STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675863	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frank M Tejeda Texas State Veterans Home	200 Veterans Dr Floresville, TX 78114

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. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms for 2 of 8 residents (Resident #2 and Resident #3) reviewed for abuse and neglect. The facility did not ensure it protected residents from abuse when Resident #1 threw lukewarm coffee, yelled, and cussed at Resident #2 and Resident #3 on 07/07/2025. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #1's admission Record, dated 06/08/25, reflected a [AGE] year-old man admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning-such as thinking, remembering, and reasoning-to the extent that it interferes with a person's daily life and activities) and anxiety disorder (feeling apprehensive, uneasy, or nervous about something). Record review of Resident #1's quarterly MDS assessment, dated 04/22/25, reflected Resident #1 had not exhibited wandering behavior and had a BIMS score of 13/15, indicating intact cognition. Resident #1 did not have physical behavioral symptoms directed toward others. Record review of Resident #1's care plan, undated, reflected At risk for psycho-social issues: emotional distress or behaviors r/t: dementia w/agitation dx, exposure to war. 7/5/25 Resident to staff and resident to resident physical aggression, yelled/cursed out loud, pushed LVN and threw warm/cool coffee at staff and two residents. With interventions 7/5/25- Increased monitoring when in common areas and around other residents. And 7/5/25- Senior Psych Med Intervention., Administer Medications as ordered., Calm and re-assure resident/patient is safe, Keep environment calm, quiet and avoid loud noises as much as possible., Redirect/educate/intervene as needed., Refer to Mental Health Providers as indicated. Referred to [Psych Services]., Refer to social service as indicated., and Separate away from other resident as needed. Record review of Resident #2's admission Record, dated 06/08/25, reflected an [AGE] year-old male admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning-such as thinking, remembering, and reasoning-to the extent that it interferes with a person's daily life and activities), Alzheimer's disease (most common form of dementia), anxiety (feeling apprehensive, uneasy, or nervous about something), and depressive episodes. Record review of Resident #2's admission MDS assessment, dated 06/30/25, reflected Resident #2 had not exhibited wandering behavior and had a BIMS score of 10/15, indicating moderate impaired cognition. Record review of Resident #2's care plan, undated, reflected Psycho-social/Behavioral Risk: Depressive Episodes, Hx of Childhood Abuse. Loneliness at times., dated 06/26/25 with interventions RISK-BEHAVIORS MONITORING-Calm and re-assure resident/patient is safe. Record review of Resident #3's admission Record, dated 06/10/25, reflected an [AGE] year-old female admitted [DATE] with diagnoses to include major depressive disorder and cognitive communication deficit. Record review of Resident #3's quarterly MDS assessment, dated 05/15/25, reflected Resident #3 had a BIMS score of 6/15, indicating severe impaired cognition. Record review of Resident #3's care plan, undated, reflected I have mood/behavior problems-feels tired, trouble concentrating on things, sad mood/depressed. Record review of Resident #1's Nursing Progress Note, dated 07/05/25 at 08:05 AM and authored by LVN A, reflected During breakfast [Resident #1] was sitting next to [Resident #3] and [Resident #2]. [Resident #3] was talking with [Resident #2] when [Resident #1] became upset and started yelling and cussing at [Resident #2]. Staff attempted to redirected, [Resident #1] then stood up, continuing to yell/cuss. Stating no one in here cares if I'm yelling. I can do what I want, what are you going to do about it. [Resident #1] then pushed [LVN A], and threw lukewarm/cool coffee across staff, [Resident #3] and [Resident #2]. Able to redirect resident to bedroom at this time, while [Resident #1] continued yelling down hallway. [Resident #1] states He is the one that started it by talking to my lady. [Resident #1] assessed. No injuries noted. [Psych] notified and [medications prescribed]. Continue to monitor behaviors. PCP/RN Supervisor/Administrator/DON notified. [Resident #1] consented to medication at this time. Record review of Resident #2's Nursing Progress Note, dated 07/05/25 at 08:05 AM and authored by LVN A, reflected, During breakfast [Resident #2] was sitting at a table with [Resident #3] and [Resident #1]. [Resident #1] became upset and started yelling/cussing at [Resident #2]. Staff attempted to redirect [Resident #1]. [Resident #2] stayed seated, while [Resident #1] continued yelling/cursing, then threw luke warm/cool coffee on [Resident #2]/[Resident #3]/staff. [Resident

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 2 of 8 residents (Resident #2 and Resident #3) reviewed for abuse and neglect. The facility did not report to the State Survey Agency (HHSC) an incident that occurred on 07/05/2025 in which Resident #1 threw lukewarm coffee, yelled, and cussed at Resident #2 and Resident #3. This incident has still not been reported in TULIP. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included:Record review of Resident #1's admission Record, dated 06/08/25, reflected a [AGE] year-old man admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning-such as thinking, remembering, and reasoning-to the extent that it interferes with a person's daily life and activities) and anxiety disorder (feeling apprehensive, uneasy, or nervous about something). Record review of Resident #1's quarterly MDS assessment, dated 04/22/25, reflected Resident #1 had not exhibited wandering behavior and had a BIMS score of 13/15, indicating intact cognition. Resident #1 did not have physical behavioral symptoms directed toward others. Record review of Resident #1's care plan, undated, reflected At risk for psycho-social issues: emotional distress or behaviors r/t: dementia w/agitation dx, exposure to war. 7/5/25 Resident to staff and resident to resident physical aggression, yelled/cursed out loud, pushed LVN and threw warm/cool coffee at staff and two residents. With interventions 7/5/25- Increased monitoring when in common areas and around other residents. And 7/5/25- Senior Psych Med Intervention., Administer Medications as ordered., Calm and re-assure resident/patient is safe, Keep environment calm, quiet and avoid loud noises as much as possible., Redirect/educate/intervene as needed., Refer to Mental Health Providers as indicated. Referred to [Psych Services]., Refer to social service as indicated., and Separate away from other resident as needed. Record review of Resident #2's admission Record, dated 06/08/25, reflected an [AGE] year-old male admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning-such as thinking, remembering, and reasoning-to the extent that it interferes with a person's daily life and activities), Alzheimer's disease (most common form of dementia), anxiety (feeling apprehensive, uneasy, or nervous about something), and depressive episodes. Record review of Resident #2's admission MDS assessment, dated 06/30/25, reflected Resident #2 had not exhibited wandering behavior and had a BIMS score of 10/15, indicating moderate impaired cognition. Record review of Resident #2's care plan, undated, reflected Psycho-social/Behavioral Risk: Depressive Episodes, Hx of Childhood Abuse. Loneliness at times., dated 06/26/25 with interventions RISK-BEHAVIORS MONITORING-Calm and re-assure resident/patient is safe. Record review of Resident #3's admission Record, dated 06/10/25, reflected an [AGE] year-old female admitted [DATE] with diagnoses to include major depressive disorder and cognitive communication deficit. Record review of Resident #3's quarterly MDS assessment, dated 05/15/25, reflected Resident #3 had a BIMS score of 6/15, indicating severe impaired cognition. Record review of Resident #3's care plan, undated, reflected I have mood/behavior problems-feels tired, trouble concentrating on things, sad mood/depressed. Record review of Resident #1's Nursing Progress Note, dated 07/05/25 at 08:05 AM and authored by LVN A, reflected During breakfast [Resident #1] was sitting next to [Resident #3] and [Resident #2]. [Resident #3] was talking with [Resident #2] when [Resident #1] became upset and started yelling and cussing at [Resident #2]. Staff attempted to redirected, [Resident #1] then stood up, continuing to yell/cuss. Stating no one in here cares if I'm yelling. 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[Resident #2] stayed seated, while [Resident #1] continued yelling/cursing, then threw luke warm/cool coffee on [Resident #2]/[Resident #3]/staff. [Resident #2] was redirected to bedroom at this time. Resident #2 was assessed. No injuries noted r/t coffee. [Resident