

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 07/30/2025
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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of three residents reviewed for accidents and hazards. The facility failed to ensure CNA A did not provide personal care for Resident #1 without another staff member (which he required) on 07/27/25. She yanked on his right arm when attempting to roll him to his side, and he heard a pop. He was in excruciating pain and was subsequently diagnosed with a shoulder sprain at the hospital. The noncompliance was identified as PNC. The IJ began on 07/27/25 and ended on 07/29/25. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk of pain, injury, and hospitalization. Findings included: Review of Resident #1's undated face sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including morbid obesity, PTSD, major depressive disorder, and unspecified lack of coordination. Review of Resident #1's quarterly MDS assessment, dated 06/26/25, reflected a BIMS score of 15, indicating he was cognitively intact. Section GG (Functional Abilities) reflected he required extensive assistance (2+ personal physical assist) with toileting/repositioning. Review of Resident #1's quarterly care plan, dated 06/28/25, reflected he required total care with all aspects of daily care with an intervention of staff assisting him in daily care. Review of Resident #1's progress note, dated 07/27/25 at 11:15 AM and documented by RN B, reflected the following: While in to see resident and bring his meds, noted facial grimace and he was rubbing his right upper arm and shoulder. [Resident #1] explained that he had a bad, rough night and thinks he got hurt at his rt shoulder (his bad arm), after hearing and feeling a pop while being repositioned in bed. Rated pain 8-9/10. Review of Resident #1's progress note, dated 07/27/25 at 2:33 PM and documented by the ADM, reflected the following: Received information resident upset regarding the care that was provided during the night shift. He further reports as the CNA finally came in early this morning towards the end of her shift around 5:45 - 6AM she was distracted while providing care and yanked on his right arm causing pain to his shoulder. He heard a pop and told her she had hurt him. Review of Resident #1's progress note, dated 07/27/25 at 9:40 PM and documented by RN B, reflected the following: NP was notified earlier regarding [Resident #1]'s situation and orders were ok'd for rt shoulder x ray. [Resident #1] stated the tramadol for pain and the bio freeze helped 'a lot!' Review of Resident #1's hospital records, dated 07/28/25, reflected a right shoulder sprain. During an interview on 07/30/25 at 11:32 AM, Resident #1 stated he had recently had his pain medication, so he was not experiencing pain. He stated in the morning of 07/27/25, CNA A was in a rush to change his brief and was not paying attention to him. She stated when going to turn him, she yanked on his right arm, and he heard a pop. He stated he saw stars in his eyes while he was screaming and telling her she hurt him. He stated his pain was over a 10 and he felt pain from his shoulder to his wrist. He stated he was supposed to have two people providing him care, and he normally did. He stated he got an x-ray the same day, the results came back the next day saying he had a fracture. He stated the staff sent him to the hospital where he was told it was just a sprain. He stated the staff had been giving him pain medication when he needed it which was managing his pain, and he was happy CNA A got fired. He did not have any further concerns. During an interview on 07/30/25 at 11:40 AM, the CRN, the ADM, and the DON stated CNA A was suspended the same day (07/27/25) and texted the DON the following day stating she had quit. They were unable to get a statement from her. The ADM stated Resident #1's RP, NP, and the Ombudsman were notified of the incident immediately. The DON stated a STAT x-ray was immediately ordered, they conducted safe surveys on all residents, emotional assessments were being conducted for Resident #1 every shift by nursing staff, and all staff were in-serviced on abuse and neglect, resident rights, and ADL self-care. During an interview on 07/30/25 at 11:52 AM, RN B stated on 07/27/25 in the morning she asked Resident #1 how his night was, and he told her he had a rough night. She asked him to explain further, and he told her CNA A was really rough with him and he felt a pop when she yanked his right arm. She stated she assessed him, administered him pain medication, applied bio freeze, and notified the ADM, his RP, and the NP. The NP ordered a STAT x-ray which was done that day. She stated she was in-serviced that day on abuse and neglect and safe ADL care. She stated no one should provide care to a resident alone when they required two people. During an interview on 07/30/25 at 1:18 PM, MA C stated she was recently in-serviced by the DON and ADM on abuse and neglect and two-person assistance. She stated the ADM was their abuse and neglect coordinator and</p>		