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	11/19/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a signficant change in his or her treatment for one (Resident #1) of seven residents reviewed for resident rights. The facility failed to notify Resident #1's family of an IV fluid (solutions administered directly into a patient's vein to provide hydration, electrolytes, and nutrients.) order before attempting to start the IV fluid. This failure could place the residents, who received care at the facility, at risk of not being informed of their health status, in order to make informed decisions regarding their care. Findings included: Review of Resident #1's face sheet printed 10/20/2025 reflected an [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE] with the following dx. Alzheimer's Disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), Dementia in other diseases classified else (a general term for a group of conditions that cause a decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life.), Generalized Anxiety Disorder (a condition characterized by excessive or unrealistic anxiety about two or more aspect of life). Review of Resident#1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 99, indicating the resident was unable to complete the interview. It also reflected Resident #1 had both short-term and long-term memory problems. Review of Resident 1's care plan revised 04/21/2025 reflected Resident #1 had an ADL selfcare performance deficit r/t Dementia,Limited Mobility, Chronic/ Progressive decline in intellectual functioning characterized by; deficit in memory, judgment, decision making and thought process related to mental illness, long term memory loss. Care plan also reflected that Resident #1 had a signed and valid DNR. Do Not resuscitate should the resident stop breathing. Per legal guardian., per resident revised 04/21/2024. Care plan initiated 08/18/2025 reflected Resident #1 had a terminal prognosis and/or is receiving hospice services Hospice under [Hospice Physician], attending and medical director Primary dx Alzheimer's Disease call Hospice for any question, changes in condition or at time of death with interventions as followed: if receiving hospice services, work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. review resident's living will and ensure it is followed. Involve family in discussion, encourage support system of family and friends. Review of Resident #1's physician orders reflected an order dated 01/12/2022 which reflected: Admit to [XXX] Hospice under [Dr. XXX], attending and medical director Primary dx Alzheimer's Disease call [xxx] Hospice for any question, changes in condition or at time of death. Review of Resident #1's MAR for the month of September 2025 reflected: Fluid: NS Rate(ml/hr): 100 total amounts to be infused in ml: 1000 one time only for dehydration prevention for 7 Days, signed by ADON on 09/23/2025 at about 09:26 pm. Review of Resident #1's progress notes reflected no documentation of Resident #1's family and hospice being notified of order for IV fluids or attempts made to start IV fluids. There was no documentation regarding change of condition for Resident #1 from 09/23/2025 through 09/29/2025. Review of Resident #1's progress notes dated 09/29/2025 at 09:52 am written by the DON reflected: Late Entry: Residents [family] called to discuss concerns with IV. Educated family on new IV program, assured family member resident was not dehydrated, and was only triggering for possible dehydration d/t decreased oral intake. Family member appreciative of information, assured family that resident is happy and well taken care of here. During an interview on 10/20/2025 at 10:18 am, Resident #1's family stated she and hospice were not made aware of new order for IV fluids to be started on Resident #1. Resident #1's Family stated she found out about the IV fluid order when she went to visit Resident #1 and saw the bruise on her left arm. Resident #1's Family stated she called to find out and Hospice was not notified too. Resident #'s Family stated it was the DON that got the order for the IV fluids and the DON contacted her later after she raised concerns. Resident #1's Family stated IV fluid therapy was too severe for the facility not to contact the family or hospice before initiating the treatment. Resident #1's Family stated the facility was supposed to get permission from hospice for any medication changes, any type of change if Resident #1 was that ill before attempting the care. During an interview on 10/20/2025 at 1:14 pm, the ADON stated When a resident is on hospice, the hospice followed the Resident and the facility get orders from hospice, and the MD is notified to approve the order. The ADON stated the MD had recommended IV fluids for Resident #1 and she worked with Resident #1 on the day of the recommendation. The ADON stated the DON got the orders from the MD for Resident #1's IV fluids, and she [ADON] did not notify Resident #1's