behaviors noted. Review of Resident #1's Care Plan, dated 05/05/25, reflected no notes related to aggression and other behaviors. Resident #1 had impaired cognitive function/dementia or impaired thought process related to Alzheimer's dementia. All staff was required to keep his routine and caregivers consistent to decrease confusion, administer medications as ordered, ask yes/no questions to determine his needs, and break tasks one step at a time. There was no other interventions noted. Resident #1 was also at risk for elopement and/or wandering with unsafe boundaries related to his dementia. Nursing staff and the SW was required to assess his continued need for residing in the memory care/secure unit and identify exit seeking patterns and intervene as appropriate to minimize behavior. There was no other interventions noted. Resident #1 also had a communication problem related to his Alzheimer's dementia. Nursing staff was required to anticipate and meet his needs, notify the MD PRN for changes in communication, and encourage him to continue stating thoughts even if he was having difficulty. There was no other interventions noted. Review of Resident #1's Progress Notes reflected:-A nursing progress note by LVN A on 05/27/25 at 11:38 a. m., While taking BS before lunch, I heard screaming. Found [Resident #1] in the door way standing up with his Foley dragging on the ground. [Resident #2] was lying on the floor. [Resident #1] punch [Resident #2] who tried to enter is room in the face. [Resident #2] was punched to the ground, [Resident #1] needed to be held back by staff to keep him from hitting [Resident #2] again. [Resident #1] was screaming, 'I ain't done with him.' Was able to talk [Resident #1] down and keep him in his room to avoid further altercation. MD made aware. Will continue with plan of care. Review of Resident #2's admission Record, dated 07/22/25, reflected he was an [AGE] year-old male who was admitted to the facility on [DATE] and had an RP. Resident #2 had medical diagnoses including dementia, late onset Alzheimer's disease, repeated falls, mood disorder, unsteadiness on feet, and cognitive communication deficit. Review of Resident #2's admission MDS, dated [DATE], reflected he had a BIMS score of 8/15, which indicated he had moderate cognitive impairment. Resident #2 did not have any acute onset mental status change in behaviors noted. Resident #2 had physical and verbal behaviors directed towards others and other behavioral symptoms not directed toward others that occurred every 1-3 days noted. Resident #2 also had wandering behaviors that occurred every 1-3 days. Review of Resident #2's Care Plan, dated 04/08/25, reflected no notes related to aggressive behaviors. Resident #2 was also at risk for wandering with unsafe boundaries related to his cognitive impairment/judgement and safety awareness. Nursing staff and the SW were required to assess Resident #2's need for residing in the memory care unit and wander guard use as interventions for his wandering risk. There were no other interventions noted. Resident #2 also chose not to follow recommendations made by his physician and clinical team related to his care and services. Nursing staff were required to ensure his safety and health by attempting several times to provide care even if he initially refuses and to redirect and approach again when he was no longer agitated. There were no other interventions noted. Resident #2 also

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and establish policies and procedures to investigate any such allegations for two out of eight residents (Resident #1 and Resident #2). 1.The facility staff did not report Resident #1 and Resident #2's resident-to-resident altercation to the administrator immediately after the incident on 05/27/25. 2. The facility failed to report to Health and Human Services alleged abuse that occurred in the facility's secured unit on 05/27/25 involving Resident #1 and Resident #2. This failure resulted in the identification of Immediate Jeopardy (IJ) on 07/02/25 at 5:00pm. While the immediacy was removed on 07/03/25 at 12:58pm the facility remained out of compliance at scope of isolated and severity no actual harm due to the facility's need to monitor the implementation of the plan of removal. This failure could place residents at risk of ongoing abuse, neglect, pain, and diminished quality of life.Findings included: Review of Resident #1's face sheet, dated 06/07/25, reflected a [AGE] year-old male admitted on [DATE] with diagnoses of basal cell carcinoma of skin (skin cancer), iron deficiency anemia, vitamin D deficiency, chronic kidney disease, Alzheimer's disease, psychotic disturbance, mood disturbance and anxiety. Review of Resident #1's MDS assessment, dated 04/25/25, reflected a BIMS score of 04 reflecting severe cognitive impairment. The MDS did not indicate any behavior concerns. Review of Resident #1's care plan, dated 05/28/25, reflected Resident #1 can become aggressive when he perceived that others are invading his space. The relevant intervention was to monitor/document/report to MD PRN of any unexpected side effects to anti-anxiety therapy like mania, hostility, rage, aggressive or impulsive behavior and hallucinations. Review of Resident #1's progress notes on electronic medical record (EMR), dated 05/27/25 at 11:46 am authored by LVN A, reflected: While taking BS [a resident] before lunch, I heard screaming. Found resident [Resident #1] in the doorway standing up with his Foley dragging on the ground. His peer was lying on the floor. Resident punch his peer [Resident #2] who tried to enter his room in the face. His peer was punched to the ground, resident needed to be held back by staff to keep him from hitting his peer again. Resident was screaming I ain't done with him. Was able to talk resident down and keep him in his room to avoid further altercation. MD made aware. Will continue with plan of care. Progress notes of Resident #1 by LVN A on 05/27/25 at 14:40pm reflected: CNA notified this nurse that resident had bruising to the corner of left eye. When assessing resident eye noted pupil is enlarged and covering part of iris. Reached out to on-call MD, for sending out for CT of head. Also notified MD, who states to reach out to RP and if they prefer to be sent out or monitored in-house. RP- states to monitor in-house and if eye worsens to be sent out. MD made aware. Will continue with plan of care. Review of Resident #2's face sheet, dated 06/07/25, reflected an [AGE] year-old male admitted on [DATE] with diagnoses of Alzheimer's disease, mood disorder due to known physiological condition, type 2 diabetes, chronic kidney disease and unsteadiness on feet. Review of Resident #2's MDS, dated [DATE], reflected a BIMS score 8 reflecting moderate cognitive impairment. The MDS indicated physical and verbal behavioral symptoms directed towards others. Review of Resident #2's care plan, dated 05/28/25, reflected Resident #1 was at risk for elopement and/or wandering, r/t: cognitive impairment/judgement and enter other residents' rooms uninvited and do not want to leave as it happened on 05/27/25 . The relevant interventions were, assessing his continued need for residing on the memory care/secure unit and putting pictures on the wall beside the door of Resident #1's room to identify which room was his. Review of progress notes, dated 05/27/25 at 11:30 am, of Resident # 2 authored by LVN A reflected : While taking BS [a resident at the facility] heard resident scream. He (Resident #2) was found on the floor in the hallway, he had been punched in the face d/t entering another resident (Resident #1) room without permission. No injuries noted. Record review of Resident #1 and Resident #2's Q15 minute Behavior related time observation 72-hour hot box revealed 15 minutes check on Resident #1 and Resident #2 were commenced on 05/27/25 at 11:30 am and ended on 05/29/25 at 6:00 pm. Record review of safe surveys among the residents residing in memory care dated 05/27/25 revealed there were no negative remarks from any of the residents in the safe survey. During a telephone interview on 06/07/25 at 2:30pm, LVN A stated during her rounds on 05/27/25 at about 11:00 am, she saw Resident #1 in his bed sleeping. At about 11:30 am, while she was attending another resident, she heard a screaming from Resident #1's room. She stated she rushed to Resident #1's room to see Resident #2 was on the ground and Resident #1 was standing against him with [NAME]. LVN A said the staff intervened and separated them without further incidents. She

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and establish policies and procedures to investigate any such allegations for two out of eight residents (Resident #1 and Resident #2) 1.The facility staff did not report Resident #1 and Resident #2's resident-to-resident altercation to the administrator immediately after the incident on 05/27/25. 2. The facility failed to report to Health and Human Services alleged abuse that occurred in the facility's secured unit on 05/27/25 involving Resident #1 and Resident #2. This failure resulted in the identification of Immediate Jeopardy (IJ) on 07/02/25 at 5:00pm. While the immediacy was removed on 07/03/25 at 12:58pm the facility remained out of compliance at scope of isolated and severity no actual harm due to the facility's need to monitor the implementation of the plan of removal. This failure could place residents at risk of ongoing abuse, neglect, pain, and diminished quality of life. Findings included: Review of Resident #1's face sheet dated 06/07/25, reflected a [AGE] year-old male admitted on [DATE] with diagnoses of basal cell carcinoma of skin (skin cancer), iron deficiency anemia, vitamin D deficiency, chronic kidney disease, Alzheimer's disease, psychotic disturbance, mood disturbance and anxiety. Review of Resident #1's MDS assessment, dated 04/25/25, reflected a BIMS score of 04 reflecting severe cognitive impairment. The MDS did not indicate any behavior concerns. Review of Resident #1's care plan dated 05/28/25 reflected Resident #1 can become aggressive when he perceived that others are invading his space. The relevant intervention was to monitor/document/report to MD PRN of any unexpected side effects to anti-anxiety therapy like mania, hostility, rage, aggressive or impulsive behavior and hallucinations. Review of Resident #1’s progress notes on electronic medical record (EMR) dated 05/27/25 at 11:46 am authored by LVN A reflected : “While taking BS [a resident] before lunch, I heard screaming. Found resident [Resident #1] in the doorway standing up with his Foley dragging on the ground. His peer was lying on the floor. Resident punch his peer [Resident #2] who tried to enter his room in the face. His peer was punched to the ground, resident needed to be held back by staff to keep him from hitting his peer again. Resident was screaming I ain’t done with him. Was able to talk resident down and keep him in his room to avoid further altercation. MD made aware. Will continue with plan of care.” Progress notes of Resident #1 by LVN A on 05/27/25 at 14:40pm reflected: “ CNA notified this nurse that resident had bruising to the corner of left eye. When assessing resident eye noted pupil is enlarged and covering part of iris. Reached out to on-call MD, for sending out for CT of head. Also notified MD, who states to reach out to RP and if they prefer to be sent out or monitored in-house. RP- states to monitor in-house and if eye worsens to be sent out. MD made aware. Will continue with plan of care.” (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's face sheet dated 06/07/25, reflected an [AGE] year-old male admitted on [DATE] with diagnoses of Alzheimer’s disease, mood disorder due to known physiological condition, type 2 diabetes, chronic kidney disease and unsteadiness on feet. Review of Resident #2's MDS, dated [DATE], reflected a BIMS score 8 reflecting moderate cognitive impairment. The MDS indicated physical and verbal behavioral symptoms directed towards others. Review of Resident #2's care plan dated 05/28/25 reflected Resident #1 was at risk for elopement and/or wandering, r/t: cognitive impairment/judgement and enter other residents' rooms uninvited and do not want to leave as it happened on 05/27/25 . The relevant interventions were, assessing his continued need for residing on the memory care/secure unit and putting pictures on the wall beside the door of Resident #1’s room to identify which room was his. Review of progress notes dated 05/27/25 at 11:30 am of Resident # 2 authored by LVN A reflected : “While taking BS [a resident at the facility] heard resident scream. He (Resident #2) was found on the floor in the hallway, he had been punched in the face d/t entering another resident (Resident #1) room without permission. No injuries noted….” Record review of Resident #1 and Resident #2’s “Q15 minute Behavior related time observation 72-hour hot box” revealed 15 minutes check on Resident #1 and Resident #2 were commenced on 05/27/25 at 11:30 am and ended on 05/29/25 at 6:00 pm. Record review of safe surveys among the residents residing in memory care dated 05/27/25 revealed there were no negative remarks from any of the residents in the safe survey. During a telephone interview on 06/07/25 at 2:30pm, LVN A stated during her rounds on 05/27/25 at about 11:00 am, she saw Resident #1 in his bed sleeping. At about 11:30 am, while she was attending another resident, she heard a screaming from Resident #1’s room. She stated she rushed to Resident #1’s room to see Resident #2 was on the ground and Resident #1 was standing against him with [NAME]. LVN A said the staff intervened and separated them without further incidents. She said she had conducted a head-to-toe assessment on both and found no injuries, pain, or deformation. She stated both the residents spent the rest of the days with their normal activities. LVN A stated ,at about 2:30 pm, CNA B reported a hematoma at the left orbit of the left eye of Resident #1 . She stated during observation she noticed dilated pupils of the left eye as well. LVN A stated she immediately contacted the RP and NP for further instructions for care. LVN A said she was not sure if the injury occurred from the incident between Resident #1 and Resident #2 or an injury of unknown origin as there was no injuries observed during the initial assessment immediately after the incident . LVN A stated she reported the incident to UM. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 06/07/25 at 3:40 pm, CNA B stated she had witnessed the incident as she was in the 800 Hallway when the incident was occurred. She stated both Resident #1 and Resident #2 resided in Hall-800. CNA B stated at about 11:30 am, while she was doing the bed of Resident #2, she heard a loud argument between Resident #1 and Resident #2 . She stated Resident #2, who was shorter than Resident #1, was standing at the door of Resident #1 facing towards Resident #1. His right arm was up towards Resident #1’s face, and in a fraction of a second, Resident #1 punched both of Resident #2’s shoulders, and knocked him down. She stated she believed during the fall, Resident #2’s right hand might have brushed Resident #1’s left side of the face. She stated staff immediately intervened and deescalated the situation. She said she explained the incident to the charge nurse, LVN A, who was present to separate the residents. During an interview on 06/07/25 at 1:25 pm, the NP stated she visited and assessed Resident #1 on 05/28/25 . She stated she observed a hematoma at the left periphery of his left eye. The NP said there was no swelling or discomfort noticed at that time. She stated, during her assessment, Resident #1 asked her why everybody was inquiring if his eyes were hurting though he did not have any issue with his eyes. During an interview on 06/07/25 at 1:10 pm, the UM stated she was the manager for the memory care unit where Resident #1 and Resident #2 resided. She said the staff reported to her, that on 05/27/25 at about 11:30 am, Resident #1 knocked Resident #2 down to the floor when Resident #2 wandered into Resident #1’s room. She stated Resident #2 was a wanderer whereas Resident #1 preferred to be in his room, and was protective of his personal space. The UM stated Resident #1 shared his room with another resident and he never had any issue with him, however, Resident #1 did not like if anyone else intruded into his space without his permission. The UM said Resident #1 and Resident #2 had no injuries from the incident, however, a few hours after the incident, Resident #1 developed a hematoma to the left side of his left eye. She added, it was unclear if the injury was from the incident between him and Resident #2. During another interview on 06/20/25 at 11:20 am, the UM stated she reported the incident on 05/27/25, immediately after the incident, to the DON. She stated she did not report the incident directly to the ADM, who was the abuse coordinator, since she had reported it to the DON so that he would report the incident to the ADM. During a phone interview on 06/07/25 at 1:10 pm, the DON stated he had not witnessed the incident, however, he saw the resident when the staff reported of the hematoma at the left eye area, and conducted a neuro assessment . He stated the facility informed the RP about the plan to send Resident #1 to the hospital, however theRP stated it would be okay to put him under observation at the facility if the injury was not serious. The DON stated, per his assessment, the resident had a discoloration at the periphery of the left eye with a dilated pupil. He stated no swelling , pain, or other issues were noticed . He stated the NP at the facility did an assessment on him later, and recommended to keep him under close observation at the facility. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/20/25 at 12:20 pm, the DON stated the UM phoned him and let him know about the incident, and he thought she had informed the ADM as well. He said per facility policy, any abuse or neglect were reported to the ADM, the abuse coordinator, directly instead of following the chain of command. He stated in-services conducted on abuse and neglect that covered reporting. He stated he was under the impression that all staff were aware of it. The DON stated he did not conduct any knowledge check on staff in this regard. The DON stated in-services were conducted by the clinical management team that included peoples like the DON, the Physical therapy manager and the wound care nurse. The DON stated, after the incident, the nurse conducted a head-to-toe assessment on Resident #1 and Resident #2, mental status assessments were completed on all residents to ensure emotional safety, safe surveys were conducted by the social worker, and the family and physician were contacted. The DON stated both the residents involved were under close monitoring every 15 minutes for 72 hours, and there were no incidents after the incident occurred on 05/27/25, between Resident #1 and Resident #2. During an interview on 06/20/25 at 10:30 am, CNA C stated she worked at the facility for about 3 years. She said she received in-services often on abuse and neglect. CNA C stated she would follow the chain of command and would report abuse and neglect to the nurse in charge. She stated she believed the abuse coordinator was the ADM though she was not very sure. During an interview on 06/20/25 at 10:20 am, the HK D stated he worked at the facility for two months. He stated he received abuse and neglect training during orientation. HK D stated if he witnessed any abuse or neglect, he would report it to the nurse in charge. He stated he did not know who the facility abuse coordinator was. During an interview on 06/20/25 at 11:55 am, MA E stated she would follow the chain of command and report any abuse or neglect to the nurse in charge so that she would be able to report it to the ADM who was the abuse coordinator. During an interview on 06/20/25 at 12:00 pm, CNA F stated she has been working at the facility since October 2024 . She said if she was in suspicion of any abuse or neglect at the facility, she would report that to the ADM and nurse in charge. CNA F stated she did not know who the abuse coordinator was. During an interview on 06/20/25 at 12:05 pm, CNA G stated she would report abuse or neglect to the nurse in charge of the unit on that day. She stated she did not know who the abuse coordinator was. An observation on 06/20/25 in Hall A, B, C and D revealed the abuse coordinator’s name (ADM) and phone number was displayed in the nursing stations, instructing to contact him to report abuse and neglect. During an interview on 06/07/25 at 12:30 pm, the ADM stated he had no idea about any reportable incidents that occurred at the facility recently. He stated he was not aware of the altercation between Resident #1 and Resident #2 that occurred on 05/27/25. He stated he was not aware of it as no one reported to him. The ADM stated there was no specific system of reporting in writing, however, staff members generally met him at the office to report incidents or phoned him if he was away from facility. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/20/25 at 1:30 pm, the ADM stated he was the abuse coordinator, and it was his responsibility to report any reportable incidents reported to state agency. He stated, in his absence, it was delegated to other responsible team members and ensured that the incidents were reported by them in a timely manner in his absence. He stated the staff required further training in reporting abuse and neglect directly to him instead of following the chain of command. He stated he monitored if reportable incidents were reported to him, by reviewing the progress notes and reports in EMR, daily rounding in the facility by administrative staff, talking to residents about any concerns or incidents, discussing in the daily morning staff meeting, and reviewing 24 hours reporting forms. Record review on 06/20/25 of the in-services since 03/01/25 reflected revealed in-services on abuse and neglect and reporting were conducted on 6/18/25, 6/12/25,5/28/25, 5/12/25, 4/17/25, and 3/23/25. These in-services indicated: “You should report ANE incidents immediately or no later than two hours after the incident occurs or suspected to Administrator /Abuse coordinator.” “It is the responsibility of everyone to stop any instances of ANE and then report it to the proper authorities. Immediately report abuse/neglect to the abuse and neglect coordinator [ADM] ph. xxxx.” Record review on 06/07/255 of Texas Unified Licensure Information Portal (TULIP- the online portal used by healthcare providers in Texas to report various incidents, including those related to abuse and neglect) reflected no initial self-report by the facility for an incident occurred on 05/27/25 involving Resident #1 and Resident #2. Record review of the facility’s policy “Abuse Guidance: Preventing, Identifying and Reporting” implemented in February 2017 reflected: “…… Seven Elements of ANE: Screening - All team members are to report any signs and symptoms or suspicions of abuse/neglect to the Administrator/Abuse Coordinator, their supervisor or to the Director of Nursing immediately. Training- All new and existing team members receive periodic in-service training relative to resident rights and abuse neglect and exploitation ANE prevention, identification, protecting and reporting. Prevention- The Administrator/Abuse Coordinator has the overall responsibility for the coordination and implementation of the ANE prevention and reporting program. Identification- It is the responsibility of our team members, consultants, attending physicians, family members, visitors, etc. to promptly report any incident of suspected neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to the Abuse Coordinator/Administrator and/or community’s management. Protection- Our community will protect residents from harm during investigations of abuse allegations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675857	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William R Courtney Texas State Veterans Home	1424 Martin Luther King Jr LN Temple, TX 76504

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Reporting/Response- All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities are individuals as may be required by law and per the current state/federal reporting requirements. Investigation- All phases of the investigation will be kept confidential in accordance with the Community’s policies concerning the confidentiality of medical records. …Reporting Allegations or Suspicions of Abuse : Allegations of, incidents of or suspicions of abuse or neglect are reportable to state authorities in accordance with HHSC’s PL 19-17. A community owner, operator or team member who has knowledge of an allegation of or cause to believe that abuse, neglect, or exploitation has been allegedly occurred should report the suspicion or allegation of abuse, neglect, or exploitation to state authorities and may also be reported to local authorities as indicated… ….Report alleged or suspicions of abuse to HHSC by email reporting or via TULIP reporting within the designated time frames in accordance with HHSC’s PL 19-17 (Replaces PL 17-18)…. ….Resident-to-resident altercation should be reviewed as a potential situation of abuse, as per HHSC’s PL 19-17 (Replaces PL 17-18)…” On 07/02/25 at 5:00pm an Immediate Jeopardy (IJ) was identified. The ADM was notified. The ADM was provided with the IJ template, and a Plan of Removal (POR) was requested at that time. The following Plan of Removal, submitted by the facility and accepted on 07/03/2025 at 12:58 pm, indicated the following: Plan of Removal Community’s Name: [facility] Immediate Plan of Removal for: Abuse and Neglect/Resident to resident Failure to report. Immediate Response: All residents were immediately assessed by the nurse to ensure physical and emotional well-being. Date Completed: 7/2/2025. Outcome: No s/s of physical or emotional distress (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Risk Response: Risk: All residents and those who reside on the memory care unit may potentially be affected. · “Administrator/Social Worker/Director of Nursing/Designee will conduct team members and resident interviews to identify any concerns. If any are identified nursing and social service will assess, notify the physician, local authorities and the IDT and will review the plan of care as indicated. Date completed: 7/2/2025.Outcome: No negative outcomes were identified.” Interviews with staff and residents and record review of inservice files on 07/03/25 revealed this was accomplished on 07/02/25. · “Vice President of Operations conducted re-education to the Director of Nursing and Administrator regarding the Abuse and Neglect, Identifying and Preventing; thus, having the identified risk identified on the plan of care and to ensure appropriate monitoring and supportive interventions are in place and an investigation is conducted.” Date completed: 7/2/2025. Record review of the in-service folder on 07/03/25 revealed vice president of operations conducted an in service on 07/02/25. Review of the sign in sheet revealed Director on Nursing Services and Administrator had attended. During an interview on 07/03/25 the DON and ADM stated they attended the reeducation program. · “Vice President of Operations conducted a re-education of Abuse and Neglect reporting guideline to the Director on Nursing Services and Administrator. Date completed: 7/2/2025.” Record review of the in-service folder on 07/03/25 revealed vice president of operations conducted an in service on 07/02/25. Review of the sign in sheet revealed Director on Nursing Services and Administrator had attended. During an interview on 07/03/25 the DON and ADM stated they attended the reeducation program. · “The Director of Nursing Services conducted education to the Assisted Director of Nursing Services, Memory Care Director, and Health Information Coordinator on Abuse and Neglect reporting guidelines and regarding the Abuse and Neglect, Identifying and Preventing; thus, having the identified risk identified on the plan of care and to ensure appropriate monitoring and supportive interventions are in place and an investigation is conducted. Date Completed: 7/2/2025.” Record review of the in-service folder and interviews with various staff members on 07/03/25 revealed this was accomplished on 07/02/25. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	System Response: · “Director of Nursing / Assistant Director of Nursing, Health Information Coordinator and Memory Care Director conducted re-educated to the team members regarding the Abuse and Neglect, Identifying and Preventing; thus, having the identified risk identified on the plan of care and to ensure appropriate monitoring and supportive interventions are in place. Date completed: 7/2/2025.” Record review of the in-service folder and interviews with various staff members on 07/03/25 revealed this was accomplished on 07/02/25. “Director of Nursing / Administrator / Designee provided education to all team members regarding the process for monitoring, observing, and reporting all concerns, involving resident to resident altercations or s/s ANE, by anyone, including family, visitors or staff immediately to their immediate supervisor and administrator/abuse coordinator in order to protect the safety and well-being of all residents and to ensure appropriate interventions are in place and the care plan/ Kardex are adhered to as per facility’s expected practices. Date completed: 7/2/2025.” Record review of the in-service folder and interviews with various staff members on 07/03/25 revealed this was accomplished on 07/02/25. · “Director of Nursing / Designee to conduct re-education for all team members on Abuse and Neglect and reporting of Abuse and Neglect to all new team members and if when using agency staff. Date completed: 7/2/2025.” Record review of the in-service folder and interviews with various staff members on 07/03/25 revealed this was accomplished on 07/02/25. · “Ad Hoc QAPI held with Administrator, Director of Nursing and Medical Director to review abuse and neglect policy, reporting abuse and neglect and review the plan of removal. Date Completed: 7/2/2025.” Record review on 07/03/25 of the facility document “Ad Hoc quality and performance improvement meeting” revealed the meeting was conducted on 07/02/2025 to discuss “Observations and monitoring regarding a resident-to-resident Altercation that occurred on the memory care unit”. The review of the sign in sheet revealed 10 attendees including Administrator, Director of Nursing and Medical Director were participated. Monitoring Response: · Director of Nursing / Administrator / Social Worker / Designee will conduct random daily rounds 3-7 days a week, on various shifts to validate the safety and well-being of our residents by conducting safe surveys. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	· Director of Nursing/Designee will utilize an audit monitoring tool to review progress notes, changes in conditions, risk management reports and the nursing 24 hr report daily 5-7 days per week during the morning clinical meeting in order to validate appropriate follow up and necessary interventions are in place accordingly. The Administrator will provide oversight by monitoring and validating this task to confirm completions. The regional nurse assigned to the community will review this system during her visits to validate completed. · This plan will remain in place for the next 2 months and findings will be reported to the QAPI committee during monthly meeting for the next 2 months. The QAPI committee will then determine compliance or identify a need for additional training. The Administrator was informed the Immediate Jeopardy was removed on 07/03/25 at 1:40 pm. The facility remained out of compliance at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.