STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER: Copperas Cove Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 607 W Ave B, Copperas Cove, TX 76522	

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on interviews and record review, the facility failed to provide the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing for 1 (Resident # 1) of 6 (Resident's 2.3.4.5.amd 6) residents reviewed for following hospital discharge orders. The facility failed to follow hospital discharge orders for follow up with Urology secondary to a urethral stent (a thin tube placed between the kidney and bladder to help urine flow) placement on 4/26/2024. On 10/12/24 at 5:10 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/16/24, the facility remained out of compliance at a scope of Isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure resulted in Resident # 1 with worsening medical condition and hospitalization . Finding included: Review of Resident # 1's face sheet reflected a [AGE] year old male originally admitted on [DATE] with a readmission on 8/16/2024 with diagnoses that included type 2 diabetes mellitus without complications (is a chronic condition that happens when you have persistently high blood sugar levels effecting your body not to use insulin properly), obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional, which can cause a backup of urine into the kidneys), and discharged to the hospital on 10/10/2024. Review of Resident # 1 Quarterly MDS dated [DATE] reflected a BIMS score of 10 (10-12 suggests moderate cognitive impairment). Review of Resident #1's Care plan dated 9/18/2024 ad 10/11/2024 reflected in part: Focus: Resident # 1 has a hx of UTI's (infection that affects the urinary tract, the system for drainage of urine), urinary retention (the inability to completely empty the bladder), obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional, which can cause back up of urine into the kidneys.) (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: Resident will not have an UTI through the review date. Target Date 12/6/2024. Interventions/Task Check at least every 2 hours for incontinence, wash, rinse, and dry soiled areas. Encourage adequate fluid intake, monitor/document/report to MD PRN for s/sx of UTI: Frequency, urgency, malaise (a vague feeling of bodily discomfort), foul smelling urine, dysuria (pain with urination), fever, nausea, vomiting, flank(lower back) pain, supra-pubic (area around the genitals), hematuria (blood in the urine), cloudy urine, altered mental status, loss of appetite, and behavioral changes. Review of Resident # 1's medical record of Hospital A's history and physical and discharge orders dated 8/16/2024 reflected an order for follow up with urology in 1 week. The discharge diagnosis was a ureteral stone (stone in the urethra (a thin tube leading from the bladder) with hydronephrosis (a swelling of one or both kidneys due to urine build up). Review of Resident # 1's medical records reflected no order for urology follow up from readmission (8/6/2024) through discharge (10/10/2024). Resident was assessed on 10/9/2024 for weakness, found to have a low-grade temperature all other vitals, resident was offered to go to emergency room and refused, MD was notified. On 10/10/2024 resident was found unresponsive with low blood pressure, emergency phone line was contacted, resident was transferred to the hospital. MD was notified. ADON notified Daughter of transfer. Review of outside medical records of Resident # 1's for Hospital B's admitting history and physical dated 10/10/2024 by Physician C reflected Abdominal CT scan showed the presence of severe left-sided hydronephrosis (an accumulation of urine around the kidney) in spite of the presence of a stent. It was felt the patient likely septic shock is from the left Pyelonephritis (kidney infection). Admitting diagnosis to Hospital B on 10/10/2024 include Septic shock (a potentially fatal medical condition that occurs when sepsis, which is organ injury or damage in response to infection, leads to a dangerously low blood pressure and other abnormalities), occlusion of ureteral stent, acute renal failure, left pyelonephritis, and respiratory failure (the result of inadequate oxygen flow). Resident was incubated (a tube placed in the airway to assist with oxygen flow) and placed in ICU upon admission . In an interview with the ADON on 10/12/2024 at 1:30 PM he stated that the readmission process was similar to the admission process. After report was received by the nurse and the resident has returned to the building and an assessment has been completed, the orders were reviewed. All new orders were to be verified with the resident's physician, medication orders were then sent to the pharmacy, and any follow up appointments sent to transportation for scheduling. He was not sure how the appointment for Resident # 1 was missed and he admitted he reviewed the orders again and was not able to locate the orders. It was his expectation that all orders to be confirmed with resident doctor and followed . He stated that after the orders are uploaded to the electronic medical record it is review by the DON or himself. He stated that not setting up the follow up appointment could result in worsening medical condition and failure of interventions that may have occurred during the appointment or hospital stay. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN Weekend supervisor on 10/12/2024 at 1:00 PM she stated that she also works are the charge nurse during the week at times. She stated when a resident returns from the hospital the nurse assigned to the hall , completes a head to toe assessment, reviews the discharge information and calls the doctor with any changes, sends any medication to pharmacy, any follow up appointments are sent to the transportation coordinator and the discharge paperwork is placed in the medical records basket. She stated missing an order could be harmful to the resident. Interview with DON on 10/14/2024 at 9:30 am she stated that when a resident is returned to the facility from a medical appointment or hospital stay the nurse assigned to their hall will do an physical assessment, review the discharge or review of medical appointment and call to verify with the doctor any new orders, fax new medications to pharmacy and notify transportation of any new appointments. She or the ADON will review the discharge or review of medical appointment once uploaded to the medical record which can be sometimes 2-3 later depending on when the resident returned to the building. She stated that potential harm is possible when doctors' appointment is missed either not scheduled or not attended. In an interview with CNA E who was responsible for transportation on 10/14/2024 at 1:30 PM she stated that she was not notified of an appointment for Resident # 1 for urology consult in August and she reviewed her book to verify. Attempted a phone interview with the agency nurse that readmitted Resident # 1 on 8/16/2024, no answer, and no voicemail set up . Interview with the ADM on 10/12/2024 at 3 PM revealed her expectations were that when a resident returned from the facility after seeing a medical provider, either a doctor visit, emergency room visit, or hospital stay that the order was to be reviewed and carried out . Nursing is responsible for carrying out physician orders, the nurse assigned to the hall does the assessment and order review when the resident returns to the facility. Review on 12/12/2024 at 1:00 PM of the policy titled Admission Assessment and Follow up: Role of the Nurse revised September 2012 revealed 7. Conduct an admission assessment (history and physical) including a. A summary of the individual's recent medical history, including hospitalization , acute illness, and overall status prior to admission. B. Relevant medical, social, and family history C. a list of active medical diagnoses and patient problems (such as recurrent fall or impaired mobility) especially those most related to reasons for admission to the facility and those that are affecting function. This was determined to be an Immediate Jeopardy (IJ) on 10/12/2024 at 5:10 PM. The Administrator was notified. The Administrator was provided with the IJ template on 10/14/2024 at 6:00 PM. The following Plan of Removal submitted by the facility was accepted on 10/16/24 at 8:07 am: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan of Removal for Immediate Jeopardy F 684. Action Taken The following is a plan of removal, which was immediately implemented at the facility, to remedy the immediate jeopardy which was imposed on 10/14/2024 at 5:10 PM. On 10/12/2024 an abbreviated survey was initiated at the facility. On 10/14/2024 the surveyor provided an immediate Jeopardy (IJ) Template notification the regulatory services have determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to follow physician orders regarding a follow up appointment that needed to be completed for the resident. The follow actions will be completed by 5:00 PM on 10/15/2024 with continued follow-up scheduled staff. 1. An Inservice regarding Physician orders policy and procedure of admission/readmission was initiated with licensed clinical staff on 10/14/2024 by the DON and ADON. Scheduled staff will be completed before allowing patient assignment/care. 2. The past 90 days of active admissions/readmission will have a full chart order review by the Regional Corporate nurse, the DON, and the ADON to ensure compliance with applicable physician orders in place. 41 residents' readmission/admission orders were reviewed for accuracy. Of the 41 residents 12 residents required physician contact/order review to ensure accuracy. This will be completed by 10/15/2024. 3. Regional nurse-corporate completed an in-service with the DON and ADON regarding review of physician orders and implementation of orders per policy and procedure. This was completed 10/14/2024. 4. A review of the policy titled Admission assessment and follow up- Role of the Nurse was reviewed on 10/14/2024 at 5:45 PM by the regional director of operation and the Regional Nurse Consultant with the following changes in response to this identified immediate jeopardy: * Title change to include readmissions as part of the policy with definition that admission in the policy represents readmission as well as defined. * The policy has been reviewed and updated to define who is responsible for the initial step of the admission/readmission process and implementation of a follow up process for compliance review. Monitoring for complaint ,(IJ) the DON and/designee will review all admission/readmissions and follow up accordingly regarding orders daily during the weekdays. The weekend RN supervisor will be responsible for Saturday and Sunday admission/readmission audit reviews. The IDT will review and assess the admissions/readmissions weekly to determine what further actions/ interventions or changes were needed if necessary. Members of the meeting were to include the ADM, the DON, the ADON, the MDS Coordinator, the Social Worker, the Therapy representative, the RNC, and RDO. Record review of in-service dated 10/15/2024 and 10/16/2024 revealed all licensed staff that were on duty between 10/12/2024 and 10/16/2024 signed the in-service for Physician orders and Admission/readmission policy . All staff not in serviced will complete the training prior to the start of their shift. Record review of audit of charts reviewed by the RNC and the DON revealed 12 residents which needed order verification . All residents' physicians were notified, and order clarification obtained. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 10/16/2024 at 10:15 am the DON and the ADON stated they were in-serviced by the RNC on physician orders and the changes to the admission policy on 10/15/2024. Interview on 10/16/2024 from 10:30 to 1:30 PM with 6/ 11 of Clinical staff from the AM staff, revealed they were in-serviced by the DON or the ADON on Physician orders and Admission policy prior to the start of their shift. All staff interviewed were able to verbalize understanding and changes to policies . An attempt was made to contact a PM shift staff member with no answer and no returned phone call. On 10/12/24 at 6:00 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/16/24, the facility remained out of compliance at a scope of Isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.