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	11/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Cove Ltc Partners, Inc.	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 (Resident #2) of 4 residents reviewed for resident rights.The facility failed to follow their policies and procedures and provide full-time translation or interpretation services to Resident #2, a [NAME] speaking resident.This failure could place residents at risk of miscommunication between the resident and staff, lead to misunderstandings about a resident's medical condition and treatment options, and improper care or inappropriate treatments or prescriptions.Findings include:Record review of Resident #2's face sheet, dated 11/14/25, revealed a seventy-four-year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses included Alzheimer's disease (progressive decline in episodic memory, with variable involvement of other cognitive domain), dementia (a decline in brain function), and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities). Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) Quarterly assessment dated [DATE] reflected a BIMS score of zero indicating severe cognitive issues, and Resident #2's preferred language was Korean. Record review of Resident #2's care plan dated 05/30/25 reflected Resident #2 had a communication problem related to language barrier. Resident #2 spoke Korean and needed an interpreter with interventions dated 05/30/25 to be conscious of Resident #2's position when in groups, activities, dining room to promote proper communication with others. Resident #2 preferred communicating while family was present to translate in Korean, and for staff to anticipate and meet Resident #1's needs.Observation and attempted interview on 11/20/25 at 6:43 pm with Resident #2 reflected, CNA A knocked on the door to Resident #2's room asking in English to enter to room. Resident #2 was laying in her bed. Surveyor was unable to communicate with Resident #2. Resident #2's room and Resident #2 appeared clean.Interview on 11/21/25 at 8:40 am with CNA C reflected he worked in the facility's secured unit for about 1 (one) year and had worked with Resident #2. He said Resident #2 only spoke Korean. He thought Resident #2 understood a little bit of English, but not a great deal. He said he communicated with her using body language and hand gestures. He felt like he communicated with her effectively about 50 percent of the time, but it was hard to know her ability to communicate because her dementia played a role. They did not have a communication board for Resident #2. He said there was a nurse, LVN F, who worked in another hall who spoke Korean. They got LVN F to talk to Resident #2 when Resident #2 was being aggressive, hurting, and staff needed an explanation of where she was hurting. Sometimes they called LVN F on the phone to talk to Resident #2 when LVN F was not in the building. He did not know if a communication board would help Resident #2 because of her dementia. He felt like they could at least try a communication board. Interview on 11/21/25 at 9:08 am with CNA D reflected she had worked in secured unit for 10 (ten) years. CNA D said they used hand gestures when they communicated with Resident #2. When they took Resident #2 to the restroom, they pointed to the restroom. When it was time to eat, they gestured eating. Staff had nothing that would help them communicate in Resident #2's language. CNA D said sometimes she thought Resident #2 did understand a little bit of English. When Resident #2 was really upset or hurting, they asked LVN F to talk to her. LVN F spoke Resident #2's language and could communicate with Resident #2 successfully. She thought having more communication in Korean might be more successful for Resident #2, but no one tried that.Interview on 11/21/25 at 9:51 am with LVN F reflected she helped communicate for Resident #2 when they needed something conveyed to her, and the staff could not get her to understand. Staff in the secured unit would come and grab her to communicate with Resident #2, but this was not too often. Resident #2 was pretty directable with hand gestures. When Resident #2 was admitted to the facility, they realized she did not understand English. LVN F had never seen a communication board for Resident #2. LVN F said she was always accessible if they needed her to speak with Resident #2 and always kept her phone on her. The facility should have tried to provide a way to communicate with the residents who speak another language. The possible negative effect of not being able to communicate with a resident who speaks another language would be an unwitnessed fall. Staff could not communicate with Resident #2 to find out what happened or where she might be injured. It was everyone's responsibility to make sure they could communicate with a resident. Staff needed to tell the ADON and DON if there was a communication issue

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to respect a resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 (Resident #1) of 5 residents reviewed for resident rights.The facility failed to obtain a valid DNR for Resident #1 which resulted, on [DATE], in Resident #1 receiving CPR when she was found unresponsive. This failure could place residents at risk of their rights to refuse or discontinue treatment being disrespected, being resuscitated against their wishes or placed on life support.Findings included:Record review of Resident #1's face sheet, dated [DATE], revealed an eighty-four-year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses included adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol), fracture of the right femur (a break in the thigh bone, which is the longest and strongest bone in the human body), recurrent depressive disorders (the person has a history of at least two depressive episodes (depressed mood or loss of pleasure or interest in activities) for long periods of time).Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Quarterly assessment dated [DATE] revealed a BIMS score of zero indicating severe cognitive issues.Record review of Resident #1's care plan revealed a focus dated [DATE] reflected Resident #1 had an order for Do Not Resuscitate (DNR) with interventions dated [DATE]: 1. All aspects of DNR will be explained to Resident #1 or responsible party.2. In absence of blood pressure, pulse, respiration, CPR will not be initiated.3. Notify MD of change of condition.4. Resident #1 will be maintained at a level of comfort as ordered by physician.5. Social Services to consult with resident and RP regarding their decision to continue DNR.Record review of Resident #1's Out-of-hospital Do-Not-Resuscitate (OOH-DNR) order Texas Department of State Health Services dated [DATE] revealed it was unsigned by a physician. Record review of page 28 of Resident #1's facility admission papers dated [DATE] signed by Resident #1's RP reflected Informed Consent - I have been informed of my rights to make advanced directives for health care decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives such as Directive to Physicians and/or Living Will or Durable Power of Attorney for Health Care. Beig so informed, it is my decision to: I have previously executed a document and will supply copies to the facility for my or my relative's clinical record and physician use. Record review of Resident #1's order dated [DATE] by RN H reflected order summary DNR advance directive status current and verified. Interview on [DATE] 10:47 am with the DON reflected that she was alerted by a CNA (name of CNA unknown) that Resident #1 was unresponsive. A family member of Resident #1 was in the building. The DON said they assumed that Resident #1 was a full code because she did not have a DNR. The DON said the Resident #1 was not on hospice. The DON said she began placing her hands on Resident #1 to do chest compressions, and the family member told her to stop because Resident #1 had a DNR. She said EMS arrived and were informed by the DON that Resident #1 did not have a DNR and they began to attempt to do chest compressions and again the family member told them to stop because Resident #1 had a DNR. She said the family member received a copy of the DNR via his telephone from another family member, but the DNR did not have the signature of a MD. She said EMS received approval from a member of their team to not proceed with compressions. Interview on [DATE] at 3:38 pm with a family member of Resident #1, who was present when she died, reflected the facility did not have the correct DNR because the former nursing facility did not send it when Resident #1 was transferred to the current facility. The family said the MD's name was printed on the DNR, but it had no MD signature. He said the former nursing facility was to forward all the information about Resident #1 to her current facility. Interview on [DATE] at 10:57 am with the ADON reflected she had been the ADON at the facility for 1 (one) month. The ADON did not know the facility policy regarding resident DNRs. She said she did not know if the facility required residents to have either a DNR or full code established when they came into the facility, she stated she would hope so, but she did not know. She said she did not know who was responsible for making sure that the residents had the correct code status information when they were admitted to the facility, her first thought would be the nurse, but she did not know which nurse, she would have to look at the policy. She said it was very important to have the residents correct and complete code status because it was a matter of life and death.Interview on [DATE] at 11:32 am with LVN E reflected the charge nurse upon a residents'

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for one (Resident #1) of 7 (seven) residents reviewed for weight loss.The facility failed to follow its procedures and provide effective interventions to prevent weight loss in Resident #1, who had a 10.39% weight loss between 10/09/25 and 11/03/25. Resident #1 was not weighed when she was admitted to the facility on [DATE]. Resident #1 was not weighed weekly x 4 weeks after her admission to the facility. Nutritional supplements were recommended by the RD on 10/15/25. They were ordered 11/14/25. Resident #1 died on [DATE].This failure could place residents at risk of dehydration, malnutrition, functional decline and death.Findings included:Record review of Resident #1's face sheet, dated 11/20/25, revealed an eighty-four-year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses included adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol), fracture of the right femur (a break in the thigh bone, which is the longest and strongest bone in the human body), recurrent depressive disorders (the person has a history of at least two depressive episodes (depressed mood or loss of pleasure or interest in activities) for long periods of time).Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Quarterly assessment dated [DATE] revealed a BIMS score of zero indicating severe cognitive issues. Record review of Resident #1's care plan revealed a focus dated 10/20/25 of Resident #1 refused to eat/resisted feeding with interventions dated 10/20/25 of 1. Administer medications as ordered. Monitor/document for side effects and effectiveness.2. Resident #1 needed encouragement/support to be independent with eating. Allow Resident #1 to feed self if desired, regardless of skill.3. Empower Resident #1 by allowing choices in mealtime, menu selection, dining location.4. Invite Resident #1 to food-related activities and offer food, beverages of choice to encourage intake. Record review of Resident #1's facility weights reflected two weight records 10/09/25 scale mechanical lift value 129.0 pounds and 11/03/25 scale mechanical lift value 115.6 pounds representing a weight loss of 10.39 percent in 25 days. Record review of Resident #1's progress notes dated 10/15/25 reflected Resident #1 refused meals. RD recommended providing supplemental support house supplement 2. 0 120 ml QID in between meals; update related to food preferences to provide meals and snacks of choice. Record review of Resident #1's order dated 11/14/25 reflected diet supplement of house supplement order type medication aide supplement four times a day for house supplement 2.0 (a nutrient-dense supplement for managing weight loss, malnutrition) four times a day. Resident #1's November 2025 MAR for House Supplement four times a day for house supplement 2.0 four times a day reflected no refusals of supplement by Resident #1.Interview on 11/20/25 at 10:47 am with the DON reflected Resident #1 died on [DATE], and she was not on hospice care. The DON said Resident #1 died from failure to thrive. She said the RA did the facility weights and if the RA was not there, CNA B did resident weights. The DON said it was the responsibility of the ADON to make sure that the weights were taken. The DON said Resident #1 should have been weighed on 10/03/25 when she was admitted to the facility. The DON did not see documentation that Resident #1 refused to be weighed during Resident #1's time at the facility. She said the facility did not follow its policy for weighing residents. The DON said the possible negative effects of not weighing residents according to facility policy was that staff could not tell if residents had a significant amount of weight loss. She said when the RD entered the facility on 10/15/24, it would have been important to have given the RD the correct weight information for a resident who was not eating. The DON said the facility should have been on top of the weights. The DON said the RD recommended a supplement, but the supplement was not ordered until 11/14/25. She was not sure why it took so long for the order to be placed. She said Resident #1's supplement was not received timely and Resident #1's weight loss was not appropriately addressed. The DON said she knew the responsibility for weights and monitoring the ordering of supplements, fell on her. The DON said they did not know Resident #1 had that amount of weight loss, and had she known, she would have tried to get more supplements and spoken with the family to see if they would have been interested in hospice. The DON said she would have done a lot of things differently. She said the lack of addressing the weight loss could have led to Resident #1's failure to thrive and ultimately her death.