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	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William R Courtney Texas State Veterans Home	1424 Martin Luther King Jr Lane 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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one resident (Resident #1) out of 11 residents reviewed for abuse and neglect in that:CNA B observed CNA A tapping Resident # 1's mouth, several times, during care, while she was when she went to ask CNA A if she needed assistance with getting Resident #1 to bed on 05/21/2026.This failure could place residents at risk of physical and mental or emotional harm, fear, and anxiety. Findings included:Record review of Resident #1's admission recorded dated 06/15/2026 documented an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses included: Alzheimer's Disease(progressive, irreversible brain disorder that slowly destroys memory and thinking skills), dementia(decline in mental ability-such as memory, thinking, and reasoning severe enough to interfere with daily life), and chronic kidney disease(long-term condition where the kidneys are damaged and lose their ability to properly filter waste and excess fluid from the blood).Record review of Resident #1's Quarterly MDS assessment, dated 03/09/2026 , revealed the resident had a BIMS score of 8 indicating the resident had moderate cognitive impairment.Record review of Resident #1's care plan, dated 06/14/2026, revealed Resident #1 was care planned for memory problems. Resident #1 was at risk for further decline in cognition that may affect the ability to communicate needs and wants r/t cognitive deficit.Review of facility's investigation of physical abuse dated 05/29/2026 reflected a thorough investigation was completed, and the allegation of physical abuse was confirmed and training was conducted over abuse. CNA A was suspended immediately after the incident was reported and was terminated.An interview with Resident #1 on 06/14/2026 at 4:05 pm, he stated he was safe but could not recall an incident of abuse. Resident # 1 started talking back in time.An interview with Resident #1's RP on 06/15/2026 at 3:01 pm revealed it was not appropriate for CNA A to have tapped the resident on the mouth with her hand. Resident #1's RP stated that Resident # 1 did not recall the incident and there were no injuries. Resident # 1's RP stated she was pleased that the facility had suspended CNA A immediately after the incident and terminated her once the investigation was completed.An interview with CNA B on 06/15/2026 at 2:09 pm revealed that she could not recall the date of the incident back in May around 10:00 pm or 11:00 pm where she witnessed the incident with Resident # 1 and CNA A. CNA B stated she was in the hallway and overheard CNA A tell Resident # 1 to get in bed. CNA B stated she went to Resident #1's room to ask CNA B if she needed help getting Resident # 1 in bed. CNA B stated she had observed CNA A tapping Resident #1's lips with her hand because Resident # 1 was cursing and being combative. CNA B stated CNA A kept tapping Resident #1's lips until he was put in the bed and Resident #1 had told CNA A to stop. CNA B stated CNA A said she had done that so Resident # 1 would calm down. CNA B stated she immediately left the room and reported the incident to the charge nurse. CNA B stated Resident # 1 did not have any injuries and that was not right what CNA had done. CNA B stated she had worked for agency that night and she could not recall the name of the charge nurse she reported the incident to.An interview with the Social Worker on 06/15/2026 at 1:00 pm, she stated that she was made aware of the incident on 05/22/2026 at 9:00 am in the morning huddle. The Social Worker stated Resident # 1 had pretty advanced (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	dementia and could not remember what happened due to a very low BIMS score. The Social Worker stated Resident # 1 was at his normal baseline with no observed changes or distress. An attempted interview with CNA A was made on 06/15/2026 at 1:59 pm, 3:04 pm, and 5:15 pm. Voice messages were left with no returned call back by exit.An interview with the DON on 06/15/2026 at 2:20 pm revealed that CNA B had witnessed the incident on 05/21/2026 with CNA A and Resident # 1. The DON stated CNA A was immediately suspended and removed from the facility when CNA B reported the incident immediately after witnessing it. The DON stated that after the investigation was fully completed, it was confirmed the incident had occurred and CNA A was terminated. The DON stated it was expected for Resident # 1 to have been touched inappropriately by CNA A. The DON stated that the incident was unacceptable and could have led to injuriesAn interview with the ADM on 06/15/2026 at 5:58 pm revealed CNA A should never have placed her hands on Resident #1's mouth. The ADM stated it was not expected for CNA A to have done that, and it could have caused injuries. The ADM stated it was expected for CNA A to have been professional with Resident #1.Review of CNA A's personnel file reflected that she was hired on 09/01/2025 and was terminated on 05/28/2026.Review of facility's Policy dated 02/01/2017 and revised 01/27/2020 titled Abuse, Neglect, Misappropriation Prevention Program reflected: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.