STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676438	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Killeen Nursing & Rehabilitation	5000 Thayer Dr Killeen, TX 76549

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on observations, interviews and record reviews, the facility failed to ensure each resident had the right to be free from abuse for 1 (Resident #1) of 5 residents reviewed for abuse. The facility failed to ensure Resident #1 was safe from sexual abuse. On 02/27/24, Resident #1 alleged she was sexually assaulted, facility staff transferred her to the hospital, and hospital staff took a sexual assault exam. On 04/16/24, the sexual assault exam results showed a presence of semen in Resident #1's brief and on and in her vagina. An IJ was identified on 05/10/24. The IJ template was provided to the facility on [DATE] at 6:24 p.m. While the IJ was removed on 05/13/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because of the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for injury, harm, psychosocial harm, and a decreased quality of life. Findings included: Record review of Resident #1's face sheet, dated 04/18/24, revealed a 73-years old female who was admitted to the facility on [DATE], readmitted on [DATE], had an RP, and had diagnoses including unspecified dementia (A group of thinking and social symptoms that interferes with daily functioning) that was mild, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, unspecified sequelae of cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), generalized anxiety disorder, contracture (A permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of muscle unspecified lower leg, difficulty in walking, unspecified single episode unspecified major depressive disorder, other reduced mobility, right and left knee contracture, weakness, unspecified altered mental status, cognitive communication deficit, and generalized muscle weakness. Record review of Resident #1's quarterly MDS assessment, dated 04/08/24, revealed a BIMS score of 7, indicating she had severe cognitive impairment. (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: 676438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024
NAME OF PROVIDER OR SUPPLIER: Killeen Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 5000 Thayer Dr Killeen, TX 76549	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's comprehensive care plan, dated 04/16/24, revealed she was at risk for psychosocial deficits/PTSD related to trauma (sexual assault). Interventions included: female only to provide care, female staff to accompany if male nurse on shift, services from a Licensed Mental Health Provider as indicated, monitor for signs and symptoms of depression, anxiety, eating disorders, sleep disturbances, and substance abuse disorder, psych services visit routinely, staff assist with recovery and avoid traumatization by ensuring immediate safety and addressing physical injuries resulting from the assault, providing medical care, including forensic evidence collection, in a sensitive manner and prioritizing well-being and minimizing further harm, and creating a safe environment for disclosure. Record review of Resident #1's progress notes revealed a note by RN C on 02/27/24 at 8:51 p.m., Resident complained of vaginal pain. Assessed residents peri area. No skin tears, bleeding nor lacerations noted. Hyperpigmentation noted (baseline) with redness from moisture of incontinence. ADON, family aware.' A note by RNC on 02/27/24 at 8:55 p.m., Entered resident room with officer for interview. Family in process of bathing resident. Family instructed to refrain from completing bath until investigation completed related to resident allegation of sexual assault. Interview completed by the officer. EMS contacted for transport for further assessment. A note by RNC on 02/27/24 at 9:55 p.m., Resident transported by EMS. Family awaiting resident at hospital. A note by ADON on 02/27/24 at 11:43 p.m., CNA alerted [ADON] that Resident #1 expressed allegations of sexual assault. Notified ADM and RDO. Law enforcement contacted; family present at time of allegation.; resident currently at hospital for further evaluation. A note by ADON on 02/28/24 at 7:07 p.m., Received nurse to nurse report from Hospital staff at 1907 (7:07 p.m.). According to the report, Resident #1 was clear of signs of sexual assault. Family and resident stated they are comfortable and feel safe related to resident returning to facility. Per report received, Resident #1 has no current complaints of pain or distress, and will be returning to the facility before 8:00 p.m. No new orders expected for Resident #1 post hospital admission. Care plan to continue. Administrator notified; RNC notified. Record review of Resident #1's POC history, from 02/24/24 through 02/27/24, revealed all CNAs who provided ADL care to Resident #1 were female except CNA A, who was a male, provided support to Resident #1 for bed mobility and supervised Resident #1's toileting on 02/26/24 at 4:56 a.m., and observed Resident #1's level of control with bowel and bladder function on 02/26/24 at 5:02 a.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's vital checks, from 02/26/24 through 02/28/24, revealed all staff who checked and documented vitals taken from Resident #1 were female. Record review of Resident #1's MAR and TAR, from 02/24/24 through 02/27/24, revealed all female staff worked with Resident #1. Record review of the facility's staff schedule, from 02/24/24 through 02/28/24, revealed all female staff worked on the hallway Resident #1 resided on. Record review of the facility's sign in and out sheet, from 02/20/24 through 02/27/24, revealed Resident #1's RP visited her on 02/20/24 at 8:30 p.m., 02/21/24 at 9:53 p.m., 02/23/24 at 2:18 p.m., 02/24/24 at 8:00 p.m., and 02/27/24 at 7:00 p.m. Resident #1's family member also visited her on 02/23/24 at 2:18 p.m. and 02/27/24 at 7:00 p.m. Resident #1 had no other visitors listed. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's provider investigation report, undated, revealed Resident #1 alleged the abuse incident occurred on 02/27/24 at an unknown time in her room. The facility self-reported the incident on 02/27/24 at 8:49 p.m. There was no alleged perpetrator and witnesses listed. The investigation summary stated, On 02/27/24, Resident #1 told CNA B and RP that she had been raped by two men. CNA B notified the ADON and the ADON went and spoke further to Resident #1. Resident #1 at this time told the ADON that it was 2 men, 1 light skinned and 1 dark skinned, but that she did not know what time it happened at. Resident #1 was asked if she wanted to go to the hospital for further examination and Resident #1 at this time stated no. RN C did complete assessment and nothing from baseline noted. Once PD arrived, Resident #1 did give more information to officers with RN C present. When asked what occurred, Resident #1 stated that 1 guy came in and was talking dirty to her and a 2nd man came in and they were talking. Resident #1 was asked what happened next and she stated that one turned her on her side and put his penis inside her, Resident #1 also stated both had put their penis inside her but it did not hurt and they got busy but not too fast. When asked for a description of the men, Resident #1 stated 1 was a little guy, light skinned in his 20's and the other was a big guy dark skinned in his 30's. When asked if they worked here at the facility, Resident #1 stated no. When asked if they were wearing scrubs or regular clothes, Resident #1 said regular clothes. Resident #1's room was located near nursing station 2 close to the nurses station and staff on pod 2 were interviewed by the ADON and staff did not see anyone with the description that was given on the two males. After interview with Resident #1, staff assisted with placing brief and hospital gown and RP left to meet Resident #1 at the hospital. Resident #1 was transferred to the hospital for further evaluation and a SANE exam. The ADON spoke to a hospital staff member, who stated Resident #1 was clear of signs of sexual assault, RP and Resident #1 stated to the ADON that they felt safe at the facility. Resident safe surveys were completed for all female residents on 02/27/24 and revealed all residents indicated they never been inappropriately touched in the facility, never seen anyone being inappropriately touched in the facility, knew who to report abuse and neglect to, and felt safe living at the facility. Staff in-services were also initiated by the ADON on 02/27/24 and revealed staff were retrained on abuse and neglect reporting and preventing. MD and Ombudsman were also notified on 02/27/24. The investigation findings were unfounded. Staff statements attached to the report revealed ADON interviewed four CNAs on the evening of 02/27/24, who were all female, and all other staff who worked on the hallways in which Resident #1 resided on and was near, which revealed they did not witness any males matching Resident #1's description of the two alleged perpetrators. RNC and a PD officer also interviewed Resident #1 with RP present on 02/27/24 at 8:55 p.m. RP was bathing her even though they were instructed not to bathe Resident #1. RP indicated they did not bathe any of Resident #1's private areas, only her top half. Statement given by Resident #1 in response to questions by PD officer were also attached and stated the following: Can you tell me what occurred? 1 guy came into room and was talking dirty to me. A 2nd man came in and they were talking. Do you know if they work here? they said they don't work here What happened next? one turned me [Resident #1] on my side and put his penis inside me Did both men put their penis in you? yes, it didn't hurt and they got busy but not too fast Did they finish? I think so Do you think they were wearing a condom? I don't know (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Were they wearing scrubs or regular clothes? regular clothes When did this occur? this afternoon Was it before or after your roommate left? after Can you describe them? 1 was little guy, light skinned. 1 was big guy dark skinned Do you know what age they appeared? little guy 20's, big guy 30's How was their hair? poofy During an interview on 03/08/24 at 1:27 p.m., Resident #1 revealed a tall dark-skinned male and short light-skinned male came into her room and sexually assaulted her. Resident #1 could not recall what the alleged perpetrator(s) wore and if they were visitors or staff. Resident #1 stated there were no staff in her room and her roommate was not in her room around the time of the incident. Resident #1 also stated staff last checked on her on 02/27/24 at 3:00 p.m Resident #1 could not remember the nurse or nurse aide who checked on her on 02/27/24 at 3:00 p.m. Resident #1 stated she never been sexually assaulted at the facility in the past. Resident #1 also stated she felt safe at the facility at the time of the interview. Resident #1 stated she had no concerns or issues about how staff handled the incident. Resident #1 also stated staff checked on her often. Resident #1 also stated her RP was notified of the incident. The interview was stopped because Resident #1 began to cry and was unable to answer any additional questions. An observation of the front entrance on 04/18/24 at 9:05 a.m. revealed the front entrance doors automatically opened by motion sensors. The inside of the front entrance had a keypad. The receptionist was not at the front desk. There was a camera mounted on one of the walls in the front entrance area that was blinking a green light and angled at the front entrance doors. There was a sign in and out sheet that visitors were signing before entering further into the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/18/24 at 9:26 a.m., the ADM revealed the hospital notified staff that they did not find any results of sexual assault on Resident #1 on 02/27/24. The ADM explained the hospital staff swabbed Resident #1 and sent the sexual exam kit to the crime lab to be examined on 02/27/24. The ADM went on to explain that due to the delay in lab results because of the state's backlog, the PD received and notified the facility of the semen found in and on Resident #1 and in Resident #1's brief on 04/16/24. The ADM stated staff initiated resident safety surveys, trauma assessment on Resident #1, employee questionnaires, and in-services on abuse again after PD's notification of the sexual assault exam results. The ADM also stated a Quality Assurance meeting was arranged to discuss interventions to implement after the PD's notification of the sexual exam results in addition to the interventions implemented after Resident #1 reported the allegation on 02/27/24. The ADM also stated staff revised Resident #1's care plan to reflect Resident #1 would receive care and services from female-only caregivers. The ADM stated Resident #1's roommate told her that she felt safe at the facility, did not see anything, and did not see anything happen to Resident #1 on 02/27/24. The ADM also stated all female staff worked with Resident #1 on the day of the incident (02/27/24). The ADM stated while there were cameras in the area near Resident #1's room, the cameras were aimed at the nursing station and did not record because they were set to stream live feed. The ADM also stated staff interviewed Resident #1 again after the PD's notification of the sexual exam results, who had a similar recollection of the incident as compared to her recollection on 02/27/24. The ADM stated Resident #1 was not at the facility because the MD recommended to send her to the hospital again for another DNA test collection after staff notified the MD of the sexual assault exam results. The ADM stated Resident #1's RP initially did not want Resident #1 to go to hospital again, did not explain why and later agreed to send Resident #1 to the hospital because they did not want staff to document that they were refusing to seek medical attention for Resident #1 on 04/17/24. Her and staff did not know if Resident #1 provided another DNA sample at the hospital on 04/17/24 and hospital staff did not inform them if Resident #1 agreed to provide another sample. The ADM stated the PD informed her that all male staff except three male staff members volunteered to provide a DNA sample, did not indicate who were the three male staff who refused to volunteer, and there were three male staff who were unable to provide their DNA sample until 04/19/24. The ADM stated Resident #1's RP and a male family member were in Resident #1's room on 02/27/24. The ADM explained the RNC and PD observed Resident #1's RP showering Resident #1 on 02/27/24, stopped the RP from showering Resident #1, and explained to the RP that they needed to collect a sample of Resident #1's DNA. The ADM went on to explain the RP told staff that she continued to shower Resident #1 because she wanted Resident #1 to feel clean. During an interview on 04/18/24 at 10:24 a.m., Resident #1's RP revealed Resident #1 has been at the hospital since 04/17/24. RP questioned why she was not directly notified by the State Agency of Resident #1's incident, why the State Agency did not wait for the PD's sexual exam results before unsubstantiating Resident #1's allegations during the surveyor's initial visit on 03/08/24, and alleged the facility refused to provide her with their policies and procedures and investigation of the incident. When an attempt to ask the RP questions about her and a male family member visiting Resident #1 on the day Resident #1's alleged she was sexually assaulted on 02/27/24 was made, the RP stated that she was not in the mental state to answer any questions, was dealing with a lot, stated that she might be in a better headspace around 2:00 p.m. or 3:00 p.m. and advised to call back around 2:00 p.m. or 3:00 p.m. because she had questions to ask and to answer questions. RP abruptly ended the call because she was receiving another call. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/18/24 at 11:41 a.m., RNC revealed Resident #1's roommate left to the hospital on 02/27/24 at 3:30 p.m. RNC stated she informed the ADON to inform Resident #1's RP not to bathe Resident #1 after Resident #1 reported her allegation to staff and to have a nurse assess Resident #1 on 02/27/24. RNC also stated her, and the PD walked into Resident #1's room and observed Resident #1 lying in bed, undressed and being bathed by RP. RNC stated there was a male family member also present in Resident #1's room at the time. RNC explained Resident #1's RP told her and the PD that she was informed by the ADON not to bathe Resident #1 but continued to bathe Resident #1 because she wanted Resident #1 to feel clean. RNC explained Resident #1's RP was also adamant about Resident #1 not going out to hospital before the PD arrived at the facility on 02/27/24 and Resident #1 agreed to go to the hospital after the PD directly asked her if she wanted to go. During an interview on 04/18/24 at 12:15 p.m., RNC revealed a male family member visited Resident #1 a few times. RNC did not know if the three staff members worked in the facility after PD notified them of Resident #1's sexual assault exam results and if there have been any positive matches from the DNA samples collected. During an interview on 04/18/24 at 12:22 p.m., the ADM revealed she had not received any notifications from the PD regarding any positive matches from the DNA samples collected. During an interview on 04/18/24 at 12:31 p.m., the ADON revealed she could not remember who the CNA was who notified her of Resident #1's allegation and if she were the first person the CNA notified on 02/27/24. The ADON also revealed RN C might have been the staff member who notified her of Resident #1's allegation on 02/27/24 between 8:20p.m. and 8:30 p.m. The ADON explained she entered Resident #1's room and observed Resident #1's RP and a male family member in the room before RP began to give Resident #1 a shower. The ADON stated she informed Resident #1's RP not to shower Resident #1 because a nurse needed to assess Resident #1, the PD were on their way to interview Resident #1, and Resident #1 was going to be sent to the hospital for an evaluation. The ADON stated Resident #1's RP continued to give a bed bath to Resident #1 despite being told to wait. The ADON expressed something did not sit right with her about the male family member who was in Resident #1's room because she observed him linger while Resident #1's brief was changed. The ADON explained the male family member normally stepped out the room when incontinent care took place. The ADON explained she asked the male family member if he wanted to step out the room and the male family member stayed in there, did not explain why and stated, No I'm good. The ADON further explained the male family member also never hung around Resident #1's bed until 02/27/24. During an interview on 04/18/24 at 12:35 p.m., the ADM clarified four male staff have not provided a DNA sample because they were not working on the day the initial sample was collected and were scheduled to provide a sample on 04/19/24. During an interview on 04/18/24 at 12:41 p.m., the ADM revealed no male staff worked at the nursing station near Resident #1's room because the facility did not have many male staff and after PD notified them of the sexual assault exam results. The ADM stated she was not present when Resident #1 reported the allegation on 02/27/24. The ADM expressed she thought it was odd Resident #1's RP was not upset on 02/27/24, was adamant about not wanting Resident #1 to go to the hospital on 02/27/24 and told her that Resident #1 would not have been sent to the hospital again if she (ADM) had been at the facility on 04/17/24. (continued on next page)

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

During an interview on 04/18/24 at 1:06 p.m., RNC revealed it struck her odd Resident #1's RP continued to bathe Resident #1 despite staff telling her not to because Resident #1's POC (Resident records) revealed staff showered Resident #1 earlier in the day of 02/27/24. RNC also stated it struck her odd that Resident #1's RP did not initially want Resident #1 to go to the hospital on 02/27/24.

During an interview on 04/18/24 at 2:27 p.m., CNA B revealed on 02/27/24 during the 2:00 p.m. through 10:00 p.m. shift, she checked on and asked Resident #1 if she was doing okay, Resident #1 told her no, she asked Resident #1 why, Resident #1 told her that she had been raped, and she asked Resident #1 who sexually assaulted her, and Resident #1 told her two Black males. CNA B also stated Resident #1's RP and the male family member were not in room at the time Resident #1 alleged she was sexually assaulted. The can explained she immediately went to the ADON and reported Resident #1's allegation before dinner time, (CNA B indicated dinner time was between 5:00 p.m. and 6:00 p.m.). CNA B went on to explain her and CNA D performed incontinent care on Resident #1 after Resident #1 finished eating dinner. CNA B stated she observed Resident #1 was not wet during incontinent care. CNA B also stated Resident #1's RP and the male family member came in Resident #1's room [ROOM NUMBER] minutes after her and CNA D finished performing incontinent care on Resident #1. CNA B stated she was in the room when Resident #1's RP asked Resident #1 how she was doing, and Resident #1 told her RP that she had been raped. CNA B stated Resident #1's RP knew Resident #1 was confused and asked Resident #1 if she really got raped. CNA B could not remember if Resident #1's RP then went to look for the ADON or asked her to bring the ADON to her. CNA B explained she was at the nursing station with RN C when the male family member came and stated nobody could have touched Resident #1 because Resident #1's legs would have been broken. CNA B stated the ADON had RN C assessed Resident #1. CNA B could not remember if Resident #1's RP proceeded to bathe Resident #1 before or after RN C assessed Resident #1. CNA B stated the PD might have not stopped Resident #1's RP from finishing Resident #1's bath. CNA B stated she observed the male family member bringing Resident #1's RP bath supplies while the RP bathed Resident #1. CNA B explained she was not in the room when Resident #1's RP bathed Resident #1. CNA B stated she had never seen the male family member prior to 02/27/24.

An attempt to contact Resident #1's RP was made on 04/18/24 at 3:12 p.m. A voicemail and call back number. Resident #1's RP did not return the call prior to exit.

An attempt to contact the PD was made on 04/18/24 at 4:02 p.m. A voicemail and call back number was left.

During an interview on 04/18/24 at 4:09 p.m., the ADM revealed PD asked to review the facility's video cameras aimed at the nursing station. The ADM explained PD were unable to review the video cameras because the cameras streamed live feed and did not record. The ADM stated she discussed with Resident #1's RP about Resident #1's right to install a camera in her room for video monitoring if Resident #1's roommate consented, managers conducted daily rounds and asked residents if they felt safe at the facility, and all female residents were interviewed on 02/27/24 and 04/17/24. The ADM also stated the receptionist desk had a visitor sign in and out sheet that was implemented before the alleged incident on 02/27/24.

An attempt to contact RN C was made on 04/18/24 at 4:24 p. m. A voicemail and call back number was left. RN C did not return the call prior to exit.

(continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An observation of the front entrance on 04/19/24 at 9:20 a.m. revealed the receptionist was not at the front desk. There was also a sign in and out sheet that visitors were signing before entering further into the facility. During an interview on 04/19/24 at 9:28 a.m., the PD revealed she had the hospital conduct the SANE exam on Resident #1 on 02/27/24. The PD stated Resident #1's recollection of her allegation on 04/17/24 was the same as what she informed PD on 02/27/24. The PD also stated Resident #1's SANE exam found Resident #1 had semen in her vagina, on her vagina, and in her brief. The PD stated Resident #1's family told them that Resident #1 did not go out on pass and never left the facility since her readmission on 10/20/20. The PD also stated all male staff except three agreed to volunteer in providing and testing their DNA to rule them out as the alleged perpetrator(s). The PD explained of the three staff who denied, two staff did not explain why they did not want to volunteer and one denied due to personal and political beliefs. The PD stated there were three male staff who were going to give a sample of their DNA on 04/19/24 because they were not in the facility when the initial sample collection was taken. The PD also stated they were waiting on Resident #1's second DNA sample to be tested and determine if the semen belonged to more than one male. The PD stated the Maintenance Director informed her that there was no camera footage to review because the cameras streamed on a live feed and did not record. The PD also stated Resident #1's RP told her that she was willing to send Resident #1 to the hospital on 04/17/24 after she was notified of Resident #1's SANE exam results. The PD was unable to provide a copy of the SANE exam results because Resident #1's criminal investigation was ongoing. The PD informed the surveyor that they would email the surveyor a confirmation that they reviewed Resident #1's SANE exam and the results were positive. Record review of an email from the PD, dated 04/19/24 at 10:30 a.m., revealed the following, Hello, I am the Detective who's assigned the case pertaining to [Resident #1]. During our investigation, swabs from [Resident #1's] sexual assault exam were sent to the Crime Lab and came back with the presence of semen being positive in her vaginal swabs and in the crotch of her [brief]. Our investigation will remain open, and we will continue our investigation until the suspect/suspects are found. During an interview on 04/19/24 at 11:23 a.m., the ADM revealed residents and residents' family/RP had the keypad code for the front entrance. The ADM explained there were no restricted visiting hours because residents have the right to have visitors whenever they wanted. The ADM further explained the front entrance doors remained unlocked during the hours the receptionist occupied the front desk and were locked outside the receptionist's hours. During an interview on 04/19/24 at 11:28 a.m., the Receptionist revealed she worked Monday through Friday from 8:00 a.m. through 5:00 p.m. The Receptionist stated there were managers on duty who worked during the weekends at the front desk. The Receptionist also stated the front entrance door was locked outside her working hours. The Receptionist explained visitors would use the intercom system, which notified the nursing stations when there was a visitor and the nursing station had access to unlock the front door entrance. The Receptionist further explained residents and residents' family/RP also had the keypad code to unlock the front entrance door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Killeen Nursing & Rehabilitation	5000 Thayer Dr Killeen, TX 76549

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/19/24 at 11:35 a.m., CNA D revealed she never had a resident allege they were sexually abused. CNA D stated she reported to a nurse or the ADM if she received any reports related to abuse. CNA D stated she checked on residents every two hours. CNA D stated she never worked with Resident #1. CNA D also stated she never popped into a resident's room whenever residents' had family/RP in the room because she tried to give them space, but she did pop in to ensure residents were doing okay. CNA D did not know if the cameras aimed at the nursing station near Resident #1's room worked. CNA D stated the front entrance door had an intercom system that notified staff at the nursing station if there were visitors outside normal business hours. An observation of the nursing station near Resident #1's room on 04/19/24 at 11:40 a.m. revealed there were two cameras mounted and aimed at the nursing station. There were also three staff occupying the nursing station. During an interview on 04/19/24 at 11:42 a.m., CNA E revealed she never had a resident allege they were sexually abused. CNA E stated she reported to human resources if she received any reports related to abuse. CNA E stated she checked on residents every two hours. CNA E stated she worked with Resident #1 and Resident #1 never reported abuse to her. CNA E also stated she had only seen Resident #1's RP visit and in Resident #1's room. CNA E explained she has never seen a male visit Resident #1 or in Resident #1's room. CNA E stated she popped into residents' rooms whenever residents' family/RP were in the room. CNA E did not know if the cameras aimed at the nursing station near Resident #1's room worked. CNA E stated the front entrance door had an intercom system that notified staff at the nursing station if there were visitors outside normal business hours. During an interview on 04/19/24 at 11:49 a.m., CNA F revealed she worked at the facility for one month. CNA F stated she never had a resident allege they were sexually abused. CNA F also stated she reported to the ADM if she received any reports related to abuse. CNA F stated she checked on residents in their rooms every two hours. CNA F did not know if the cameras aimed at the nursing station near Resident #1's room worked. CNA F also stated the front entrance door had an intercom system that notified staff at the nursing station if there were visitors outside normal business hours. During an interview on 04/19/24 at 11:55 a.m., Resident #2 revealed she was Resident #1's roommate. Resident #2 stated she often observed Resident #1 scream all night and staff did not see or check on her or Resident #1. Resident #2 stated Resident #1 told staff someone came, pulled her clothes down and raped her. Resident #2 could not remember what day Resident #1 told staff about the incident. Resident #2 stated Resident #1 started telling her about the rape two weeks ago. Resident #2 stated Resident #1 never told her who raped her. Resident #2 also stated Resident #1's RP and a male family member visited Resident #1. Resident #2 stated she did not observe anything happen to Resident #1 because she often went out the room. Resident #2 stated she never observed any males come into her and Resident #1's shared room other than the male family member who visited Resident #1. Resident #2 also stated she never observed any male residents come into her and Resident #1's shared room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Killeen Nursing & Rehabilitation	5000 Thayer Dr Killeen, TX 76549

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/19/24 at 12:12 p.m., Charge Nurse G revealed she never had a resident allege they were sexually abused. Charge Nurse G stated she also has never seen any male caregivers work in the hallways or nursing station near Resident #1's room. Charge Nurse G also stated she reported to the ADM if she received any reports related to abuse. Charge Nurse G stated she checked on residents in their rooms every two hours. Charge Nurse G also stated she had CNAs round when they first come in and start their shifts, during their shifts, and just before the end of their shifts. Charge Nurse G stated there were no gaps in staff coverage. Charge Nurse G also stated she never observed visitors in Resident #1's room. Charge Nurse G did not know if the cameras aimed at the nursing station near Resident #1's room were in operable condition. Charge Nurse G stated the front entrance door had an intercom system that notified staff at the nursing station if there were visitors outside normal business hours and staff had access from the nursing station to unlock the front entrance door. During an interview on 04/19/24 at 12:13 p.m., Charge Nurse H revealed Resident #1 alleged on 04/17/24 that she was sexually assaulted by two white men and explained that one male fingered her, and the other male watched. Charge Nurse H stated Resident #1 had an altered mental status. Charge Nurse H also stated she had never seen any male caregivers work on the hallways or nursing station near Resident #1's room. Charge Nurse H stated she reported to the ADM if she received any reports related to abuse. Charge Nurse H stated she checked on resident in room every two hours. Charge Nurse H stated she had CNAs round when they first come in and start their shifts, during their shifts, and just before the end of their shifts. Charge Nurse H stated there were no gaps in staff coverage. Charge Nurse H also stated she had never observed visitors in Residen [TRUNCATED]