STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676227	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Hollow Nursing & Rehabilitation Center	345 Country Club Dr Caldwell, TX 77836

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure that residents are free of any significant medication errors for 1 (Resident #1) of 6 residents reviewed for pharmacy services. The facility failed to ensure staff ordered and administered Resident #1's antibiotic medication when he returned from the hospital on [DATE] after being diagnosed with sepsis (a life-threatening condition that occurs when the body's response to an infection damages its own tissues and organs) from a prostate infection. Resident #1 was sent back to the hospital by EMS on 03/22/25 due to no improvement in his condition. Resident #1 was readmitted to the hospital and diagnosed with Severe Sepsis. An IJ was identified on 05/02/25. The IJ template was provided to the facility on [DATE] at 6:15 p.m. While the IJ was removed on 05/03/25, the facility remained out of compliance at a scope of pattern and a severity of potential for more than minimal harm because of the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of further decline, infection, dehydration, and hospitalization. Findings include: Review of Resident #1's admission Record, dated 05/02/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. Resident #1 had diagnoses including mild cognitive impairment, generalized muscle weakness, hemorrhage (loss of blood from blood vessels) of anus and rectum, type 2 diabetes mellitus without complications, and acute respiratory failure with hypoxia (a serious condition where the lungs are unable to deliver enough oxygen to the blood). Review of Resident #1's admission and Modified MDS, dated [DATE], reflected he had a BIMS score of 10, which indicated he had moderate cognitive impairment. Resident #1's MDS assessments did not indicate that he had any infections and taking any high risk antibiotics during the last seven days or since admission/entry. Resident #1 required partial/moderate assistance with toileting. Resident #1 was always incontinent with urinary and bowel movements. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Care Plan, initiated 01/22/25, reflected he required 2-person assistance with all care and ADLs. Resident #1 had an ADL self-care performance deficit and required CNAs to assist him with using the toilet. Resident #1 also had bladder incontinence and required CNAs to provide incontinent care at least every two hours and report to the charge nurse any foul smelling urine or if the urine was any color other than yellow. Review of Resident #1's Progress Notes reflected: -A transfer notification note by LVN A on 03/17/25 at 9:41 a.m., [Resident #1] was transferred to the hospital on [DATE] 9:41 a.m. related to AMS. -A nursing progress note by LVN A on 03/18/25 at 10:33 a.m., Spoke with [Nurse] at hospital and the admitting dx is AMS for resident. Review of the facility's copy of Resident #1's Hospital Visit and Discharge Summary and Orders, printed on 03/18/25 at 12:39 p.m., reflected he was admitted to the hospital on [DATE] at 11:04 a.m. with a primary diagnosis and chief complaint of altered mental status. Resident #1 also had diagnoses including chronic prostate cancer (a type of cancer that develops in the prostate gland, a walnut-sized organ in the male reproductive system located below the bladder, which can persist and affect a person's health for many years) and chronic prostatitis (a long-lasting inflammation of the prostate gland, typically lasting three months or more). Resident #1's hospital evaluation reflected he met the systemic inflammatory response syndrome criteria (a set of objective findings that indicate a systemic inflammatory response to an insult, whether it's an infection or a non-infectious event) with intermittent tachycardia (a heart rate that is faster than normal) and tachypnea (a rapid shallow breathing in which the respiratory rate exceeds the normal range for a person's age) with a mildly elevated white blood cell count at 11.8 during his labs on 03/17/25 at 11:26 a.m. Resident #1's Assessment and Plan reflected he had a differential diagnosis of urosepsis (when a urinary tract infection leads to sepsis) during his AMS assessment, sepsis of chronic prostatitis (inflammation or infection in the prostate) in which his prostate was markedly enlarged and tender on examination and was required to take Ciprofloxacin IV twice a day for four weeks through 04/18/25 that was converting to by mouth on hospital discharge. Resident #1's medications changed and he was required to start taking one 500 MG tablet of Ciprofloxacin HCl by mouth two times daily (one tablet in the morning and one tablet at bedtime) for the inflammation of his prostate gland. Resident #1 was required to take antibiotics exactly as prescribed, not to skip doses and not stop taking antibiotics even if he felt better. Resident #1's vitals were stabilized, he was awake, alert and oriented, his next dose of one 500 MG tablet of Ciprofloxacin HCl by mouth two times daily was due on 03/18/25, and he was discharged back to the facility on [DATE]. Review of Resident #1's readmission Nurse's Note, effective 03/18/25 at 6:04 p.m. and signed by RN B on 03/18/25, reflected: readmitted from the hospital or ER visit: Yes. Arrived by: EMS. Does the resident have IV access: No. Bowel Control: Incontinent. Date of last BM: 03/18/25. Urine Control: Incontinent. Additional Information: Incontinent=Briefs. Toileting: 1-person assistance. Review of Resident #1's continued Progress Notes reflected: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-A nursing note by RN B on 03/18/25 at 6:04 p.m., readmission Note: readmitted /returned from the hospital . Arrived by: EMS .Accompanied by FAM .Incontinent. Date of last BM: 03/18/25. Urine Control: Incontinent. Urinary observations: No negative findings. Additional Urinary information: incontinent=briefs .ADL Assistance needed: .Toileting - 1 person assist .Behaviors: No known behaviors. -A nursing note by RN B on 03/18/25 at 6:14 p.m., RN C on 03/19/25 at 1:06 a.m., RN B on 03/19/25 at 6:33 p.m., RN C on 03/20/25 at 12:20 a.m., RN B on 03/20/25 at 4:21 p.m., LVN D on 03/21/25 at 1:49 a.m., LVN E on 03/21/25 at 3:22 p.m., LVN D on 03/22/25 at 1:30 a.m., LVN A on 03/22/25 at 11:22 a.m., and LVN F on 03/22/25 at 3:03 p.m., reflected, Skilled Nurse Note: Interventions/Treatments Received Post admission -. Staff did not document any interventions/treatments that Resident #1 was to receive on readmission. Review of Resident #1's Order Summary Report, January - May 2025, reflected there were no orders listed regarding his one 500 MG tablet of Ciprofloxacin HCl by mouth two times daily (one tablet in the morning and one tablet at bedtime) for the inflammation of his prostate gland. Review of Resident #1's Medication Administration Record for March 2025 reflected there were no administrations listed regarding his one 500 MG tablet of Ciprofloxacin HCl by mouth two times daily (one tablet in the morning and one tablet at bedtime) for the inflammation of his prostate gland. Review of Resident #1's Discharge MDS, dated [DATE], reflected there was no BIMS score indicated. Resident #1 was not triggered for any infections and taking any high risk antibiotics during the last seven days or since admission/entry. Resident #1 required partial/moderate assistance with toileting. Resident #1 was always incontinent with urinary and bowel movements. Resident #1 had an unplanned discharge to a short-term hospital. Review of Resident #1's e-Transfer form, effective on 03/22/25 at 8:29 p.m. and signed by LVN F on 03/22/25, reflected, [Resident #1] was hospitalized earlier in the week for sepsis. FAM felt he was not improving and needed fluids and requested that he be sent out by EMS. Date and Time of Transfer: 03/22/25 at 4:40 p.m. Incontinence: .Date of last BM: 03/22/25. Review of Resident #1's continued Progress Notes reflected: -A transfer notification note by LVN F on 03/22/25 at 8:29 p.m., [Resident #1] was transferred to a hospital on [DATE] at 4:40 p.m. related to resident was hospitalized earlier in the week for sepsis. [Resident #1's] FAM felt he was not improving and needed fluids and requested that he be sent out by EMS Review of the facility's admission and Discharge Report, from 03/01/25 through 05/02/25, reflected Resident #1 was transferred to an acute care hospital on [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Hospital Records, printed on 05/05/25 at 4:34 p.m., reflected he was admitted to the hospital from [DATE] through 03/25/25. Resident #1's medication list prior to admission, reviewed by a hospital MD on 03/22/25 at 9:55 p.m., reflected his Ciprofloxacin HCl 500 MG tablet order was authorized, ordered and started on 03/18/25 and was discontinued on 03/25/25. Emergency department provider notes, dated 03/22/25 at 5:58 p.m., reflected Resident #1 presented with a chief complaint of weakness and an evaluation of sepsis with an onset on 03/17/25 and EMS reported he was recently discharged on 03/17/25, hospitalized due to sepsis and prostate infection, and the facility was supposed to give and did not give his one 500 MG tablet of Ciprofloxacin HCl by mouth two times daily (one tablet in the morning and one tablet at bedtime) for the inflammation of his prostate gland. Review of Resident #1's systems reflected his genitourinary (the organs involved in both reproduction and urination) was positive for hesitancy (delay in initiating urination). Sepsis Care Summary reflected severe sepsis was identified and present on 03/22/25 at 7:00 p.m. on the day of Resident #1's hospital evaluation. Emergency Department Course reflected on 03/22/25 at 7:31 p.m., C-reactive protein (protein produced by the liver in response to inflammation) is very high at 317.1, lactic acid is elevated at 2.5 .complete blood cell count is elevated, white blood cell count 12.3 not unexpected given that [Resident #1] had not been receiving his antibiotics for his prostatitis .admission IV antibiotics ordered. Resident #1's labs reflected his white blood cell count was 11.8 on 03/17/25 at 11:26 a.m. , 9.4 on 03/18/25 at 5:38 a.m., and 12.3 on 03/22/25 at 6:18 p.m. Resident #1 stayed at the hospital for two days based on medical necessity for sepsis and discharged on 03/25/25. Emergency Department note, dated 03/22/25 at 5:16 p.m., reflected, [Resident #1] was discharged from [hospital] on Monday (03/17/25) after being diagnosed with sepsis from a prostate infection. [Resident #1] was supposed to be on antibiotics, but [facility] did not order them. 20G IV left forearm with normal saline bolus. FAM stated [Resident #1] had declined since being discharged back to [facility]. Another Emergency Department note, dated 03/22/25 at 7:55 p.m., reflected, discharged from [hospital] last Monday (03/17/25), sent to [facility]. Per emergency medical services, [Resident #1] has not received prescribed antibiotic since discharge .[Resident #1] reports lethargy (a state of abnormal drowsiness or lack of mental alertness and energy) and feeling weak. 20g to left forearm, received 800 mL normal saline en route. Resident #1's Medical History and Physical reflected he was admitted to the hospital for systemic inflammatory response syndrome/sepsis. Resident #1's History of Present Illness reflected, [Resident #1] had a past medical history significant for metastatic prostate cancer to bone .presents with worsening mental status, lethargy, fatigue, confusion .was recently discharged here 03/18/25 after a similar presentation with what felt to be a component of chronic prostatitis, poly pharmacy (the regular use of 5 or more medications at the same time). Unfortunately, he has not received any antibiotic. Resident #1's Hospital Course reflected, [Resident #1] presented from facility for worsening mental status, lethargy, fatigue, confusion .He was admitted for Sepsis and Metabolic Encephalopathy (a change in how the brain works due to an underlying condition) due to Chronic Prostatitis in the setting of suspected medication noncompliance and progression of his metastatic prostate cancer. Unfortunately, FAM stated he had not received any of his prescribed antibiotics at facility. Per previous documentation, [Resident #1] was correctly prescribed his Ciprofloxacin regimen x 6 weeks and sent to the proper facility pharmacy. Receipt was confirmed by pharmacy on this hospitalization. Facility was contacted and stated the had the proper documentation and admitted to providing the correct antibiotic regimen. On admission, he was found to be septic. Urinalysis indicated of infection. He was started on empiric antibiotics (the use of antibiotics before the specific bacteria causing an infection is identified and its susceptibility to different antibiotics is known) and IVF . He had some improvement in his mental status and lab work. Family ultimately wanted to honor [Resident #1's] wishes and decided to pursue a comfort pathway due to his progressive metastatic prostate cancer. [Resident #1] remained medically stable and discharged on home hospice. Disposition reflected Resident #1 went home with hospice. (continued on next page)

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	676227	A. Building B. Wing	05/07/2025

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/02/25 at 12:43 p.m., MA G stated MAs and nurses were responsible for administering medications to residents. MA G stated charge nurses were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' orders when residents readmit to the facility. MA G stated she knew the importance of reviewing residents' hospital discharge orders, updating readmitted residents' orders and said, It is very important to put the orders in the MAR because the medications were ordered from the hospital. The orders were to treat the resident for a reason. To untreat could worsen their conditions. MA G stated she knew the importance of residents receiving their antibiotics and said, Residents could have worsening infections if they did not receive their antibiotics. MA G stated she could not recall if Resident #1 was given antibiotics for infections during his readmission to the facility . During an interview on 05/02/25 at 1:11 p.m., CNA H stated MAs and nurses were responsible for administering medications to residents. CNA H stated the charge nurses or DON were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' orders when residents readmit to the facility. CNA H stated there were no residents who reported they did not receive their medications. During an interview on 05/02/25 at 1:22 p.m., CN stated charge nurses were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' orders when residents readmit to the facility. CN said, Usually, the nurses would obtain the hospital discharge orders the same day the resident returned from the hospital or in the following 24 hours. CN stated she did not know what happened with Resident #1's hospital discharge orders on 03/18/25, who reviewed and was supposed to order Resident #1's hospital discharge medication orders during his readmission on [DATE], and where the breakdowns were that resulted in him not getting the medication from 03/18/25 through 03/22/25. During an interview on 05/02/25 at 1:27 p.m., CNA I stated MAs and nurses were responsible for administering medications to residents. CNA I stated the charge nurses or DON were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' orders when residents readmit to the facility. CNA I stated there were no residents who reported they did not receive their medications. During an interview on 05/02/25 at 1:38 p.m., FAM stated Resident #1 had an inactive prostate cancer before his admission to the facility. FAM stated Resident #1 resided at the facility for two and a half months. FAM stated Resident #1 went to the hospital on [DATE] for AMS. FAM stated Resident #1 was diagnosed with sepsis and a prostate infection. FAM stated the hospital staff wanted Resident #1 to take Ciprofloxacin for his prostate infection. FAM stated Resident #1 returned to the facility from the hospital on [DATE]. FAM stated EMS provided the facility staff with the hospital discharge orders on 03/18/25. FAM stated Resident #1 did not notify her that he did not receive his Ciprofloxacin order during his readmission to the facility. FAM stated she believed Resident #1's Ciprofloxacin order for his prostate infection should have been started and administered to him from 03/18/25 through 03/22/25. FAM stated Resident #1 not receiving his Ciprofloxacin order for his prostate infection was negligent. FAM stated the facility staff did not notify her that Resident #1 was not receiving his Ciprofloxacin order from 03/18/25 through 03/22/25. FAM stated she requested the facility staff to send Resident #1 to the hospital on [DATE]. FAM stated she believed she should not have had to send Resident #1 to the hospital on [DATE]. FAM stated she believed Resident #1's lack of antibiotics could have pushed him closer towards his death because he was already declining. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/02/25 at 2:24 p.m., RN B stated charge nurses were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' orders when residents readmit to the facility. RN B stated she knew the importance of reviewing residents' hospital discharge orders, updating readmitted residents' orders, and said, You got to see the changes in residents' orders. What was changed, ordered, discontinued, appointments, and numerous other things. RN B stated she knew the importance of residents receiving their antibiotics and said, So whatever infection residents have could be cured. RN B stated she knew the importance of reviewing residents' hospital discharge orders, updating their orders, antibiotics orders, and said, Residents could face a delay of antibiotics if they did not receive their antibiotics orders. RN B stated she could not recall if she reviewed Resident #1's hospital discharge orders during his readmission to the facility on [DATE] and she would have to see his hospital discharge paperwork to remember. RN B stated she knew Resident #1's discharge orders should have been updated before he came back to the facility from the hospital on [DATE]. RN B stated the ADON or DON oversaw to ensure charge nurses reviewed residents' hospital discharge orders and updated residents' orders in their EHR upon residents' readmission to the facility. RN B stated charge nurses were also responsible for notifying the physician of any medication changes. RN B stated she could not recall if she notified the physician about Resident #1's hospital discharge orders if she did review his discharge orders. During an interview on 05/02/25 at 2:58 p.m., LVN F stated charge nurses were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' orders when residents readmit to the facility. LVN F stated charge nurses were also required to notify the physician and discuss with the ADON and/or DON whenever there were new medications to be started on the hospital discharge orders. LVN F stated she knew the importance of reviewing residents' hospital discharge orders, updating readmitted residents' orders, and said, First and foremost, the medication changes. If something needs to be started, it needs to be ordered to get it started. Resident could decline very fast, especially when they have sepsis. LVN F stated she did not readmit Resident #1 to the facility on [DATE]. LVN F stated she caught that Resident #1's antibiotic discharge order from the hospital was not ordered. LVN F stated she could not recall when she observed Resident #1's antibiotic discharge order was not ordered. LVN F stated she notified the former DON and current MD on an unknown date about Resident #1's antibiotic discharge order from the hospital not being ordered. LVN F stated she discussed with FAM about her not administering any antibiotics to Resident #1 that were prescribed from the hospital on an unknown date. LVN F stated FAM wanted to send Resident #1 to the hospital ER on [DATE] due to him missing several days of antibiotics and he still had sepsis. LVN F stated she agreed with FAM and sent Resident #1 to the hospital on [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/02/25 at 3:07 p.m., the DON stated charge nurses were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' new orders as soon as residents readmit to the facility. The DON stated there was no ADON. The DON stated she was responsible for overseeing and reviewing residents' discharge orders to ensure residents' orders were entered in their EHR within 48 hours of readmission. The DON stated she began her employment with the facility on 03/17/25 and did not have access to residents' EHR until the end of March 2025. The DON stated she did not believe there was an interim staff member who was overseeing residents' admission/readmission process during the time she did not have EHR access. The DON stated she was unsure if she went back and reviewed residents who were admitted /readmitted to the facility from 03/17/25 through 03/31/25 after obtaining EHR access. The DON stated she did not in-service staff on the admission/readmission process and medication order process from 03/17/25 through 05/02/25. The DON stated she knew the importance of reviewing residents' hospital discharge orders, updating readmitted residents' orders, and said, So residents get medications that were prescribed to them. The DON stated charge nurses were also responsible for notifying the MD whenever residents had new medication orders from the hospital. The DON stated she knew the importance of antibiotics and said, Antibiotics were to get rid of infections. The DON stated she knew the importance of residents receiving their antibiotic medication and said, Residents could get sicker, end up in the hospital and get sepsis. The DON stated she was not notified about Resident #1's medication changes when he returned from the hospital on [DATE]. The DON stated she did not know why Resident #1 went back to the hospital on [DATE]. During an interview on 05/02/25 at 3:30 p.m., the MD stated nurses were responsible for obtaining and reviewing residents' hospital discharge orders and notifying her whenever there were changes in residents' medications upon their readmission to the facility from the hospital. The MD stated she knew the importance of antibiotics and said, Antibiotics were used to mainly treat and prevent infections. The MD stated she knew the importance of residents receiving their antibiotics and said, They could have burning urination, urgency, and it could exacerbate infection if they did not receive their antibiotics. The MD stated Resident #1 had an inactive prostate cancer when he was admitted to the facility. The MD said, [Resident #1] went from being alright to not doing well at the facility. The MD stated unknown facility staff notified her on unknown date that there was a mix-up with some of Resident #1's medications that did not get ordered after his readmission to the facility on [DATE]. The MD stated she believed the unknown facility staff told her that one of the pages to Resident #1's hospital discharge orders, which illustrated his medication changes, was missing. The surveyor showed to the MD Resident #1's hospital discharge orders provided to the facility from EMS on 03/18/25. The MD stated the unknown facility staff notified her on 03/22/25 that they found the missing page and that Resident #1 was supposed to be started on a few medications when he returned from the hospital. The MD stated she believed one of Resident #1's medications that was supposed to be started on 03/18/25 was an antibiotic. The MD stated the unknown facility staff notified her on an unknown date that Resident #1's Ciprofloxacin medication was not started on 03/18/25 and could not recall the reason she was provided as to why the medication was not started. The MD stated FAM could not decide what treatment she wanted Resident #1 to have and decided to send him to the hospital on [DATE]. The MD stated the unknown facility staff notified her on an unknown date that that Resident #1 was placed on hospice services and sent home from the hospital on an unknown date. During an interview on 05/05/25 at 10:02 a.m., FAM stated a Hospitalist called the unknown facility staff on an unknown date and was told by the facility staff that Resident #1 received his antibiotic medication. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/06/25 at 11:33 a.m., LVN E stated charge nurses were responsible for obtaining and reviewing residents' hospital discharge orders and updating residents' orders when residents readmit to the facility. LVN E stated she would review the residents' hospital discharge orders, put in the orders into the residents' order summary report, which would directly go to the facility's pharmacy, and notify the MD within 24 hours of any medication changes. LVN E stated the DON oversaw to ensure charge nurses reviewed residents' hospital discharge orders and updated residents' orders in their EHR upon residents' readmission to the facility daily. LVN E stated she knew the importance of reviewing residents' hospital discharge orders, updating readmitted residents' orders, and said, We have to maintain resident's continuation of care from the hospital. Very important. LVN E stated she was in-serviced on admission/readmission process a few months ago by the former DON. LVN E stated she learned the hospital orders must be reviewed, updated in residents' EHR, and completed upon residents' readmission to the facility from the hospital. LVN E stated she did not readmit Resident #1 to the facility on [DATE]. LVN E stated she knew the importance of antibiotic medication, residents receiving their antibiotic medication, and said, To get rid of infection. Residents could get worse if they did not receive their antibiotic medication. LVN E stated she could not recall administering Resident #1's Ciprofloxacin medication to his because she did not believe she was assigned to his hallway. LVN E stated she was not notified that Resident #1 did not receive his Ciprofloxacin medication before the surveyor visited the facility on 05/02/25. Review of the facility's in-services, from 03/01/25 through 05/02/25 , reflected no in-services related to admission/readmission process and medication orders process. Review of the facility's Medication Orders policy, dated 2003, reflected, Procedure: 2. Documentation of the medication order A. Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the physician order sheet or the telephone order sheets (if it is a verbal order) and the Medication Administration Record (MAR). B. The following steps are initiated to complete documentation: -Clarify the order -Enter the orders on the medication order and receipt record -Call (or fax) the medication order to the provider pharmacy -Transcribe newly prescribed medications on the MAR or treatment record. When a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing A DISCONTINUED on the MAR. Enter the new order on the MAR as a separate entry with arrows drawn to the start date. 3. Specific Procedures for the four types of medication orders (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperas Hollow Nursing & Rehabilitation Center	345 Country Club Dr Caldwell, TX 77836

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A. NEW HANDWRITTEN ORDERS signed by the prescriber. The charge nurse on duty at the time the order is received, notes the order and enters it on the physician order sheet if not written there by the prescriber. If necessary, the order is clarified before the prescriber leaves the nursing station whenever possible. C. WRITTEN TRANSFER ORDERS (SENT WITH A RESIDENT BY A HOSPITAL OR OTHER HEALTH CARE FACILITY). Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete or the date signed is different from the date of admission. If the order is unsigned or signed by another prescriber or the date is other than the date of admission, the receiving nurse verifies the order with the current attending physician before medications are administered. The nurse documents verification on the admission order record by entering the time, date, and signature. Example: A Order verified by phone with Dr. [NAME]/M. [NAME], R.N. Review of the facility's Admission/readmission policy, dated 2003, reflected, readmission to a facility occurs after a hospitalization or therapeutic leave. readmission involves a review of the initial admission data with reinforcement where needed and an update of information regarding health status. Procedure: 2. Review the medical diagnoses and physician orders. admission orders should include as applicable: . orders for medications (prn orders will state specific use), orders for treatments, code status, and other orders as specified by the physician. 3. Inquire about any immediate needs and facilitate handling of those needs. This failure resulted in the identification of an IJ on 05/02/25. The ADM was notified and provided with the IJ template on 05/02/25 at 6:15 p.m. The following Plan of Removal was submitted by the facility and accepted on 05/03/25 at 12:52 p.m.: On 05/02/2025 an abbreviated survey was initiated at the facility. On 05/02/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to residents' health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure Resident #1 received his antibiotic medication from 03/18/25 through 03/22/25. Plan of Removal 1. Resident #1 no longer resides in the facility as of 5/2/25. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Action: A 100% audit of all orders from residents who were admitted or readmitted in the last 30 days was completed to ensure all orders including antibiotic orders were transcribed in PCC and started as ordered. All residents who were admitted and readmitted in the last 30 days were assessed for a change in condition. No additional findings were identified. Start Date: 05/02/2025 Completion Date: 05/02/2025 Responsible: This audit was completed by DON and Regional Compliance Nurse 3. Inservice Action (Leadership): The Administrator and DON were in-serviced 1:1 on following topics. o Abuse and Neglect: Failure to transcribe and administered an ordered medication including antibiotics could cause a change in condition and be considered neglect. o Medication Reconciliation Policy: transcribing orders for admission and readmissions o Following Physician Orders Policy o Notification of Change in Condition Policy Employee Retention Checks: Administrator and DON were provided with written in-service cheat sheets to place in name badge for quick reference, signature and verbal acknowledgements were obtained. Start Date: 05/02/2025 Completion Date: 05/02/2025 Responsible: This in-service was completed by Area Director of Operations and Regional Compliance Nurse 4. Inservice Action (All Direct Care Staff): All direct care staff (CNAs, Med Aides, Licensed Nurses) were in-serviced on the following topics. All staff who are not present for in-servicing will not be permitted to work their assignment until in-serviced. All new hires will be in-serviced during facility orientation. All agency staff will be in-serviced prior working their floor assignment. <BR

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record reviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible and systematically organized for one resident (Resident #3) of 5 residents reviewed for medical records. The facility failed to ensure LVN B documented administration of Atorvastatin Calcium (for cholesterol), Donepezil (for dementia), Apixaban (for pulmonary embolism), Carvedilol (for high blood pressure), Oxybutynin Chloride (for myopathy), Sacubitril-Valsartan (for congestive heart failure), and Mirtazapine (for depression) to Resident #3 on 05/20/25 during the evening medication schedule. This failure could place residents at risk of not receiving the intended benefits of the medications and supplements, worsening or exacerbation of chronic medical conditions, or hospitalization. Findings included: Review of Resident #3's undated face sheet revealed an admission date of 05/16/2025 with diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), essential hypertension (high blood pressure), and hyperlipidemia (abnormally high levels of fats in the blood). Review of Resident #3's Care Plan, initiated on 05/19/25, reflected Resident #3 had hypertension and required anti-hypertensive medication as ordered. Resident #3 also had a cognitive heart failure and required cardiac medication as ordered. Review of Resident #3's admission MDS assessment, dated 05/26/25, reflected a BIMS score of 99, which indicated resident was unable to complete the interview. Review of Resident #3's physician's orders dated 05/16/25 reflected the following medications: 1.Atorvastatin Calcium Oral Tablet 80 MG (Atorvastatin Calcium)-Give 1 tablet via PEG-Tube one time a day for cholesterol 2.Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride)-Give 1 tablet via PEG-Tube one time a day for Dementia 3.Apixaban Oral Tablet 5 MG (Apixaban)-Give 1 tablet via PEG-Tube two times a day for pulmonary embolism 4.Carvedilol Oral Tablet 3.125 MG (Carvedilol)-Give 1 tablet via PEG-Tube two times a day for HTN hold for systolic bp <100 or diastolic bp 5.Sacubitril-Valsartan Oral Tablet 49-51 MG (Sacubitril-Valsartan)-Give 1 tablet via PEG-Tube two times a day for CHF Hold for =systolic bp <100 or diastolic bp 6.Mirtazapine Tablet 15 MG Give 1 tablet via PEG-Tube one time a day for depression. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident#3's physician' orders dated 5/19/25 reflected, Oxybutynin Chloride Tablet 5 MG-Give 0.5 tablet via PEG-Tube two times a day for myopathy. Record review of the May 2025 MAR for Resident #3 reflected blanks (no documentation) on the following medications on 05/20/25 for the PM (evening) scheduled medications: 1.Atorvastatin Calcium Oral Tablet 80 MG (Atorvastatin Calcium)- Give 1 tablet via PEG-Tube one time a day for cholesterol 2.Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride) Give 1 tablet via PEG-Tube one time a day for Dementia 3.Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet via PEG-Tube two times a day for pulmonary embolism. 4.Carvedilol Oral Tablet 3.125 MG (Carvedilol) Give 1 tablet via PEG-Tube two times a day for HTN hold for systolic bp <100 or diastolic bp. 5.Oxybutynin Chloride Tablet 5 MG Give 0.5 tablet via PEG-Tube two times a day for myopathy 6.Sacubitril-Valsartan Oral Tablet 49-51 MG (Sacubitril-Valsartan) Give 1 tablet via PEG-Tube two times a day for CHF Hold for =systolic bp <100 or diastolic bp. 7.Mirtazapine Tablet 15 MG Give 1 tablet via PEG-Tube one time a day for depression. During an interview on 06/03/25 at 12:18 PM, the DON stated she spoke on the phone with the nurse responsible for providing the medication on 05/20/25. She stated LVN B told her she gave the medication to Resident #3, but she forgot to click off and record the administration in the system. The DON added that LVN B was on her way to the facility to receive an in-service regarding this issue. During an interview on 06/03/25 at 12:31 PM, the DON stated she spoke with LVN B again, she told her she remembered clicking off that she administered the medications in the system but did not remember why it was not recorded in the system. During an interview on 06/03/25 at 1:13 PM, LVN B stated she worked the 2:00PM to 10:00PM shift. She stated after administering medications, staff must document in PCC. She stated nurses document in the NMAR or TAR even if a resident refuses the medication. LVN B stated she administered and documented all the medications for Resident #3 on 05/20/25. She stated if a medication is missed, the system alerts staff by showing it in red. She stated she checked Resident #3's MAR and TAR before leaving and saw no red alerts. LVN B stated she attributed the missing documentation to a glitch in PCC. She stated that failure to document could lead to miscommunication, medication errors, overdose or even the loss of a life. During an interview on 06/03/25 at 3:35 PM, Resident #3 stated she did not remember whether she received her medication on 05/20/25, but she said she felt ok. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/03/25 at 4:46 PM, LVN K stated she worked the 2:00PM to 10:00PM shift and provided care to Resident #3. She stated she believed she worked with the resident on 05/21/25 and she did not notice any changes in condition. She stated the staff was required to document all medication administration or refusals in PPC and that leaving blanks could result in double dosing. During an interview on 06/03/25 at 5:07 PM, the DON stated the facility's expectation was for the staff to document all medication administration in the MAR or the TAR. If a resident refused, staff must select the appropriate documentation option in PCC. She stated there should not be blanks on the MAR. She stated the negative outcome could result in the resident not receiving medications. She stated she had not observed any change in condition in Resident #3 after 05/20/25. Review of the facility's Medication Administration and General Guidelines policy, dated 2005, reflected, Medication are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so The resident's MAR is initiated by the person administering a medication, in the space provided under the date line for that specific medication dose administration. Or if utilizing an Electronic Medical Record, the initials of the nurse are electronically stamped into the record. All licensed personnel/ nurses will be assigned a secure password which will not be shared or given out to other personnel.