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	05/01/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Abbreviations: Based on interview and record review, the facility failed to immediately notify the resident's representative when the resident experienced a change in condition for 1 of 3 residents (Resident #1) reviewed for a change of condition. The facility failed to notify Resident #1's Responsible Party (RP) when she was put on contact isolation precautions for E coli. This failure could place residents at risk delayed coordination when they experience a change in condition. Findings include: Record review of Resident #1's face sheet, dated 05/01/2026, reflected [AGE] year-old female admitted on [DATE] with diagnosis of personal history of urinary tract infection (a bacterial infection affecting the bladder, urethra, or kidneys). Record review of Resident #1's quarterly MDS assessment, dated 04/04/2026, reflected BIMS level of 15, intact cognition, and always incontinent for bladder and bowel (no episodes of continent voiding) Record review of Resident #1's nursing note, dated 04.18.2026, revealed Resident #1 continue to be on antibiotic therapy for a urinary tract infection, resident on contact isolation for e coli, isolation precaution in place, staff and resident reminders to handwash and wear proper personal protective equipment, fluids encouraged and consumed, no noted adverse effects. Record review of Resident #1's nursing progress notes written by LVN A, dated 04/16/2026 at 11:29, reflected a note Family came in this morning very upset that they were not notified by staff that Resident #1 was put on enhanced barrier precautions related to E. coli (E. coli infections are highly contagious, typically spreading via the fecal-oral route through contaminated food, water, or direct contact with infected people/animals) in her urine. I apologized to them for the inconvenience and mistake on our part. RP then stated that she would not be taking resident's laundry home per usual and she would like for facility to wash her laundry until treatment of Resident #1 was completed and then she would resume taking it home again. RP then came to nurse's station upset and verbally complaining about upset she was to not have received a phone call. She also spoke to nurse on 500 hall about it and then told me that she would be contacting our administrator regarding this incident. I apologized to the family once again and let he know it wound not happen again.[sic] Resident #1 remains on contact precautions for UTI: 3/10 days. During an interview on 05/01/2026 at 1:15 p.m., Resident #1 stated that she was told that she had E. coli in her urine and she was put on isolation when her roommate moved out to a different room. She stated that her RP was not notified when it happened. During an interview on 05/01/2026 at 3:21 p.m., Resident #1's RP stated that she was not notified regarding Resident #1 having E. coli infection in her urine and being put on contact isolation. She stated that she found out about this information when she came to the facility and spoke to Resident #1. She stated that not receiving the information about change of condition made her very upset and felt like she could not trust the facility, giving her truthful information about Resident #1's condition. During an interview on 05/01/2026 at 2:26 p.m., DON stated that per facility's policy they should notify Medical Director, nurse practitioner and RP immediately of resident's change of condition. She stated that charge nurse on Resident #1's unit was responsible to notify Resident #1's RP as soon as she received information about E. coli in urine and putting her on contact isolation. She stated that RP was notified about UTI (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status but not about E. coli in the urine and Resident #1's contact isolation status. She stated that not updating residents' RPs on change of condition including new infection could violate the resident's right regarding the notification of changes. During an interview on 05/01/2026 at 4:26 p.m., LVN A stated she spoke to Resident #1 RP on 04/16/2026 when she was upset about not being notified regarding Resident #1 being on contact isolation for E.coli in her urine. She stated that charge nurses were responsible for notification of physician, MD and RPs regarding change of condition. She stated that RP was notified by other charge nurses before her shift started regarding UTI status of Resident #1, but not regarding E. coli and implementation of contact isolation precautions. She stated that she was trained on notification of change of condition at hire and if RP was not informed immediately, it could cause delayed communication and violation of residents' rights. During an interview on 05/01/2026 at 4:36 p.m., MD stated that she was informed regarding Resident #1's change of condition including E. coli and contact isolation precautions. She stated that Resident #1's RP should be notified immediately regarding residents' status change including isolation precautions and new infection. Record review of Facility's policy Charting and Documentation dated July 2017 indicated: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in resident's medical record. 7. Documentation of procedures and treatments will include care-specific details, including f. Notification of family, physician of other staff, if indicated.