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	04/13/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrates they were unavoidable, and a resident with pressure ulcers received necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 5 Residents (Resident #1) reviewed for quality of care. The facility failed to complete wound care treatment for Resident #1 on 01/03/2026, 01/30/2026, 02/05/2026, 02/07/2026, 02/08/2026. This failure could place residents at risk of rapid wound deterioration.Findings included:A record review of Resident #1's face sheet, dated 04/11/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included pressure ulcer of sacral region,(shield -shaped bone at the base of the lumbar spine connecting the spine to the pelvis) stage 4 (full thickness wound extending to muscle, tendon, or bone), pressure ulcer of unspecified site, unspecified stage, multiple sclerosis (immune system destroys the myelin sheath (protective layer fatty tissue) protecting nerves in the brain and spinal cord), anemia (deficiency of healthy blood cells), and paraplegia(impairment motor of sensory function in the lower half of the body)A record review of Resident #1's care plan, dated 04/11/2026, reflected Resident #1 had a pressure injury or potential for pressure injury development r/t immobility. Stage 4 wound to Coccyx (tailbone) related to being paralyzed from the waist down, wound to lateral foot(outside of foot), blood blister the left toe, and unstageable deep tissue injury(severe wound classifications where the true dept is hidden) on the side of the right planter lateral fifth(common site for foot pain), . resistive(refusing) to turning/repositioning, refuse repositioning and offloading while in bed, despite ongoing education and encouragement, refusing to get out of bed and wound care with interventions of air mattress, wound cleansing, monitor dressing every shift to ensure it is intact(not broken) and adhering(sticking firmly), notify a nurse immediately of any new areas of skin breakdown discoloration, educate Resident # 1 of the possible outcome of not complying with treatment or care, encourage, frequent change positions, weekly treatment to document to include measurement of the area of skin breakdown width, length, dept type of tissue, if Resident #1 resist(refuse) give a clear explanation of care, leave, return 5-10 minutes later and try againA record review of Resident #1's admission MDS assessment, dated 10/28/2026 , reflected Resident #1 had BIMS score of 14,indicated cognitive intact. Resident # 1 was at risk of developing pressure ulcers/injuries and had one stage 4 pressure ulcer and one or more unhealed pressure ulcers/injuries.A record review of Resident #1's Quarterly MDS assessment, dated 02/14/2026 , reflected Resident #1 had BIMS score of 11,indicated moderate cognitive impairment. Resident # 1 was at risk of developing pressure ulcers/injuries and had one stage 4 pressure ulcer and one or more unhealed pressure ulcers/injuries.A record review of Resident #1's physician's order dated 11/18/2025 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner every day shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing start date 11/18/2025. A record review of Resident #1's Physician's order dated 12/18/2025 reflected cleanse the wound on the lateral foot every day shift (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (sterile, non-adhering petrolatum dressing) to the wound bed then cover with a foam dressing start date 12/18/2025. The Physician's order dated 12/18/2025 reflected to change the dressing every day shift per protocol or as needed for soiling or dislodgement and continue treatment until healed or as directed by the provider start date 12/18/2025. A record review of Resident #1's Physician's order dated 12/18/2025 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) to the blister and surrounding intact skin. Leave the blister open to air start date 12/18/2025.A record review of Resident #1's TAR dated 01/03/2026, 02/05/2026, 02/07/2026, and 02/08/2026 reflected cleanse the wound on the lateral foot every day shift with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (antiseptic used to kill bacteria) to the wound bed then cover with a foam dressing was not signed off completed in PCC (Electronic Health Record)by LVN C on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 01/30/2026, 02/05/2026, 02/07/2026, and 02/08/2026 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) to the blister and surrounding intact skin. Leave the blister open to air was not signed off completed in PCC by LVN C on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 01/03/2026, 01/30/2026, 02/05/2026, 02/07/2026, and 02/08/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner every day shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN C on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's weekly wound care assessments and skin sheets dated 03/11/2026, 03/18/2026, and 3/25/2026 revealed no wound infections. Resident #1 was sent out to the hospital on [DATE] and there was no wound care assessmentA record review of Wound Care Doctor Visit on 04/02/2026 reflected the Wound Care Doctor done a debridement on Resident #1's right planter(bottom foot) lateral(outer edge extending from the heel to the little toe) fifth MTP(joint where the long bones of the foot meet). Resident # 1 had experienced discomfort and requested for the Wound Care Doctor to stop.Review of Hospital records dated 04/04/2026 reflected Resident #1 was admitted to the hospital for Sepsis secondary to UTI and possible pneumonia borderline hypotensive(low blood pressure) on 04/04/2026 but blood pressure improved Resident #1 remained confused encephalopathic(altered function of brain)During an interview with Resident #1's RP on 04/11/2026 at 9:59 AM stated that facility staff would contact her when Residdent #1 would refuse care. Resident #1's RP stated that Resident #1 had admitted to the facility with wounds and had wound care orders. Resident#1's RP stated she was lead to believe wound care orders was not being followed due to Resident #1's recent hospitalization when it was determined the resident had sepsis.During an interview with the Wound Care Doctor on 04/12/2026 at 12:20 PM the Wound Care Doctor stated that if Resident #1 had missed or refused any wound care treatments he would have identified any change of condition and would have identified any infections The Wound Care Doctor stated that Resident # 1 was not sent out for wounds on 04/04/2026 and he had did a debridement on Resident #1's right planter(bottom foot) lateral(outer edge extending from the heel to the little toe) fifth MTP(joint where the long bones of the foot meet) on 04/02/2026. Resident # 1 had experience some discomfort and asked him to stop.Attempted an interview with LVN C on 04/13/2026 at 1:20 PM, 2:00 PM, and 4:13 PM and was unsuccessful. Left LVN voice mail messages and no return call was received by exit 04/13/2026. LVN C was no longer employed with the facility.During an interview with the DON on 04/13/2026 at 3:35 PM, the DON stated it was expected for LVN C to have completed wound care for Resident #1 on 01/03/2026, 01/30/2026, 02/05/2026, 02/07/2026, and 02/08/2026. The DON stated it was expected for LVN C to have followed the physician's order. The DON stated if orders were not followed a resident's condition could worsen.During an interview with the ADM on 04/13/2026 at 3:55 PM, the ADM stated it was expected for LVN C to have completed the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound care for Resident #1. The ADM stated that LVN was expected to follow the doctor's order to prevent any further complications.Record review of the facility's policy, dated 2001 revised 10/2010 , titled wound care reflected The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following information should be recorded in the resident's medical record:The type of wound care givenThe date and time the wound care was givenThis position in which the resident was placedThe name and title of the individual performing wound careAny change in the resident's conditionAll assessment data (i.e., wound bed color, size, drainage, etc) obtained when inspecting the woundHow the resident tolerated the procedureAny problems or complaints made by the resident related to the procedureIf the resident refused the treatment and the reason(s) whyThe signature and title of the person recording the data

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for complete and accurate records.The facility failed to ensure Resident #1's wound care cleaning was documented completed in PCC for 01/10/2026, 01/25/2026, 02/14/2026, 02/17/2026, 02/19/2026, 02/21/2026, 02/23/2026, 02/26/2026, 03/06/2026, 03/07/2026, 03/10/2026, 03/11/2026, 03/13/2026, 03/16/2026, 03/17/2026, 03/22/2026, 03/23/2026, and 03/30/2026.This failure could place residents of staff not knowing whether treatment and services were provided for. Findings include:A record review of Resident #1's face sheet, dated 04/11/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included pressure ulcer of sacral region,(shield -shaped bone at the base of the lumbar spine connecting the spine to the pelvis) stage 4 (full thickness wound extending to muscle, tendon, or bone), pressure ulcer of unspecified site, unspecified stage, multiple sclerosis (immune system destroys the myelin sheath (protective layer fatty tissue) protecting nerves in the brain and spinal cord), anemia (deficiency of healthy blood cells), and paraplegia(impairment motor of sensory function in the lower half of the body)A record review of Resident #1's care plan, dated 04/11/2026, reflected Resident #1 had a pressure injury or potential for pressure injury development r/t immobility. Stage 4 wound to Coccyx (tailbone) related to being paralyzed from the waist down, wound to lateral foot(outside of foot), blood blister the left toe, and unstageable deep tissue injury(severe wound classifications where the true dept is hidden) on the side of the right planter lateral fifth(common site for foot pain), resistive(refusing) to turning/repositioning, refuse repositioning and offloading while in bed, despite ongoing education and encouragement, refusing to get out of bed and wound care with interventions of air mattress, wound cleansing, monitor dressing every shift to ensure it is intact(not broken) and adhering(sticking firmly), notify a nurse immediately of any new areas of skin breakdown discoloration, educate Resident # 1 of the possible outcome of not complying with treatment or care, encourage, frequent change positions, weekly treatment to document to include measurement of the area of skin breakdown width, length, dept type of tissue, if Resident #1 resist(refuse) give a clear explanation of care, leave, return 5-10 minutes later and try againA record review of Resident #1's admission MDS assessment, dated 10/28/2026 , reflected Resident #1 had BIMS score of 14,indicated cognitive intact. Resident # 1 was at risk of developing pressure ulcers/injuries and had one stage 4 pressure ulcer and one or more unhealed pressure ulcers/injuries.A record review of Resident #1's Quarterly MDS assessment, dated 02/14/2026 , reflected Resident #1 had BIMS score of 11,indicated moderate cognitive impairment. Resident # 1 was at risk of developing pressure ulcers/injuries and had one stage 4 pressure ulcer and one or more unhealed pressure ulcers/injuries.A record review of Resident #1's physician's order dated 11/18/2025 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner everyday shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing start date 11/18/2025.A record review of Resident #1's Physician's order dated 12/18/2025 reflected cleanse the wound on the lateral foot every day shift with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (sterile, non-adhering petrolatum dressing) to the wound bed then cover with a foam dressing start date 12/18/2025. The Physician's order dated 12/18/2025 reflected to change the dressing every day shift per protocol or as needed for soiling or dislodgement and continue treatment until healed or as directed by the provider start date 12/18/2025. A record review of Resident #1's Physician's order dated 12/18/2025 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the blister and surrounding intact skin. Leave the blister open to air start date 12/18/2025.A record review of Resident #1's Physician's order dated 2/26/2026 reflected cleanse the wound on the right lateral foot every day shift with normal saline or approved wound cleaner, pat dry, apply calcium alginate (highly absorbent dressing) and gauze border dressing start date 02/26/2026.A record review of Resident #1's Physician's order dated 11/14/2025 reflected cleanse the unstageable deep tissue injury on the side of the right planter lateral fifth MTP(joint where the long bones of the foot meet) with wound cleaner. Apply Betadine daily and leave open to air. Every day shift for wound healing start date 11/14/2025.A record review of Resident # 1's Physician's order date 04/05/2026 reflected for 23 days, cleanse wound to non-pressure wound of the right planter(bottom of foot), lateral(extend from heel to the little toe)MTP(joint where the long bones of the foot meet) toe with wound cleanser and apply alginate calcium(highly absorbent sterile pad) QD and PRN if saturated, soiled, or dislodged, and cover with BDR. Apply skin prep to peri-wound area QD and PRN for dislodgement or soiled dressing one time a day for wound healing related to pressure ulcer of unspecified site , unspecified stage start date 04/05/2026.A record review of Resident #1's TAR dated 01/10/2026 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) to the blister and surrounding intact skin. Leave the blister open to air was not signed off completed in PCC (electronic health record)by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 01/10/2026 reflected cleanse the wound on the lateral foot every day shift with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (sterile, non-adhering petrolatum dressing) to the wound bed then cover with a foam dressing was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 01/10/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner everyday shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 01/25/2026 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) to the blister and surrounding intact skin. Leave the blister open to air was not signed off completed in PCC by LVN B on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 01/25/2026 reflected cleanse the wound on the lateral foot every day shift with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (sterile, non-adhering petrolatum dressing) to the wound bed then cover with a foam dressing was not signed off completed in PCC by LVN B on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 01/25/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner everyday shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN B on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/14/2026 and 02/23/2026 reflected cleanse the wound on the lateral foot every day shift with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (highly absorbent dressing) to the wound bed then cover with a foam dressing was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/14/2026 and 02/23/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner every day shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/23/2026 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) to the blister and surrounding intact skin. Leave the blister open to air was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/17/2026, 02/19/2026, 02/21/2026, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and 02/23/2026 reflected cleanse the wound on the lateral foot every day shift with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (to the wound bed then cover with a foam dressing was not signed off completed in PCC by LVN B on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/17/2026, 02/19/2026, and 02/21/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner every day shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN B on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/17/2026, 02/19/2026, 02/21/2026, and 02/23/2026 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) to the blister and surrounding intact skin. Leave the blister open to air was not signed off completed in PCC by LVN B on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/26/2026 reflected cleanse the wound on the lateral foot every day shift with normal saline or wound cleaner, pat dry with 4x4 gauze, apply Xeroform (antiseptic used to kill bacteria) to the wound bed then cover with a foam dressing was not signed off completed in PCC by LVN D on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 02/26/2026 reflected cleanse blood blister every day shift on the left foot, above the heel and below the ankle, with normal saline or approved wound cleaner. Gently apply Betadine (antiseptic used to kill bacteria) to the blister and surrounding intact skin. Leave the blister open to air was not signed off completed in PCC by LVN D on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 03/06/2026, 03/07/2026, 03/13/2026, and 03/16/2026 reflected cleanse the wound on the right lateral foot every day shift with NS/WC, pat dry, apply calcium alginate (highly absorbent dressing) and gauze border dressing was not signed off completed in PCC by LVN D on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 03/06/2026, 03/07/2026, 03/13/2026, 03/30/2026and 3/22/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner every day shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN D on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 03/10/2026, 03/11/2026, 03/16/2026 andreflected cleanse the wound on the right lateral foot every day shift with NS/WC, pat dry, apply calcium alginate (highly absorbent dressing) and gauze border dressing was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 03/10/2026, 03/11/2026, and 03/16/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner every day shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR order dated 03/17/2026 reflected cleanse the Stage 4 pressure wound to coccyx (tailbone) with wound cleaner every day shift. Apply Medihoney (treatment for wounds), cover with calcium alginate (highly absorbent dressing), and place a dressing was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 03/17/2026 reflected cleanse the wound on the right lateral foot with NS/WC pat dry , apply xeroform(antiseptic used to kill bacteria) and gauze border dressing every day shift was not signed off completed in PCC by LVN A on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's TAR dated 03/22/2026 and 03/23/2026 reflected cleanse the wound on the right lateral foot with NS/WC pat dry , apply xeroform(antiseptic used to kill bacteria) and gauze border dressing every day shift was not signed off completed in PCC by LVN D on the 6:00 AM - 6:00 PM shift.A record review of Resident #1's weekly wound care assessments and skin sheets dated 03/11/2026, 03/18/2026, and 3/25/2026 revealed no wound infections. Resident #1 was sent out to the hospital on [DATE] and there was no wound care assessmentA record review of Wound Care Doctor Visit on 04/02/2026 reflected the Wound Care Doctor done a debridement on Resident #1's right planter(bottom foot) lateral(outer edge extending from the heel to the little toe) fifth MTP(joint where the long bones of the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	foot meet). Resident # 1 had experienced discomfort and requested for the Wound Care Doctor to stop.Review of Hospital records dated 04/04/2026 reflected Resident #1 was admitted to the hospital for Sepsis secondary to UTI and possible pneumonia borderline hypotensive(low blood pressure) on 04/04/2026 but blood pressure improved Resident #1 remained confused encephalopathic(altered function of brain)During an interview with Resident #1's RP on 04/11/2026 at 9:59 AM stated that facility staff would contact her when Residdent #1 would refuse care. Resident #1's RP stated that Resident #1 had admitted to the facility with wounds and had wound care orders. Resident#1's RP stated she was lead to believe wound care orders was not being followed due to Resident #1's recent hospitalization when it was determined the resident had sepsis.During an interview with the Wound Care Doctor on 04/12/2026 at 12:20 PM stated that nursing staff should be signing off in PCC when Resident #1 had refused wound care. The Wound Care Doctor stated that he had did a debridement on Resident # 1's right planter(bottom foot) lateral(outer edge extending from the heel to the little toe) fifth MTP(joint where the long bones of the foot meet) on 04/02/2026. The Wound Care Doctor stated Resident #1 had experienced discomfort and Resident # 1 had requested for him to stop. The Wound Care Doctor stated there was not any infections with Resident #1's wounds and he did see the Resident once a week and sometimes twice and Resident #1 ?s wounds had improved. The Wound Care Doctor was responsible for staging the wounds and determined if the wounds were infected. The Wound Care Doctor stated that he would have identified any change of condition with Resident #1's wounds if wound care had not been provided. The Wound Care Doctor stated that Resident # 1 was not sent out to the hospital on [DATE] for wounds. During an interview with LVN D on 04/13/2026 at 11:45 AMstated that Resident #1 was not compliant in wound care and she would give Resident #1 some time to agree to wound care during her work hours 6:00 AM- 6:00 PM. LVN D stated that she did not sign off in the TAR when Resident # 1 refused wound care on 02/26/2026, 03/6/2026, 03/07/2026, 03/13/2026, 03/22/2026, 03/23/2026, and 03/30/2026, LVN D stated she did not sign off at end of her shift when Resident # 1 had refused the wound care. LVN D stated she was responsible for monitoring the wounds for any change of condition. LVN D stated documentation was important to validate the services had been completed .During an interview with LVN A on 04/13/2026 at 12:19 PM stated that Resident #1 refuses wound care pretty regularly and he gives Resident #1 several opportunities throughout the day to see if Resident # 1 would eventually let him provide the wound care. LVN A stated the TAR in PCC was not signed off on for the dates 01/10/2026, 02/14/2026, 02/23/2026, 03/10/2026, 03/11/2026, 03/16/2026, and 03/17/2026 due to at the end of his shift he failed to document that Resident # 1 had refused wound care. LVN A stated it was important to sign off the TAR in PCC to show the wound care was completed.During an interview with LVN B on 04/13/2026 at 1:30 PM stated that she had completed the wound care for Resident # 1 on 01/25/2026, 02/17/2026, 02/19/2026, and 02/21/2026. LVN B stated at the end of her shift she did not sign off the wound care was completed in PCC. LVN B stated documentation was important because it was the best way to track services provided . LVN B stated if the wound treatment was not documented it would indicate it was not done.During an interview with the Wound Care Nurse on 04/13/2026 at 3:01 PM stated she started with the facility the last week in March (not able to recall exact date). The Wound Care Nurse stated it was expected for LVN A, LVN B, and LVN D to have signed off in PCC that the treatments were refused by Resident #1. The Wound Care Nurse stated when wound treatments were not signed off on it would look like the wound treatments were not completed.During an interview with the DON on 04/13/2026 at 3:35 PM, the DON stated it was expected for LVN A, LVN B, and LVN D to have signed off on the TAR on 01/10/2026, 01/25/2026, 02/14/2026, 02/17/2026, 02/19/2026, 02/21/2026, 02/23/2026, 02/26/2026, 03/06/2026, 03/07/2026, 03/10/2026, 03/11/2026, 03/13/2026, 03/16/2026, 03/17/2026, 03/22/206, 03/23/2026, and 03/30/2026 on the 6:00 AM-6:00 PM P shift The DON stated the LVNs should document Resident #1's refusals in PCC and failed to go back and sign off at the end of their shift. The DON stated if the TAR was not signed off on it would indicate it did not happen.During an (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	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Cove Nursing & Rehabilitation	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview with the ADM on 04/13/2026 at 3:55 PM, the ADM stated it was expected for LVN A, LVN B, and LVN D to have signed off wound care completed on the TAR in PCC for the dates . The ADM stated that LVN A, LVN B, and LVN D should have signed off Resident #1 refused wound care treatment in PCC. The ADM stated if the TAR was not signed off on it would have indicated that the treatment was not completed and would not verify if the wound care treatment was completed or not.Record review of the facility's policy, revised 07/2017 , titled Charting and Documentation reflected All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response care. 7.Documentation of procedures and treatments will include care-specific details including:The date and time the procedure/treatment was providedThe name and title of the individual(s) who provided the careThe assessment data and/or any unusual findings obtained during the procedure/treatmentHow the resident tolerated the procedure/treatmentWhether the resident refused the procedure/treatmentNotification of family , physician or other staff, if indicated; andThe signature and title of the individual documenting.