STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675536	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hill Country Heights	810 Industrial Ave 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation. 1.The facility failed to ensure sanitation practices (ensuring trash receptacles were securely covered, ensuring kitchen floors were free from debris, ensuring kitchen utensils were free of dried debris, ensuring kitchen utility cart was debris free, and ensuring kitchen shelving was debris free)2.The facility failed to label and date all food items in the kitchen. These failures could place residents at risk of foodborne illness. During an observation on 5/19/26 at 6:13 am, of the facility's kitchen revealed: -Utility cart next to steam table had dried food debris and spilled dried liquids of red and brown color on all 3 levels of the utility cart.-microwave revealed the inside top of the microwave to have dried food debris on the ceiling of the microwave.-overhead shelf near cooktop revealed a container of [NAME] Krispie cereal labeled cereal and dated 2026 unsure of what the open date or discard date was. Further observation revealed a container labeled Cornflakes dated 10/11/21 unsure if this is the open date or discard date.-55- gallon trash can between refrigerator and chemical closet without lid and trash inside of can.-refrigerator #1 package of sliced ham in box opened and unsecured undated and unlabeled.-refrigerator # 1 a gallon storage bag with package of sliced cheese dated 5/12/26 no discard date present.-refrigerator #1 a gallon storage bag of provolone cheese block dated 4/23/26 with use by date of 2026.-refrigerator #1 a quart storage bag of block of butter undated and unlabeled.-refrigerator # 1 a 3 lb. container of ricotta cheese dated 5/20 no discard date present.-refrigerator # 1 a gallon storage bag with a container of potato salad dated 5/6 and a use by date of 5/11.-dry storage pot/pan shelving shelf liner with dried debris stuck to shelf liner.-dry storage package of opened penne pasta dated 5/1/26 unsure if this is open date or discard date.-dry storage package of opened ziti pasta dated 4/15/26 unsure if this is open date or discard date.-dry storage package of opened spaghetti paste dated opened 4/23/26 no discard date.-dry storage 9 packages of hamburger buns undated-dry storage 3 loaves of undated bread.-dry storage 4 packages of sub rolls undated.-dry storage opened package of potato chips undated.-dry storage a gallon storage bag of opened chocolate cake mix with an open date of 5/2/26 and a use by date of 2026.-dry storage a gallon storage bag of opened yellow cake mix with an open date of 5/14/26 and a use by date of 2026.-dry storage room floor with food debris and dirt on floor and accumulated along edge of wall and edge of shelves.-utensil storage drawer a black plastic serving spoon with dried food debris.-knife storage rack dirty with dried food debris.-refrigerator # 2 a gallon storage bag of chopped lettuce unlabeled and undated.-refrigerator # 2 a gallon storage bag of shredded carrots with an open date of 5/1 and a use by date of 5/10.-refrigerator # 3 a buffet pan of pudding with a preparation date of 5/14/26 and a use by date of 5/17/26. During an interview on 5/21/26 at 11:36 am with DM she stated it was her expectation that all food items were labeled and dated correctly. DM stated if food items were removed from their original container that everything needed to be dated with the receipt date, open/preparation date, and discard date. DM stated items are kept for 3 days once prepared before being discarded. DM stated if an item is a canned or prepackaged product then those items can be kept for 7 days once opened before being discarded. DM (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the open date or the preparation date count as day 1 in the timeframe.DM stated it is ultimately her responsibility to ensure all food items are labeled and dated correctly but that it is a group effort by entire kitchen staff to label and date food items. DM stated the kitchen staff all have their food handlers license and have received training consisting of in-services, computer based training modules, and on the job training. DM stated it was her expectation that if a mess is made then it is cleaned up by whoever made ethe mess. DM stated kitchen sanitation and cleanliness were a team effort by the staff. DM there are currently no cleaning lists that the staff follow, everyone is just expected to keep the kitchen clean and orderly. DM stated it could potentially negatively impact a resident if food items are not labeled and dated because it could make residents sick because of food borne illness. DM stated it could potentially negatively impact a resident if kitchen sanitation and cleanliness are not maintained because of foodborne illness potential with compromised immune systems. During an interview 5/21/26 at 11:48 am with DON she stated she was unsure what her expectation regarding food labeling and dating would be. DON referred to the DM or Admin regarding all questions relating to the kitchen and food items. DON stated she was unsure of any regulations or requirements regarding the kitchen or food items. During an interview on 5/21/26 at 11:54 am with Admin he stated it was his expectation that no food items are expired and that all food items are labeled and dated. Admin said it is the responsibility of the cook to label and date all food items and the responsibility of the DM to supervise daily to ensure this occurs. Admin stated all items are dated upon receipt, again upon preparation or opening with the open/preparation date and the discard date. Admin stated all the kitchen staff are trained to have their food handlers and receive in-services performed by the corporate office. Admin stated it is his expectation that the kitchen is maintained in a clean manner. Admin stated all dietary staff are responsible for keeping the kitchen clean and this is supervised by the DM. Admin stated he was unsure if there are currently cleaning logs being utilized in the kitchen. Admin stated he expected trash receptacles to always be covered. Admin stated it could potentially negatively impact a resident if food items are not labeled and dated because of potentially consuming spoiled food. Admin stated it could potentially impact a resident if the kitchen sanitation and cleanliness were not maintained because of the risk of spreading food borne illness. During an interview on 5/21/26 at 1:07 pm with DA she stated it is mandatory to label and date all food items, so the staff know what the item is and when it was prepared. DA stated the rule is fresh items can be kept 3 days once prepared and canned or prepackaged items can be kept 7 days once they are opened. DA stated it is the responsibility of the CK and DA to label and date the food items. DA stated she was unsure of the policy/procedure regarding food labeling and dating. DA stated she received hands on training from the morning DA, and the previous DM. DA stated it was the responsibility of the DAs and CK to keep the kitchen clean and maintain sanitation practices. DA stated it could negatively impact a resident if food items are not labeled and dated and the kitchen is not clean because it could make a resident sick if the food is old and because of bacteria. During an interview on 5/21/26 at 1:15 pm with CK she stated that the expectation regarding food labeling and dating was that it was completed every day correctly and that it was the responsibility of the CK and DA. CK stated prepared items can be kept for 3 days and pre-packaged items can be kept for 7 days. CK stated the expectation for kitchen cleanliness and sanitation is that the staff are expected to keep up with cleaning tasks daily, weekly, and monthly. CK stated cleaning schedules are followed. CK stated it is the responsibility of CK and DA to maintain kitchen sanitation and cleanliness. CK stated all trash receptacles are to be covered. CK stated it can negatively impact a resident if food items are not labeled and dated and the kitchen sanitation is not maintained because of bacteria growth making residents sick. Record review of Food Preparation and Handling policy dated 10/1/2018 and revised on 6/1/2019 reflected under heading policy:To ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes and HACCP guidelines.Under heading procedure:General GuidelinesUse clean, sanitized surfaces, equipment and utensils. Wash hands properly before beginning food preparation.Prepare (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food with the least manual contact possible. Do not allow bare hands to touch raw food directly. Do not let surfaces, equipment or utensils that have been in contact with raw meat to come into contact with other food unless the items have been cleaned and sanitized first. Do not bring soiled food carts, food equipment or garbage containers through the food preparation area. Record review of Food Storage policy undated reflected under heading policy:To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. Under heading procedure:Dry storage rooms- To ensure freshness, store open and bulk items in tightly covered containers. All containers must be labeled and dated.Where possible, leave items in the original cartons placed with the date visible. Use the first-in, first-out (FIFO) rotation method. Date packages and place new items behind existing supplies, so that the older items are used first. Refrigerators- Date, label and tightly seal all refrigerated foods using clean, non-absorbent, covered containers that are approved for food storage.Use all leftovers within 72 hours. Discard items that are over 72 hours old.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 1 resident (Resident #20) of 6 residents reviewed for care plans. The facility failed to ensure Resident #20 received her divided plate and small 4 oz. cups with a straw at mealtimes and was included in her care plan. These failures could affect residents and put them at risk of not receiving care and services to meet their needs.Record review of Resident #20's face sheet dated 05/20/2026, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: Cerebral palsy (a condition caused from damage or abnormal development to a part of the brain which is responsible for muscle movement and leads to movement disorders and may result in developmental delays and sensory impairments), unspecified severe protein-calorie malnutrition (condition where the body is not getting enough protein and calories leading to weight loss, weakness, and poor overall health), and paranoid Schizoaffective disorder (a chronic mental illness that combines symptoms of both schizophrenia and a mood disorder, such as depression or mania). An observation of Resident #20's lunch on 5/20.2026 at 12:52 PM revealed a standard dinner plate with no divisions and cups with no straw. Observation of meal card for Resident #20 stated under adaptive equipment: Divided plate, lid for hot beverage, straw.Record review of Resident #20's MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Resident #20 required Partial/Moderate assistance for eating.Record review of Resident # 20's doctor order dated 04/14/2026 and revised 05/18/2026 stated divided plate and small 4 oz. cups with straw.Record review of Resident #20's OT clarification dated 04/17/2026 stated Recommend divided plate for all meals to promote loading utensils, and use of small cups with straws for cold liquids to promote ease of accessing liquids in order to promote independence with self- feeding tasks.Record review of Resident #20's comprehensive care plan dated 05/20/26, revealed it did not address the resident requiring a divided plate or small 4 oz. cups with a straw at mealtime.During an interview on 05/21/2026 at 8:10 AM with the Occupational Therapist, he stated Resident #20 uses a divided plate to make it easier for resident to self-feed and to scoop the food onto her spoon. He said the small cups make it easier for her to hold and drink from independently. He said without the divided plates or small cups it makes it more difficult for the resident to be independent with self-feeding tasks.During an interview on 05/21/2026 at 9:15 AM the Dietary manager said when she receives a written doctor order from the DON and puts it into Point Click Care as a standing order that way it is printed on the meal ticket. She said staff read the meal ticket to know what adaptive equipment a resident needs.During an interview on 05/21/2026 at 9:45 AM, the MDS nurse stated the divided plate did not need to be on the care plan because it is on the Residents Meal Card. MDS nurse said all the adaptive equipment needs are put on the meal card.During an interview on 05/21/2026 at 10:00 AM, the DON said when there is an order from the doctor for a divided plate it should be added to the care plan. She said the information in the care plan helps staff to know how to care for the residents.During an interview on 05/21/2026, at 10:15 AM, the Administrator said during morning meetings new orders are discussed and that is how the staff becomes aware. The Administrator said if there is a doctor's order and an OT clarification order for adaptive equipment, that should be added to the care plan. Record review of the facility's policy Care Plan Development, Review, and Update Policy dated 02/2017 and revised 02/2026 reveal: To ensure that each resident receives an individualized, person-centered care plan that reflects their assessed needs, goals, preferences, risks, and strengths, and that the care plan is developed, implemented and updated in accordance with federal regulations and RAI Manual guidance.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents goals and preferences for 1 of 1 resident (Resident #7) reviewed for tracheostomy care. The facility failed to ensure ADNS LVN used aseptic technique (a procedure that healthcare providers use to prevent the spread of germs that cause infection) during tracheostomy care and tracheostomy suctioning for Resident #7 by not performing hand hygiene, placing barriers, performing proper suction depth procedures or using sterile equipment during care on 05/20/2026. This failure could place residents at risk for respiratory infections and respiratory distress.Findings included: Review of Resident #7's face sheet dated 05/21/2026 reflected a [AGE] year old female admitted to the facility on [DATE] with the following diagnoses: cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain. It is caused by disrupted blood supply (ischemia) and restricted oxygen supply (hypoxia).), diabetes mellitus (A condition results from insufficient production of insulin, causing high blood sugar.), tracheostomy status (hole that surgeons make through the front of the neck and into the windpipe (trachea)), and cardiac arrest (stopping of the heart muscle). Review of Resident #7's quarterly MDS dated [DATE] reflected she was assessed to not have a BIMS conducted indicating she had severe cognitive impairment. Resident #7 was assessed to be on oxygen and to have a tracheostomy with tracheostomy care and suctioning performed to resident daily. Review of Resident #7's comprehensive care plan reflected a focus area dated 05/18/2026 I am at risk for experiencing shortness of breath. History of respiratory failure with hypoxia requiring trach placement. Interventions included Administer my respiratory treatments / nebulizers as ordered by my doctor; Alert my nurse for concentrator alarms and/or if my oxygen tank needs to be changed; Avoid lying flat. My position should facilitate adequate breathing; upright or slightly elevated HOB. Further review reflected a focus area dated 03/12/2026 reflected Tracheostomy related to Impaired breathing mechanics, Respiratory Failure. Interventions included .Provide trach care as ordered / indicated; Provide treatments and suctioning as ordered/recommended by my physician. Review of Resident #7's physician orders reflected orders dated 03/16/2026 to change Resident #7's disposable inner cannula twice daily; suction trach every shift and tracheostomy care with tracheostomy care kit daily and as needed. Observation on 05/20/2206 at 2:35 PM ADNS LVN and RN A had on PPE when surveyor entered the room. Without hand hygiene being conducted, the ADNS LVN was observed to touch the over bed table and nightstand and multiple other surfaces in the room to collect supplies. She then got the sterile suction kit, placed it on the overbed table that had a barrier of wax paper (not sterile); and without hand hygiene she donned the sterile gloves contaminating the gloves in the process by touching the sterile outside of the gloves with her contaminated hands. The ADNS LVN placed the sterile suction supplies on the non-sterile barrier (not using the sterile drape that comes in the trach suction kit). The ADNS LVN then grabbed the non-sterile suction tubing at the bedside with both hands and contaminated both hands (the dominant hand is to remain sterile to use the sterile suction catheter) performed suctioning by inserting the suction Cath into the trach. She did not insert the suction tubing past 1.5 to 2 cm (with the average trach length being 5 to 6 cm) the suctioning did not clear Resident #7's mucus after multiple attempts. The ADNS LVN contaminated the sterile tubing and sterile gloves multiple times during the procedure. In an interview on 05/20/2026 at 3:50 PM the ADNS LVN stated she had used hand sanitizer when she entered the room but did not perform hand hygiene prior to donning the sterile gloves. The ADNS LVN stated she placed the sterile supplies on the wax paper barrier and did not use the sterile drape. The ADNS LVN stated she did touch dirty surfaces in the room prior to donning the sterile gloves and did not perform hand hygiene and she should have. The ADNS LVN stated she grabbed the suction tubing with both hands, and she was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to keep one hand sterile. She further stated she did contaminate her gloves during the procedure. The ADNS LVN stated she felt like she went far enough in the trach while performing suctioning on Resident #7. In an interview on 05/21/2026 at 10:58 AM with DON stated she expected staff to maintain sterile field while preforming trach care and suctioning. She stated while suctioning, the staff should insert the suction tubing until they feel resistance then pull back and suction to ensure the airway is clear. The DON stated she would do more training for staff. Review of the facility provided policy Providing tracheostomy care Checklist (not dated) reflected Performed hand hygiene and ensured the patient's privacy. Connected the connecting tubing securely to the suction machine. Activated the suction device and adjusted the vacuum regulator to maintain a pressure setting below 150 mm Hg. Verified the suction apparatus by briefly blocking the end of the suction tubing before attaching it to the suction catheter. Prepared the single-use suction catheter:1. Using sterile technique, opened the sterile catheter package on a clean surface and utilized the inside of the wrapping as a sterile field. Opened the package partially to expose the connecting end and connected the catheter to the suction tubing.2. Placed the sterile drape on the bedside table, ensuring the suction catheter did not contact nonsterile surfaces.3. Unwrapped or opened the sterile basin on the bedside table, being careful to avoid touching the inside of the basin. Filled the basin with sterile 0.9% sodium chloride solution or sterile water. Connected the suction catheter to the connecting tubing: Carefully picked up the suction catheter with the dominant hand, ensuring no contact with nonsterile surfaces. Wrapped the suction catheter around the sterile dominant hand to prevent inadvertent contamination. With the nondominant hand, picked up the connecting tubing and connected it to the suction catheter.Ensured that the dominant hand remained sterile and did not touch the connecting tubing. With the dominant hand, gently and swiftly inserted the catheter into the tracheostomy tube while keeping the control vent of the suctioncatheter open. 1. For patients at high risk of suction-related complications, advanced the catheter into the tracheostomy tube until it emerged from the end of the airway.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to provide special eating equipment and cups with straws for resident who need them for 1 of 6 (Residents #20) residents reviewed for special eating equipment. The facility failed to provide Resident #20's physician ordered divided plate and 4 oz cup with straw with lid for drinking on 05/20/2026. This failure could place residents at risk for harm by weight loss, diminished independence, and self-esteem.Record review of Resident #20's face sheet dated 05/20/2026, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: Cerebral palsy (a condition caused from damage or abnormal development to a part of the brain which is responsible for muscle movement and leads to movement disorders and may result in developmental delays and sensory impairments), unspecified severe protein-calorie malnutrition (condition where the body is not getting enough protein and calories leading to weight loss, weakness, and poor overall health), and paranoid Schizoaffective disorder (a chronic mental illness that combines symptoms of both schizophrenia and a mood disorder, such as depression or mania).An observation of Resident #20's lunch on 5/20.2026 at 12:52 PM revealed a standard dinner plate with no divisions and cups with no straw. Observation of meal card for Resident #20 stated under adaptive equipment: Divided plate, lid for hot beverage, straw.Record review of Resident #20's MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Resident #20 required Partial/Moderate assistance for eating.Record review of Resident # 20's doctor order dated 04/14/2026 and revised 05/18/2026 stated divided plate and small 4 oz. cups with straw.Record review of Resident #20's OT clarification dated 04/17/2026 stated Recommend divided plate for all meals to promote loading utensils, and use of small cups with straws for cold liquids to promote ease of accessing liquids in order to promote independence with self- feeding tasks.Record review of Resident #20's comprehensive care plan dated 05/20/26, revealed it did not address the resident requiring a divided plate or small 4 oz. cups with a straw at mealtime.During an interview on 05/21/2026 at 8:10 AM with the Occupational Therapist, he stated Resident #20 uses a divided plate to make it easier for resident to self-feed and to scoop the food onto her spoon. He said the small cups make it easier for her to hold and drink from independently. He said without the divided plates or small cups it makes it more difficult for the resident to be independent with self-feeding tasks.During an interview on 05/21/2026 at 9:15 AM the Dietary manager said when she receives a written doctor order from the DON and puts it into Point Click Care as a standing order that way it is printed on the meal ticket. She said staff read the meal ticket to know what adaptive equipment a resident needs.During an interview on 05/21/2026 at 10:00 AM, the DON said when there is an order from the doctor for a divided plate it should be added to the care plan and followed. She said the information in the care plan helps staff to know how to care for the residents.