STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Cove Ltc Partners Inc	607 W Ave B Copperas Cove, TX 76522

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews, and record review the facility failed to ensure the right to receive services in the facility with reasonable accommodation of resident needs and preferences for 2 (Resident #41 and Resident #58) of 14 residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #41's room was in a position that was accessible to Resident #41. The facility failed to ensure the call light system in Resident #58's room was in a position that was accessible to Resident #58. This failure could place Resident #41 and Resident #58 at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Review of Resident #41's Face Sheet, dated 09/19/2024, reflected that Resident #41 was an [AGE] year-old male admitted [DATE]. Resident #41 was diagnosed with Alzheimer's disease (disorder that causes the brain to shrink and brain cells to eventually die) and heart failure (heart does not pump as well as it should). Review of Resident #41's Comprehensive MDS (Minimum Data Set: tool used to measure health status) Assessment, dated 09/01/24, reflected that Resident #41 had moderate cognitive impairment with a BIMS (Brief Interview for Mental Status: tool used to screen cognitive function) score of 08. This assessment reflected that Resident #41 had a previous fall and required assistance with self-care needs. Review of Resident #41's Care Plan, dated 08/28/24, reflected that Resident #41 required assistance with daily care. One intervention was to encourage Resident #41 to assist in his daily care as able. Another focus was that the resident has high potential for falls due to waking without assistive devices. Interventions listed in the care plan were to observe gait and report changes to therapy and encourage resident to have rest periods during the day. An observation on 09/17/24 at 09:10 AM revealed that Resident #41 was lying in bed with his eyes closed. Resident #41's call light was looped over the fixture on the wall where the call light was plugged in. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #58's Face Sheet, dated 09/19/24, reflected that Resident #58 was an [AGE] year-old male admitted [DATE]. Resident #58 was diagnosed with dementia (decline in cognitive abilities) and major depressive disorder (feeling extremely sad, empty, or hopeless). Review of Resident #58's Quarterly MDS Assessment, dated 08/02/24, reflected that Resident #58 had severely impaired cognition with a BIMS score of 07. Resident #58 had experienced falls and required assistance with all areas of self-care. Review of Resident #58's Care Plan, dated 05/11/24, reflected that the resident lost balance while walking without assistive device. One intervention was to re-educate Resident #58 to ask for assistance as needed. An observation on 09/17/24 at 09:12 revealed that Resident #58 was lying in bed. Resident #58's call light was looped over the fixture on the wall where the call light was plugged in. During an interview on 09/17/24 at 10:15 AM, CNA G stated that the residents' call lights should have been within reach. CNA G stated that if a resident fell , had an emergency, or needed anything, the call light should be in his or her hand. CNA G stated that the residents depend on staff, and she tried to spend time with them and get to know their needs. During an interview on 09/17/24 at 10:25 AM, CNA H stated that the residents should have had their call lights within reach. CNA H stated that the residents forgot what the call light was and had to be reminded every day what it was and how to use it. She stated that she checked more often on the ones who did not remember to use their call light. CNA H stated that if residents have their call light in reach, she can get to them quickly to get a drink, take them to the restroom, or help them with whatever they need. During an interview on 09/17/24 at 12:45 PM, the ADON stated that all residents, even those who forget to use their call light, should have access to call any time they need assistance. The ADON stated that residents may try to get up, and risk falling, if they do not have their call light. During an interview with the DON on 09/17/24 at 01:00 PM, she stated that it was important that the residents were able to express their needs. The DON stated that some of the residents were not able to get up on their own and that the call light was a safety net. The DON stated that some residents need assistance with transfers and must be able to make their needs known timely. She stated that staff round and check on the residents frequently, but a resident may need something soon after a staff member left his or her room. She stated that the call light should always be within reach. The facility's policy Answering the Call Light, revised March 2021, reflected that when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to provide the right to personal privacy during medical treatment and personal care for two (Resident #1 and Resident #10) of thirteen residents reviewed for privacy. 1. The facility failed to ensure LVN E would close Resident #1's door while administering the resident's bolus feeding (method of tube feeding that delivers large amount of formula over a short period of time). 2. The facility failed to ensure CNA B and CNA D would close Resident #10's door while transferring the resident. These failures could place the residents at risk of not having their right to personal privacy maintained. Findings included: 1. Review of Resident #1's Face Sheet, dated 09/18/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #1's pertinent diagnoses included cerebral palsy (neurological condition that affects muscle movement) and dysphagia (difficulty in swallowing). Review of Resident #1's Quarterly MDS Assessment, dated 07/05/2024, reflected the resident was unable to complete the interview to determine the BIMS score. The Quarterly MDS Assessment indicated the resident was on a feeding tube (tube placed into the stomach to help get nutrition) while a resident of the facility. Review of Resident #1's Care Plan, dated 08/19/2024, reflected the resident required tube feeding. Review of Resident #1's Physician Order, dated 07/07/2023, reflected three times a day Nutren 2.0 1 can and Leave Upright 30-45 minutes at 0500, 1100, and 1700. Observation and interview with LVN E on 09/18/2024 at 10:41 AM revealed LVN E was about to do a bolus feeding for Resident #1 through the resident's g-tube (gastrostomy feeding tube: a tube that is surgically inserted through the skin of the belly and into the stomach). LVN E took Resident #1 from the activity area, ushered her to her room, and positioned her beside her bed. LVN E took the things needed from the nurse's cart and placed them on the resident's side table. LVN E proceeded to provide bolus feeding. LVN E did not close the door or pull the privacy curtain while providing the bolus feeding. LVN E stated she forgot to close the door before she provided the bolus feeding. She said the door should be closed every time a bolus feeding was given to provide privacy and give dignity to the resident. She said she would make sure she would close the door every time she would do a bolus feeding. 2. Review of Resident #10's Face Sheet, dated 09/18/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #10's pertinent diagnoses included unsteadiness on feet and abnormalities of gait and mobility. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's Quarterly MDS Assessment, dated 07/05/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated the resident was dependent on staff for chair/bed-to-chair transfer. Review of Resident #10's Care Plan, dated 09/17/2024, reflected the resident required two people for safe transfer due to paralysis on right side via Hoyer lift used for transfers. Review of Resident #10's Physician Order, dated 03/09/2022, reflected may use Hoyer lift for safe transfer. Observation on 09/17/2024 at 10:40 AM revealed CNA B and CNA D were about to transfer Resident #10 from the bed to wheelchair through Hoyer lift. CNA B and CNA D put the Hoyer sling under Resident #10. CNA D went out of the room to get the wheelchair from the hall. CNA B went out of the room and took the Hoyer lift from the hall. CNA B did not close the door after getting the Hoyer lift from the hall. CNA B and CNA D proceeded to transfer Resident #10 to his wheelchair. The door was open during the transfer. CNA B went out of the room with the Hoyer lift while CNA D stayed with the resident. In an interview with CNA D on 09/17/2024 at 11:37 AM, CNA D stated they should have closed the door before transferring Resident #10 to his wheelchair. She said the door should be closed to provide privacy to the resident. She said closing the door or pulling the privacy curtain should be done not only during transfers but every time care was provided. In an interview with CNA B on 09/17/2024 at 1:03 PM, CNA B stated he did not close the door after getting the Hoyer lift from the hall. CNA B said the door should have been closed when they transferred Resident #10. He said transferring the resident with the door open would be a dignity issue. CNA B said the resident could be embarrassed or their self-esteem could be affected when other people could see that he was dependent on others to go to his wheelchair. In an interview with LVN F on 09/17/2024 at 1:49 PM, LVN F stated the door should be closed every time a staff was providing care to the residents. LVN F said some residents could not communicate and even though they were feeling embarrassed, they could not verbalize it. LVN F said she would remind the CNAs to close the door every time they transfer a resident or every time they were providing care. In an interview with the DON on 09/18/2024 at 12:36 PM, the DON stated the door should be closed when the bolus formula was given to Resident #1 and the door should be closed when Resident #10 was transferred to his wheelchair. She said the door should be closed to provide privacy to the residents and to avoid embarrassment. The DON said all the staff, including her, were responsible in providing dignity to the residents. The DON said the expectation was for the staff to make sure that they were providing care, the residents' door should be closed, or the privacy curtain should be pulled. She concluded that she would continually remind the staff the importance of providing privacy and dignity through an in-service. In an interview with the Administrator on 09/18/2024 at 12:49 PM, the Administrator stated the staff must make sure that the residents were provided privacy when providing care to prevent embarrassment. She said the expectation was for the staff to close the door, not only during transfer and bolus feeding, but during all care provided. Said she would collaborate with the DON and the ADON to do an in-service about privacy and dignity. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 07/19/2024 at 8:49 AM, the ADON stated all care should be done in the privacy of the residents' room. He said care should be done where with the door was closed to provide dignity. He said it did not matter if the residents care or not, the door should still be closed while providing care. He said it was important that the residents would be safe and would not be embarrassed. He said he would coordinate with the DON to do an in-service about dignity. Record review of facility's policy, Dignity 2001 MED-PASS, Inc. revised February 2021 revealed Policy Statement: each resident shall be cared for a manner that promotes and enhances his or her sense of well-being Feelings of self-worth and self-esteem . Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 7 (room [ROOM NUMBER], #2, #3, #4, #5, #6, and #7) of 20 resident rooms reviewed for cleanliness and sanitization. The facility failed to ensure that Resident Rooms #1, #2, #3, #4, #5, #6, and #7 were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: An observation on 09/17/24 at 10:38 AM of Resident room [ROOM NUMBER] reflected the windowsill had black dirt particles on it. The air vent on the upper portion of the wall had thick dust between the vents. An observation on 09/17/24 at 10:44 AM of Resident room [ROOM NUMBER] reflected the air vent on the upper portion of the wall had thick dust between the vents. An observation on 09/17/24 at 10:46 AM of Resident room [ROOM NUMBER] reflected the windowsill had black dirt particles on it. The air vent on the upper portion of the wall had thick dust between the vents. An observation on 09/17/24 at 10:50 AM of Resident room [ROOM NUMBER] reflected the air vent on the upper portion of the wall had thick dust between the vents. An observation on 09/17/24 at 11:01 AM of Resident room [ROOM NUMBER] reflected the handrails in the resident bathroom had white stains all over it. The front of the toilet seat was cracked and chipped. There were dark stains near the connection of the base of the toilet and the toilet tank. An observation on 09/17/24 at 11:16 AM of Resident room [ROOM NUMBER] reflected the air vent on the upper portion of the wall had thick dust between the vents. The drain hole in the bathroom sink had rust around the outer portion of the ring. The top to the toilet tank was slightly off. An observation on 09/17/24 at 11:26 AM of Resident room [ROOM NUMBER] reflected the air vent on the upper portion of the wall had thick dust between the vents. The air condition unit in the resident's room had dark dirt and dust all over the front of the unit. The shower floor in the resident bathroom had black marks near the shower wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/19/24 at 10:34 AM, Housekeeping M stated she had been at the facility for 4 months. She stated they had trained her to clean all parts of the bathroom and all parts of the room. She was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, and #7. She stated they were supposed to ensure that the air vents in the resident rooms were cleaned. She stated they were to clean all the areas she had observed in the pictures. She stated that the risk of not cleaning the air vents was it could cause some residents to have breathing problems and for the dirt, yeah, not good. In an interview on 09/19/24 at 11:00 AM, the Administrator stated she had been at the facility for 4 months. She was advised of all the findings in the resident rooms. She stated that her housekeeping supervisor was on medical leave, and she had the maintenance director responsible for managing the housekeeping department. She was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, and #7, and she stated that she would have the maintenance director address the concerns. She stated the concerns observed could cause breathing issues and infection. In an interview on 09/19/24 at 12:00 PM, the Maintenance Director stated that he was responsible for supervising the housekeeping in the facility during the absence of the Housekeeping Supervisor. He was shown pictures of the concerns observed in Resident rooms #1, #2, #3, #4, #5, #6, and #7, and he stated housekeeping should clean all those areas daily. He stated housekeeping was supposed to clean the air vents at least once a week, and they should clean all areas of the resident room, including the bathroom floors and the handrails. He stated it was just him in maintenance, so he had not been able to check housekeeping's cleaning effort. He advised that not cleaning the room thorough could cause an infection. Review of the facility's policy on Cleaning and Disinfection of Environmental Surfaces (08/2019) reflected Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for three (Resident #10, Resident #11, and Resident #52) of eight residents reviewed for Care Plans. The facility failed to ensure Residents #10, #11, and #52 were care planned for oxygen administration. This failure could place the residents at risk of not receiving the necessary care and services. Findings included: Review of Resident #10's Face Sheet, dated 09/18/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #10's pertinent diagnoses included chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and history of COVID. Review of Resident #10's Quarterly MDS Assessment, dated 07/05/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #10's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. Review of Resident #10's Physician Order, dated 01/28/2023, reflected May apply O2 per nasal cannula at 2-4L when in room for shortness of breath every shift for Shortness of Breath. Observation and interview with Resident #10 on 09/17/2024 at 9:09 AM revealed Resident #10 was in his bed, awake. It was observed that he had a nasal cannula connected to an oxygen concentrator at 3 liters per minute. According to Resident #10, he was on oxygen all day and all night. Review of Resident #11's Face Sheet, dated 09/18/2024, revealed Resident #11 was a [AGE] year-old female who was admitted to the facility 12/21/2022. Relevant diagnoses included hypertension and anemia (a problem of not having enough healthy red blood cells to carry oxygen to the body's tissue). Review of Resident #11 Quarterly MDS Assessment, dated 07/28/24, revealed Resident #9 had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated the resident was on oxygen therapy during admission and while a resident of the facility. Review of Resident #11's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's Physician Order, dated 06/28/2024, revealed O2 @2LPM per nasal cannula at HS, at bedtime. Observation and interview with Resident #11 on 09/04/2024 at 8:46 AM revealed Resident #11 was in her wheelchair, awake. It was observed that she had a nasal cannula connected to an oxygen concentrator. The nasal cannula was coiled on top of the oxygen concentrator. According to Resident #11, she would only use it if she was having difficulty in breathing. She said she seldom used the oxygen. Review of Resident #52's Face Sheet, dated 09/18/2024, revealed Resident #52 was a [AGE] year-old female who was admitted to the facility 07/25/2024. Relevant diagnoses included asthma (lung disorder caused by narrowing of the airways) and anemia. Review of Resident #52 Quarterly MDS Assessment, dated 07/28/24, revealed Resident #52 was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #52's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. Review of Resident #52's Physician Order, dated 07/25/2024, revealed O2 @ 2L/min via NC every 1 hours as needed for SOB or SAT < 92%. Observation and interview with Resident #52 on 09/04/2024 at 9:19 AM revealed that Resident #52 was in her bed, awake. It was observed that she had a nasal cannula connected to an oxygen concentrator. According to Resident #52, she usually wore oxygen at night but would leave it inside the room every time she would go out of the room. In an interview with the DON on 09/18/2024 at 12:36 PM, the DON stated it was important that every resident had a comprehensive care plan to make sure they received the appropriate and suitable care they needed. The DON said the care plan should be in place so that the staff providing care would be on the same page. The DON stated the care plan was important because it reflected the resident's needs. She said the care plan should be resident-centered and should show what specific care the resident needed. She said without the care plan, there could be confusion on the care of the residents. She said the expectation was for all residents to have a complete and detailed care plan. She said she would coordinate with the ADON and the MDS Nurse to audit the care plans of the residents and make sure all the care provided were care planned. In an interview with the Administrator on 09/18/2024 at 12:49 PM, the Administrator stated all the residents should have a care plan appropriate to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. She said without the care plan, there could be confusion on the care and services of the residents. The Administrator concluded that the expectation was for the staff to ensure the residents were care planned accordingly. She said she would coordinate with the DON and the MDS Nurse to make sure all the residents were care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the MDS Nurse on 09/19/2024 at 8:38 AM, the MDS Nurse said she was responsible in making the care plans for the residents. She opened Resident #10's care plan and saw that Resident #10 did not have a care plan for oxygen administration. She said she would make a care plan for Resident #10. After finishing Resident #10's care plan for oxygen therapy, she opened Resident #52's care plan, and saw she did not have a care plan for oxygen. She said she would make a care plan for Resident #52's oxygen, as well. After doing Resident #52's care plan for oxygen, she opened Resident #11's care plan, and saw Resident #52 did not have a care plan for oxygen. She said she would make a care plan for Resident #52's oxygen. The MDS Nurse stated care plans were important to ensure the residents were getting the care needed. She said care plans served as guides on how the staff would take care of the residents. The MDS Nurse said without the care plans, the staff could miss significant interventions needed by the residents. She concluded that she would review the care plans of the residents and would make changes accordingly. In an interview with the ADON on 07/19/2024 at 8:49 AM, the ADON stated it was important that residents have a care plan to fully provide the care and services the residents needed. The ADON said that for this case, there should be a care plan for oxygen administration. He said without the care plan, there could be confusion on the care of the residents, and their needs would not be addressed. She said she was responsible in making the care plan. She said the expectation was all the issues of the residents were care planned. Record review of facility's policy, Care Plans, Comprehensive Person-Centered MED-PASS, Inc. revised December 2016 revealed Policy statement: A comprehensive care plan, person-centered care plan . to meet the resident's physical, psychological, and functional needs is developed and implemented for each resident . 8. Describe services that are to be furnished.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure residents with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown or pressure ulcers for one (Resident #66) of three resident reviewed for pressure ulcers. The facility failed to ensure LVN F cleaned the pressure ulcer on Resident #66's right heel from inside to outside. This failure could place the residents with pressure ulcers at risk for worsening of existing pressure ulcers. Findings included: Review of Resident #66's Face Sheet, dated 09/18/2024, reflected the resident was an [AGE] year-old male admitted on [DATE]. One of Resident #66's diagnosis was type 2 diabetes mellitus (body has higher sugar level) without complications. Review of Resident #66's Quarterly MDS Assessment, dated 08/13/2024, reflected the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated the resident had one or more unhealed pressure ulcers. Review of Resident #66's Comprehensive Care Plan, dated 07/27/2024, reflected the resident had an unstageable pressure injury right heel R/T immobility, nutrition, and disease process with one of the interventions to administer treatments as ordered. Review of Resident #66's Physician's Order, dated 08/15/2024, reflected Cleanse unstageable to right heel with NS, pat dry, apply betadine, and cover with foam border dressing one time a day AND as needed, or if it becomes soiled or comes off. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Cove Ltc Partners Inc	607 W Ave B Copperas Cove, TX 76522

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/17/2024 at 1:07 PM revealed LVN F prepared the things needed for Resident #66's wound care. LVN F washed her hands and put on a pair of gloves. She put pillows under Resident #66's right leg to access his right heel. LVN F peeled off the old dressing from the resident's right heel and discarded it. She took off her gloves and put on a new pair of gloves. She did not sanitize her hands before putting on the new pair of gloves. LVN F took some gauze, sprayed wound cleanser on the gauze, and started to clean the wound on the resident's right heel. LVN F started from inside the wound and then proceeded to clean around the wound using the same gauze. After cleaning around the wound, LVN F used the same gauze and cleaned again the inside of the wound. She did not get another gauze to clean the inside of the wound again. LVN F took the betadine, applied it to the wound, and covered the wound with a 4 by 4 border foam dressing. LVN F stated the proper way to clean the wound was from inside to outside. She said after cleaning the skin around the wound, the gauze should have been discarded. She said she should have gotten a clean gauze to clean the inner part of the wound again and not use the gauze that she used to clean the skin around the wound. LVN F said the gauze that touched the outside of the wound must not touch the inner portion of the wound because the skin surrounding the wound was not clean. She said she would remember to be careful to not touch the wound with the gauze that already touched the skin outside of the wound because the existing wound could get infected. In an interview with the DON on 09/18/2024 at 12:36 PM, the DON stated the proper way of cleaning the wound was from the inside to outward. The DON said this method would promote healing, prevent cross contamination, and prevent infection. The DON said the expectation was for the staff to have a conscious effort in doing the right method of wound care. The DON further added she would re-educate the staff regarding wound care and closely monitor if they were following the policy and procedure for wound care. In an interview with the Administrator on 09/18/2024 at 12:49 PM, the Administrator stated the staff should do whatever was the right procedure in doing wound care to promote healing. The Administrator said the expectation was for the staff to make sure proper technique was used in doing wound care to prevent wound infection. The Administrator said he would collaborate with the clinicians to remind the staff to use the proper technique for wound care. In an interview with the ADON on 07/19/2024 at 8:49 AM, the ADON stated the proper technique in cleaning the wound was cleaning the center first and then the outside of the wound. The ADON also said the gauze should be discarded after each wipe. The ADON said improper wound care could cause cross contamination and infection. The ADON said the expectation was for the staff to know how to clean a wound to prevent unfavorable outcomes. The ADON said he would do an in-service about wound care and monitor their adherence to the right procedure of wound care. Review of facility's policy Dressing, Sterile2001 MED-PASS, Inc. revised September 2013 revealed Procedure: . 14. Cleanse the wound from least contaminated area to the most contaminated area (usually, from the center outward).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained free of accident hazards as was possible for 1 (Resident #1) of 4 residents reviewed for accident prevention. The facility failed to obtain physician orders or a physician assessment as of 09/18/24 for Residents #1 for the usage of a scoop mattress prior to installing the mattress to assist in fall prevention. This failure could prevent residents from having an environment that was free and clear of accidents and hazards. Findings included: Record review of Resident #1's Face Sheet, dated 09/18/2024, reflected she was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included cerebral palsy (congenital disorder), lack of coordination, and abnormal involuntary movements. Record review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] reflected, she had a Brief Interview for Mental Status (BIMS) score of 99 (severe cognitive impairment) and for ADL care it reflected assistance for transfers, toileting, and bathing and the resident was totally dependent for assistance. Record review of Resident #1's physician orders dated 09/18/24 reflected no orders for a scoop mattress and no physician assessment was observed in the facility system records. An observation on 09/17/24 at 10:41 AM of Resident #1's bed revealed she was sleeping on a scoop mattress, which had the upper and lower sides of the mattress raised at least 6 inches. In an interview on 09/18/24 at 12:45 PM, the ADON and the DON advised that Resident #1 was sleeping on a scoop mattress because she had a habit of rolling off her bed, especially at night. She stated the resident was assessed by the nursing staff and physician, and the scoop mattress did not pose as a risk to the resident. They both stated the resident should have had physician orders for the scoop mattress and the use of the scoop mattress should have been added to the care plan. The DON stated the risk of the resident not having physician orders for the scoop mattress could result in the resident injuring herself if she attempted to get out of the bed. In an interview on 09/19/24 at 11:00 AM, the Administrator stated she had been at the facility for 4 months. She stated she was advised by the DON that there were no physician orders on file and there should have been one. She stated the risk of not having physician orders before providing the resident with the scoop mattress was that the resident could have a fall trying to get out of the bed. (continued on next page)

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	455515	A. Building B. Wing	09/19/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy Physician Services (02/2021), reflected The medical care of each resident is supervised by a licensed physician. The attending physician will determine the relevance of any recommended interventions from other disciplines.

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	455515	A. Building B. Wing	09/19/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for six (Resident #10, Resident #11, Resident #52, Resident #61, Resident #68, and Resident #222) of twelve residents reviewed for Respiratory Care. 1. The facility failed to ensure that Resident #10, #11, #52, and #68's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) were properly stored. 2. The facility failed to ensure that Resident #61's CPAP (continuous positive airway pressure: machine use to deliver pressurized air through a mask to keep airways open) was stored properly. 3. The facility failed to ensure that Resident #222's nebulizer (machine that turns liquid medication into a mist and breathed directly into the lungs) was stored properly. The facility failed to provide humidified (moistened) oxygen to Resident #222. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #10's Face Sheet, dated 09/18/2024, reflected the resident was a [AGE] year-old male admitted on [DATE]. Resident #10's pertinent diagnoses included chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and history of COVID. Review of Resident #10's Quarterly MDS Assessment, dated 07/05/2024, reflected the resident had a moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #10's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. Review of Resident #10's Physician Order, dated 01/28/2023, reflected May apply O2 per nasal cannula at 2-4L when in room for shortness of breath every shift for Shortness of Breath. Observation and interview with Resident #10 on 09/17/2024 at 9:09 AM revealed Resident #10 was in his bed, awake. It was observed that he had a nasal cannula connected to an oxygen concentrator at 3 liters per minute. According to Resident #10, he was on oxygen all day and all night. The nasal cannula was on the floor. He said staff went inside the room to check on him but did not notice the nasal cannula was on the floor. (continued on next page)

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	455515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's Face Sheet, dated 09/18/2024, revealed Resident #11 was a [AGE] year-old female who was admitted to the facility 12/21/2022. Relevant diagnoses included hypertension and anemia (a problem of not having enough healthy red blood cells to carry oxygen to the body's tissue). Review of Resident #11's Quarterly MDS Assessment, dated 07/28/24, revealed Resident #9 had a moderate impairment in cognition with a BIMS score of 12. The Quarterly MDS Assessment indicated the resident was on oxygen therapy during admission and while a resident of the facility. Review of Resident #11's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. Review of Resident #11's Physician Order, dated 06/28/2024, revealed O2 @2LPM per nasal cannula at HS, at bedtime. Observation and interview with Resident #11 on 09/04/2024 at 8:46 AM revealed Resident #11 was in her wheelchair, awake. It was observed that she had a nasal cannula connected to an oxygen concentrator. The nasal cannula was coiled on top of the oxygen concentrator. The nasal cannula was not bagged. According to Resident #11, she would seldom use the oxygen and she never saw a bag for the nasal cannula. Review of Resident #52's Face Sheet, dated 09/18/2024, revealed Resident #52 was a [AGE] year-old female who was admitted to the facility 07/25/2024. Relevant diagnoses included asthma (lung disorder caused by narrowing of the airways) and anemia. Review of Resident #52's Quarterly MDS Assessment, dated 07/28/24, revealed Resident #52 was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #52's Comprehensive Care Plan on 08/21/2024 reflected no care plan for oxygen therapy. Review of Resident #52's Physician Order, dated 07/25/2024, revealed O2 @ 2L/min via NC every 1 hours as needed for SOB or SAT > 92%. Observation and interview with Resident #52 on 09/04/2024 at 9:19 AM revealed that Resident #52 was in her bed, awake. It was observed that she had an oxygen concentrator at the side of her bed with a nasal cannula connected to it. The nasal cannula was hanging on top of the oxygen concentrator. The nasal cannula was not bagged. According to Resident #52, she usually wore oxygen at night but would leave it inside the room every time she would go out of the room. Review of resident #68's Face Sheet, dated 09/19/24, reflected that Resident #68 was a [AGE] year-old female admitted [DATE]. Resident #68 had a diagnoses of left tibia (long bone in lower leg) fracture and subsequent encounter for closed fracture (surgery to repair fracture). Resident #68 also had a diagnosis of COPD. Review of Resident #68's Comprehensive MDS Assessment, dated 08/27/24, reflected that Resident #68 had intact cognition with a BIMS score of 15. Resident #68 had a diagnosis of COPD and was administered oxygen therapy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455515	A. Building B. Wing	09/19/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's Care Plan, dated 09/03/2024, reflected that Resident #68 had COPD. An intervention was to identify and eliminate sources of respiratory irritation such as cigarette smoke, pollen, perfumes. An observation and interview on 09/17/24 at 08:52 AM revealed that Resident #68 was sitting up in bed. Resident #68's nasal cannula was looped over the bedrail and not secured in a bag. The humidifier bottle was connected to the oxygen concentrator. The humidifier bottle had about 15 ml of water in it. There was no date on the oxygen tubing or humidifier bottle. Resident #68 stated they have been saying they will add water to the humidifier bottle. Resident #68 stated that she has told different staff members that it's drying me out. 2. Review of Resident #61's Face Sheet, dated 09/19/2024, reflected that Resident #61 was a [AGE] year-old female. Resident #61 admitted on [DATE] with COPD (lung disease that blocks airflow and makes it difficult to breathe) and frontotemporal neurocognitive disorder (damage to the frontal and temporal lobes of the brain). Review of Resident #61's Physician Orders, dated 02/02/24, reflected CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) per settings on machine at bedtime. Review of Resident #61's Quarterly MDS Assessment, dated 09/03/2024, reflected a BIMS Assessment was not appropriate because the resident was rarely/never understood and that Resident #61 was severely impaired - never/rarely made decision regarding tasks of daily life. Resident #61's Quarterly MDS Assessment reflected that Resident #61 had not used a CPAP within the last 14 days. Review of Resident #61's Comprehensive Care Plan, dated 07/15/2024, reflected that Resident #61 was using a CPAP and one interventions for this focus included Staff will continue to apply CPAP as ordered. Staff will continue to monitor her for decline in respiratory status and report to doctor. An observation on 09/17/24 at 09:25 AM revealed that Resident #61's CPAP machine was on the table next to her bed. The attached tubing and face mask was lying on the floor beside the resident's bed. 3. Review of Resident #222's Face Sheet, dated 09/19/24, reflected that Resident #222 was a [AGE] year-old male. Resident #222 admitted on [DATE] with COPD and pneumonia (infection in the lungs). Review of Resident #222's Comprehensive MDS Assessment, dated 09/09/24, reflected that Resident #222 had severe cognitive impairment with a BIMS score of 6. Resident #222 had a diagnosis of COPD and was administered oxygen therapy. An observation on 09/17/24 at 8:45 am revealed that Resident #222 was lying in bed with his eyes closed. Resident #222's nebulizer mask was on the bedside table and not stored in a bag. Resident #222's nasal cannula tubing was connected to the oxygen concentrator (medical device that provides extra oxygen) and not to the humidifier bottle (adds moisture to air to help prevent nasal and throat irritation). The empty humidifier bottle was secured to the front of the oxygen concentrator. There was no date on the nebulizer tubing, the nasal cannula tubing, or the empty humidifier bottle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN G on 09/17/24 at 09:35 AM, she stated that the nasal cannula should have been bagged. LVN G stated that the nebulizer mask and CPAP should have also been bagged when the resident was not using them. She stated that because these items were not covered, they could have gotten bacteria on them and potentially caused the residents to get sick. Observation and interview with LVN F on 09/17/2024 at 10:21 AM, LVN F stated the nasal cannula should not be exposed nor touching anything because it could cause cross contamination and infection. LVN F said the nasal cannula should be bagged when not in use. LVN F said she would go to Resident #10, #11, and #52's room, would disconnect the nasal cannula, and would throw it in the trash can. She said she was going to change all of it and put it in a bag if the residents were not using it. In an interview with the DON on 09/18/2024 at 12:36 PM, the DON stated the nasal cannula should be bagged when not in use to keep it clean. She said if the nasal cannulas were not bagged, were exposed, or touching surfaces that were not clean, there could be cross contamination, respiratory infection, or compromised oxygen administration. The DON said the staff, including her, were responsible in monitoring if the nasal cannula, the breathing mask, and the CPAP were bagged when not in use. She said there should be water in the humidifier to prevent irritation in the nose and throat. She said the expectation was for the staff to be mindful in making sure that the nasal cannula, the breathing mask, and the CPAP mask of the residents would be bagged when not in use. The DON said she would conduct an in-service and check-off about the respiratory care. She said she would personally monitor if the staff were bagging the nasal cannula the breathing mask, and the CPAP. In an interview with the Administrator on 09/18/2024 at 12:49 PM, the Administrator stated everything that the residents were using should be kept clean to prevent infection. She said, for this incident, the nasal cannula the nasal cannula the breathing mask, and the CPAP should be bagged every time the resident was not using it. The Administrator said she would coordinate with the DON on how to go forward about the issue of respiratory care. In an interview with the ADON on 07/19/2024 at 8:49 AM, the ADON stated the nasal cannula, the nasal cannula, the breathing mask, and the CPAP mask should be bagged when not in use. He said the purpose for bagging the nasal cannula was to prevent it from being exposed and touching surfaces that were dirty. He said cross contamination and possible respiratory infections could occur. He said the humidifier should have water in it to prevent dryness of the nasal passage. He said the expectation was for the staff to bag the nasal cannula when not in use. He said she would coordinate with the DON pertaining to respiratory care. Record review of facility's policy, Departmental (Respiratory Therapy) - Prevention of Infection MED-PASS, Inc. revised November 2011 revealed Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy . Steps . 4. Check water levels of refillable humidifier units daily . d. refill with distilled water . 7. Change the oxygen cannulae and tubing every seven days . 8. Keep the oxygen cannula and tubing . in a plastic bag when not in use . Nebulizer . 7. Store the circuit in plastic bag, marked with date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. 1. The facility failed to ensure foods in the refrigerator were properly sealed from air-borne contaminations. 2. The facility failed to ensure a pitcher containing juice, located in the refrigerator, was cleaned. 3. The facility failed to ensure the ice scoop holder, located in the kitchen area, was cleaned. 4. The facility failed to ensure the food stored in the refrigerator and freezer were labeled with the use by date. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on 09/17/24 from 8:30 AM to 8:38 AM in the facility's only kitchen reflected: One large zip locked bag of frozen fries did not have a use by date. One large zip locked bag of frozen chicken parts did not have a use by date. One large zip locked bag of frozen pancakes did not have a use by date. One large zip locked bag of frozen okra did not have a use by date. One large container of refrigerated rice was wrapped in aluminum foil and was not sealed from air-borne contaminants. One large container of refrigerated tuna was wrapped in aluminum foil and was not sealed from air-borne contaminants. One large, refrigerated pitcher, containing a red beverage had a blue lid that had white, brownish, and black stains all over the lid and in the pouring spout. The ice scoop holder, next to the ice machine in the kitchen area, had yellowish fluids in the bottom of the scoop holder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455515	A. Building B. Wing	09/19/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/19/24 at 09:00 AM, the Dietary Manager stated she had been at the facility nearly [AGE] years. She was shown the pictures of the concerns observed in the facility's only kitchen. She stated all staff, including herself were responsible for storing and dating food. She stated the food should be labeled and dated properly and staff should not have wrapped the food in aluminum foil to store it. She stated the kitchen staff cleaned the kitchen daily and the items observed should not have been in those conditions. She stated these issues could cause an infection within residents. In a follow up interview with the Dietary Manager on 09/12/24 at 10:00 AM, she stated she was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. She was shown images of all the concerns observed in the kitchen. The DM advised she spoke with the staff about ensuring the tea was covered once it was prepared. She stated she did a full in-service for food rotation and storage pertaining to what the proper procedures were dealing with food rotation and storage. Further they completed a customer satisfaction training in reference to resident rights, and options on the food items. The DM advised a full in-service was done regarding proper labeling and cleaning logs of food items. She stated everyone in the kitchen was responsible for ensuring items such as the pitcher, and whoever prepares the tea was responsible for ensuring the cover was placed on it once the tea was done. In an interview on 09/19/24 at 11:00 AM, the Administrator stated she had been at the facility for 4 months. She was advised of all the findings in the facility kitchen, and she stated that she expected her dietary manager to ensure that those concerns were not in the kitchen. She stated the concerns observed would cause food-borne illnesses. Record review of the facility's policy Food Receiving and Storage (November 20222) revealed Food shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). Record review of the facility's policy Kitchen Sanitization (November 20222) revealed The food service area is maintained in a clean and sanitary manner. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. Review of TITLE 21--FOOD AND DRUGS CHAPTER I--FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES. SUBCHAPTER B - FOOD FOR HUMAN CONSUMPTION PART 110 -- CURRENT GOOD MANUFACTURING PRACTICE IN MANUFACTURING, PACKING, OR HOLDING HUMAN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #66 and Resident #68) of eight residents observed for Infection Control. 1. The facility failed to ensure that CNA A performed hand hygiene while providing incontinent care to Resident #66. 2. The facility failed to ensure that LVN F performed hand hygiene during Resident #66's wound care. 3. The facility failed to ensure that CNA C performed hand hygiene while providing incontinent care to Resident #68. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #66's Face Sheet, dated 09/18/2024, reflected resident was an [AGE] year-old male admitted on [DATE]. One of Resident #66's diagnoses was unspecified pain. Review of Resident #66's Quarterly MDS Assessment, dated 08/13/2024, reflected the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated the resident was always incontinent for bowel. Review of Resident #66's Comprehensive Care Plan, dated 07/27/2024, reflected the resident required total assistance with all daily care and the goal was the resident would maintain highest level of personal hygiene. Observation on 09/17/2024 at 11:12 AM revealed CNA A put on a gown and a pair of gloves once she was inside Resident #66's room. She did not wash her hands before putting on the gloves. CNA A went to the bathroom and took a urinal. She went back to the resident and drained his catheter bag. CNA A went back to the bathroom, poured the urine in the toilet bowl, and flushed it. She took off her gloves, unfastened the resident's brief, and tucked it on the middle. She did not have any gloves on when she unfastened the brief and tucked it in between the resident's legs. After tucking the brief, she put on a pair of gloves and instructed the resident to roll to his right. She did not do hand hygiene before putting on a pair of gloves. She pulled some wipes and started to clean the resident's bottom. After cleaning the resident's bottom, she took the new brief, and put it under the resident. She did not change her gloves after cleaning the resident's bottom. She instructed the resident to roll back and started to clean the front part of the resident. After cleaning the resident's front part, she closed the brief, fastened both sides, took off her gloves, threw it on the waste can, and went out of the room. She did not wash her hands after incontinent care. (continued on next page)

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	455515	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Cove Ltc Partners Inc	607 W Ave B Copperas Cove, TX 76522

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA A on 09/18/2024 at 1:45 PM, CNA A stated hands should be washed or sanitized before and after doing incontinent care. She said the hands should also be sanitized before putting on clean gloves. CNA A said hand hygiene was important to prevent the spread of germs and that staff had an in-service about infection control on a monthly basis. She said she should have done hand hygiene, changed her gloves after touching the soiled brief, after cleaning the resident's bottom, and before touching the new brief. She said she should not touch the soiled brief with bare hands because the germs could transfer from the soiled brief to her hands and to everything that she touched. 2. Review of Resident #66's Face Sheet, dated 09/18/2024, reflected resident was an [AGE] year-old male admitted on [DATE]. One of Resident #66's diagnoses were type 2 diabetes mellitus (body has higher sugar level) without complications. Review of Resident #66's Quarterly MDS Assessment, dated 08/13/2024, reflected the resident was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated the resident had one or more unhealed pressure ulcers. Review of Resident #66's Comprehensive Care Plan, dated 07/27/2024, reflected the resident had an unstageable pressure injury right heel R/T immobility, nutrition, and disease process with one of the interventions to administer treatments as ordered. Review of Resident #66's Physician's Order, dated 08/15/2024, reflected Cleanse unstageable to right heel with NS, pat dry, apply betadine, and cover with foam border dressing one time a day AND as needed for if it becomes soiled or comes off. Observation and interview on 09/17/2024 at 1:07 PM revealed LVN F prepared the things needed for Resident #66's wound care. LVN F washed her hands, put on a pair of gloves, peeled off the old dressing from the resident's right heel, and discarded it. LVN F removed her gloves and put on a new pair of gloves. She did not sanitize her hands before putting on the new pair of gloves. She proceeded to do wound care. After cleaning the wound, she removed her gloves and threw them in the trash can. She took a 2 by 2 foam dressing and put her initials on it. She then put on a new pair of gloves and covered the wound with the foam dressing. She did not sanitize her hands before putting on a new pair of gloves. She said she did wash her hands before wound care, but she should have performed hand hygiene before putting on a new pair of gloves. She said not sanitizing the hands before donning a new pair of gloves could cause the spread of germs and infection. She said she would include a bottle of hand sanitizer on the things needed for wound care. 3. Review of Resident #68's Face Sheet, dated 09/18/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #68 was diagnosed muscle weakness and lack of coordination. Review of Resident #68's Comprehensive MDS Assessment, dated 08/27/2014, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated Resident #68 was frequently incontinent for bladder and always incontinent for bowel. Review of Resident #68's Comprehensive Care Plan, dated 07/02/2024, reflected the resident required extensive assistance with daily care due to inability to bear weight on left lower leg and the goal was to maintain the highest level of hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 09/18/2024 at 7:29 AM revealed CNA C was about to do Resident #68's incontinent care. She took a towel and covered the resident's table before placing the things needed for incontinent care. CNA C washed her hands and put on a pair of gloves. She opened a new brief and put it on the table. She pulled some wipes and put it on top of the table. She positioned herself on the left side of the bed. She unfastened the brief, pushed it between the resident's legs, and started cleaning the front part of the resident using the front to back technique. She did it three times. She removed her gloves and put on a new pair of gloves. She did not sanitize before putting on the new pair of gloves. She instructed the resident to roll to the right and cleaned the bottom of the resident. She removed her gloves and put on a new pair of gloves. She told the resident to roll to the other side. CNA C transferred to the right side of the bed bringing with her the brief and the wipes on the left hand and the waste basket on the right hand. She put the wipes and brief beside the resident's legs and placed the waste basket beside her. She cleaned the bottom of the resident again. After cleaning the resident's bottom, she reached out and took the brief, and placed it under the resident. She did not change her gloves before touching the new brief. She told the resident to roll back, and she fixed the brief. CNA C stated she did wash her hands before and after doing incontinent care. She said the hands should also be sanitized before putting on clean gloves. CNA C said hand hygiene was important to prevent the spread of germs and infection. She said she should have done hand hygiene in between changing of gloves and changed her gloves after touching the soiled brief and the trash can. She said they did have in-services about infection control and hand washing but she cannot remember when. In an interview with the DON on 09/18/2024 at 12:36 PM, the DON stated all the staff should know that hand hygiene was the most effective way to prevent cross contamination and infection. She said, first, hands should be washed before and after incontinent care. She continued that secondly, the gloves should be changed after touching any soiled items, whether it was a soiled brief, or the trash can. She said the gloves should also be changed after cleaning the residents' bottom and before touching the new brief. She said every time the gloves were changed, staff should do hand hygiene before putting on the new gloves. She said this was applicable for incontinent care and wound care as well. She said the expectation was for the staff to do hand hygiene before and after any care, to change their gloves from dirty to clean, and to do hand hygiene when changing the gloves. She said she will do an in-service about infection control immediately after the interview and she would monitor the staff personally. In an interview with the Administrator on 09/18/2024 at 12:49 PM, the Administrator stated not doing hand hygiene before and after any care, not changing the gloves after touching soiled items, and not sanitizing the hands in between changing of gloves contribute to cross contamination and probable infection. She said the expectation was for the staff to follow the policy and procedures pertaining to infection control. She said she would collaborate with the DON to in-service the staff about infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON on 07/19/2024 at 8:49 AM, the ADON stated hand hygiene was included in all the procedures of any care. He said the staff should be mindful when taking care of the residents. He said the staff should do hand hygiene before and after any care, should change the gloves when transitioning from dirty to clean, after touching the waste can, after touching the soiled brief, and after cleaning the residents' bottom. He said the hands should be washed or sanitized before putting on a new pair of gloves. He said all the issues discussed were causes of cross contamination and probable development of infections. He said the expectation was for the staff to do hand hygiene before and after every care, after changing their gloves, when transitioning from a dirty area to a clean area. The ADON said he would coordinate with the DON on how to go forward. Review of facility policy, Handwashing/Hand Hygiene2001 MED-PASS, Inc. revised October 2023 revealed Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections . indications of hand hygiene . a. immediately before touching the resident . c. after contact with blood, body fluids, or contaminated surface . d. after touching a resident . f. before moving from work on a soiled body site to a clean body site . g. immediately after glove removal.