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	05/08/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect right of residents to be free from verbal abuse, for 1 of 4 (Resident #1) reviewed for abuse. The facility failed to protect Resident #1 from verbal abuse, when CNA A. was verbally abusive on 5/5/2026. This failure could place residents at risk for abuse with psychological injury, intimidation and a decreased quality of life.The findings included: Record review of Resident #1's face sheet, dated 5/5/2026, revealed a [AGE] year-old female was admitted to the facility on [DATE] with diagnoses including: hypertension (elevated blood pressure), dementia (neurological condition that cause memory loss), MDD (Major Depressive Disorder- mood disorder with persistent sadness, emptiness, or a loss of interest in activities), anxiety (a response to stress with a feeling of being overwhelmed), muscle weakness, bipolar disorder (mental health disorder with severe shifts in mood, energy, and daily functioning), and schizophrenia (a severe brain disorder that impairs how an individual interprets reality). Record review of Resident #1's CP, dated 2/17/2026, revealed the resident was care planned for cognitive impairment, falls, Parkinson's Disease, aggressive behaviors, anxiety, and DNR. Record review of Resident #1's QMDS, dated [DATE], revealed the resident had a BIMS score of 15, cognitively intact. Further review revealed she required minimal to moderate assistance with ADLs and a mechanical lift for transfers. During an interview on 5/7/2026 at 3:14 PM, the RP for Resident #1 said CNA A told Resident #1, you have been on the call light for 34 times, and I know you hear me. During an interview on 5/8/2028 at 1:31 PM CNA A said on 5/5/2026, she told Resident #1, you been on the call light 32 times, yes, I counted, and that was an excessive amount of time to be on the call light, and I had to take care of other residents. CNA A said she received the in-service for A&N a week ago. CNA A said she understood to say that to a resident was verbally abusive. CNA A further stated she should not say things like that because it was verbal abuse and Resident #1 would not call for help during an emergency. During an interview on 5/8/2026 at 1:45 PM, the ADM said what CNA A did was verbally abusive and it would cause emotional harm to a resident and may cause them not to use the call light in fear of being scolded. The ADM said she was not aware of what CNA A had done. The ADM said CNA would be removed immediately from the schedule, terminated and reported to EMR. During an interview on 5/8/202 at 2:15 PM, the ADON said verbal abuse could affect residents emotionally and mentally and they could feel they were being reprimanded for using the call light and may not use it if they really need it in case of an emergency. During an observation and interview on 5/8/2026 at 3:05 PM Resident #1 was awake, in her bed, laying on her left side. The camera was removed from her room per RP's and Resident #1's, permission said she did not know why the girl (CNA A) was so angry, but she did not want her to come back to do anything for her because she said those things like she was a small child. Record review of facility's policy titled, Abuse Guidance: Preventing, Identifying and Reporting, dated 1/2024, stated, Every resident has the right to be free from abuse. Residents should not be subjected to abuse by anyone, including, but not limited to, community team members. Any violation of these rights is against the law for any nursing community employee to threaten, coerce, intimidate, or retaliate against the resident for exercising their rights.

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