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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Cove Nursing & Rehabilitation	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 - Some	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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 3 of 8 residents (Residents #1, #2, & #3) reviewed for resident rights.The facility failed to ensure Residents #1, #2, & #3's call lights were within reach on 12/09/2025.This failure could place residents at risk of their needs not being metFindings include:Record review of Resident #1's admission record, dated 12/10/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Epilepsy (a brain disorder causing recurrent seizure), Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills), and muscle weakness (loss of strength in muscles making it difficult to move or perform physical task).Record review of Resident #1's admission MDS assessment, dated 10/15/2025, reflected Resident #1 had a BIMS score of 99, which indicated severe cognitive impairment. Resident #1 was dependent in the areas of shower/bathe self, upper body dressing, lower dressing, putting on/taking off footwear and personal hygiene. Record review of Resident #1's care plan, dated 12/10/2025, reflected Resident #1 was care planned for high risk for fall r/t unaware of safety needs, gait/balance problems, and seizure activity. Resident #1 had an intervention of be sure the resident's call light is within reach and encourage the resident to use it. During observations on 12/09/2025 at 10:29am and 2:47pm, Resident #1's call light was observed hanging towards the ground on the right side of her bed Resident #1 could not be interviewed due to her cognitive status. Record review of Resident #2's admission record, dated 12/10/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: chronic idiopathic constipation (long last/frequent constipation), essential primary hypertension (high blood pressure), unsteady feet (feeling wobbly, off balance, or like you might fall while walking or standing), and muscle weakness (loss of strength in muscles making it difficult to move or perform physical task).Record review of Resident #2's Quarterly MDS assessment, dated 10/08/2025, reflected Resident #2 had a BIMS score of 07, which indicated severe cognitive impairment. Resident #2 was dependent in the areas of toileting hygiene, shower/bathe self, upper body dressing, lower dressing, putting on/taking off footwear and personal hygiene. Record review of Resident #2's care plan, dated 12/10/2025, reflected Resident #2 was care planned for at risk for falls. Resident #2 had an intervention of be sure the resident's call light is within reach and encourage the resident to use it. During an observation on 12/09/2025 at 10:31am, Resident #2's call light was observed hanging towards the ground on the left side of his bed. During an interview with Resident #2 on 12/09/25 at 10:31am, Resident #2 stated that he could not reach his call light, and he would have to yell for assistance if he needed it. Resident #2 stated his call light was never in reach and must wait for staff to pass by to get assistance. Record review of Resident #3's admission record, dated 12/10/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood without any common health problems associated with the disease), gastro esophageal reflux disease without esophagitis (when stomach acid frequently flows back up into food pipe causing irritation, heartburn, and a sour taste), and Alzheimer's disease (progressive brain disorder that slowly destroys memory and thinking skills)Record review of Resident #3's admission MDS assessment, dated 10/06/2025, reflected Resident #3 had a BIMS score of 15, which indicated Resident #3 was cognitively intact. Resident #3 required partial/moderate assistance in the areas of oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower dressing, putting on/taking off footwear and personal hygiene. Record review of Resident #3's care plan, dated 12/10/2025, reflected Resident #3 was care planned for ADL self-care performance deficit r/t Alzheimer's with an intervention of encourage the resident to use bell to call for assistance. During an observation on 12/09/2025 at 10:58am, Resident #3's call light was observed approximately 3 feet away from him and out of reach. During an interview with Resident #3 on 12/09/25 at 10:58am, Resident #3 stated that he could not reach his call light, and he would have to get out of bed and crawl to get it. Resident #3 stated he did not know how long his call light had been out of reach. During an interview with CNA A on 12/09/2025 at 2:10 PM, CNA A stated she was providing care for Resident #3 during the time his call light was not within reach. CNA A stated she moved the call light when she was assisting Resident #3 and forgot to put it back within reach. CNA A stated a negative outcome could