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	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Killeen Nursing & Rehabilitation	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene for three of five residents (Resident #3, Resident #4, and Resident #5) reviewed for ADLs. The facility failed to provide showers to Residents #3, #4, and #5 in compliance with their shower schedules. This deficient practice could place residents at risk of a decline in hygiene, at risk of skin breakdown, level of satisfaction with life, and feelings of self-worth. Findings included: Review of Resident #3's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (stroke) affecting right dominant side, muscle weakness, and muscle wasting and atrophy (wasting away). Review of Resident #3's quarterly MDS assessment, dated 10/24/24, reflected a BIMS score of 10, indicating she was moderately cognitively impaired. Section G (Functional Status) reflected she required extensive assistance with her ADLs. Review of Resident #3's quarterly care plan, dated 10/29/24, reflected she had a self-care deficit and required assistance (total care) with ADLs with an intervention of providing/assisting with bath or shower as per scheduled and as needed. Review of Resident #3's shower records in her EMR, from 10/22/24 - 11/22/24, reflected she received seven baths/showers - 10/23/24, 10/31/24, 11/06/24, 11/09/24, 11/16/24, 11/21/24, and 11/22/24. During an observation and interview on 11/22/24 at 11:39 AM, revealed Resident #3 in the dining room waiting for lunch. Her hair was messy and greasy, face was oily, and her eyes were crusty. She stated she did not have a shower that day and she would go long periods of time without getting showers. She stated she believed she deserved to get showers and it made her feel sad. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including major depressive disorder, heart failure, lack of coordination, unsteadiness on feet, and muscle wasting and atrophy. Review of Resident #4's quarterly MDS assessment, reflected a BIMS score of 6, indicating he had a severe cognitive impairment. Section G (Functional Status) reflected he required extensive assistance with his ADLs. Review of Resident #4's quarterly care plan, dated 10/14/24, reflected he had self-care deficit and required extensive assistance x1 with ADLs with an intervention of providing/assisting with bath or shower as per schedule and as needed. Review of Resident #4's shower records in his EMR, from 10/22/24 - 11/22/24, reflected he received five baths/showers - 10/22/24, 11/01/24, 11/11/24, 11/12/24, and 11/15/24. During an observation and interview on 11/22/24 at 11:49 AM, revealed Resident #4 to have a greasy face and stubble on his cheeks. He stated he never got showers regularly and the last time he got one was the Thursday prior (11/15/24). He stated it made him feel bad and gross. Review of Resident #5's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including specified depressive episodes, unspecified lack of coordination, anxiety disorder, and muscle weakness. Review of Resident #5's admission MDS assessment, dated 11/06/24, reflected a BIMS score of 12, indicating she was moderately cognitively impaired. Section G (Functional Status) reflected she required limited assistance with her ADLs. Review of Resident #5's quarterly care plan, dated 11/06/24, reflected nothing related to ADLs or need for assistance. Review of Resident #5's shower records in her EMR, from 10/30/24 - 11/22/24, reflected she received one shower/bath on 11/21/24. During an observation and interview on 11/22/24 at 12:32 PM, revealed Resident #5 coming back to her room after lunch. Her hair was greasy and matted. She stated she had recently gone 2-3 weeks without a shower. She stated the staff just never show up to give her a shower or would give her excuses that she was asleep. She stated, Why can they not wake me up? She stated she had resorted to begging for wash cloths so she could give herself a sponge bath because she felt so dirty all the time. During a telephone interview on 11/25/24 at 10:58 AM, the DON stated her expectations were that aides gave the residents a shower at least three times a week or as needed. She stated if a resident refused, that should be documented as well. She stated not receiving showers regularly could lead to infections, UTIs, odors, and bad hygiene. A policy on ADLs was requested but not received prior to exiting.

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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 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of four residents reviewed for quality of care. The facility failed to assess and put treatment orders in place when Resident #1 developed a rash under her abdominal fold causing her excruciating pain. These failures placed residents at risk of improper wound management, the development of new skin integrity issues, deterioration in existing skin integrity, infection, and pain. Findings included: Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dermatitis (skin conditions), type II diabetes, reduced mobility, morbid obesity, and muscle wasting and atrophy (wasting away). Review of Resident #1's quarterly MDS assessment, dated 08/26/24, reflected a BIMS score of 10, indicating she was moderately cognitively impaired. Section M (Skin Conditions) reflected she was at risk of developing pressure ulcers/injuries. Review of Resident #1's quarterly care plan, dated 11/01/24, reflected she was at risk for pressure ulcers due to impaired mobility with an intervention of conducting a skin assessment and inspection every shift. Review of Resident #1's skin assessment, dated 11/19/24 and created by LVN A, reflected no new skin issues noted. Review of Resident #1's physician orders, on 11/22/24, reflected no orders for skin treatments. Review of Resident #1's physician orders, on 11/25/24, reflected an order dated 11/22/24 for Nystop (an antifungal powder) - 100,000 unit/gram - apply small amount to resident skin fold three times a day until healed for moisture accumulation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 11/22/24 at 2:15 PM, Resident #1 asked to speak with this Surveyor. She stated over a week ago, a CNA at night (did not remember her name) tore off her brief too fast and the Velcro got stuck on her skin and ripped it. She stated it bled for at least four days and a nurse had not assessed her until that day (11/22/24) when they put some kind of powder on it. She opened her brief which revealed an irritated red rash under her abdominal fold. Resident #1 grimaced and winced in pain when she picked up her abdominal fold to show the irritated area. CNA B entered the room and stated the red area to Resident #1 had been there for at least two weeks. She stated she had been telling nurses and no one had assessed her until that day (11/22/24) when she requested LVN C to look at it. She stated at that time, LVN C applied Nystatin powder to the area. She stated she believed Resident #1 needed to be assessed by the WCN. She stated that day (11/22/24) Resident #1 had been in the most pain from the area as she would have tears in her eyes when she rolled her over to provide incontinent care. Resident #1 stated it made her feel like she was not a priority. During an interview on 11/22/24 at 3:18 PM, LVN C stated today (11/22/24) was her first actual day working at the facility. She stated CNA B asked her to look at Resident #1's skin earlier in the day and stated the area should have been assessed long before that day. She stated she left a note for the WCN so it could be further assessed. She stated she applied Nystatin powder because it appeared to be a fungal rash. During a telephone interview on 11/22/24 at 3:47 PM, Resident #1's RP stated he visited her every single day. He stated the redness to her skin happened at least a week ago. He stated an aide snatched the brief off her and the Velcro scraped her skin. He stated they had not been able to get a nurse to look at it and she had been in a lot of pain. He stated the area was getting worse daily. During an interview on 11/22/24 at 4:00 PM, LVN A stated on 11/19/24 she and the ADON did a skin sweep (skin assessments) on all residents in the facility. She stated the ADON did Resident #1's actual skin assessment and she just signed off on it. She stated she did not remember if the ADON told her she had any skin integrity issues. During a telephone interview on 11/23/24 at 9:10 AM, the ADON stated she and LVN A did a lot of skin assessments together on 11/19/24. She stated she could not recall if Resident #1 had any new skin integrity issues. She stated Resident #1 did not have a history of a rash but did remember her having some redness to her abdominal folds at the beginning of October (2024). She stated she was not sure if she had treatment orders in place or if she was being seen by the WCN or WCD. During a telephone interview on 11/23/24 at 9:16 AM, the WCN stated she had not been notified about any skin issues for Resident #1. She stated her expectations were that the nurses notify her of any new skin integrity issues for all residents as that was the procedure. She stated if she had been aware, she would have assessed her and would have absolutely put treatment orders in place. During a telephone interview on 11/23/24 at 9:25 AM, the WCD stated he had not been notified of any skin issues regarding Resident #1. He stated his expectations were that all skin integrity issues were relayed to the WCN. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	During a telephone interview on 11/25/24 at 10:58 AM, the DON stated she was notified of redness to Resident #1's skin on 11/22/24 and a nurse assessed it. She stated their WCN assessed it over the weekend and their WCD was at the facility that day (11/25/24). She stated if no new skin issues had been marked on the skin assessment on 11/19/24 , it could mean the redness was not a new issue. She stated her expectation was that it should have been relayed to the WCN so she could assess the area and contact the WCD or NP to get orders if they chose to. She stated not providing treatment could cause worsening of skin issues. Review of the facility's Prevention of Pressure Injuries Policy, dated April 2020, reflected the following: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. . 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; Monitoring 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 3 residents (Resident #2) reviewed for infection prevention and control. CNA B failed to don PPE while performing incontinent care for Resident #2 who was on enhanced barrier precautions. CNA B and LVN C failed to perform hand hygiene while performing incontinent care and wound care for Resident #2. LVN C failed to have a clean field for supplies while performing wound care for Resident #2. The facility failed to have a liner in the trash can in Resident #2's room. These failures could place residents at risk for infection. Findings include: Review of Resident #2's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dermatitis (skin conditions), type II diabetes with other specified complications, Obesity, Cellulitis (a bacteria skin infection that can often affect the lower legs), unsteady to the feet, and muscle wasting and atrophy (wasting away). Review of Resident #2's quarterly MDS assessment, dated 09/24/24, reflected a BIMS score of 15, indicating she had no cognitive impairment. Section M (Skin Conditions) reflected she was at risk of developing pressure ulcers/injuries. Review of Resident #2's quarterly care plan, dated 11/21/24, reflected she had non pressure wound Location: Right posterior thigh, Treat area per physician order. She was on Transmission-Based Precautions related to wound care with approaches to Encourage me to use good clean hygiene techniques to avoid cross-contamination, especially hand washing before meals and after bowel movements, ensure appropriate PPE is worn based on my isolation status, ensure aseptic technique is performed on any wound care if ordered. Review of Resident #2's skin assessment, dated 11/21/24 reflected non pressure wound at right posterior thighs. Review of Resident #2's physician orders, on 11/14/24, reflected non pressure wound of the right, posterior thigh: Clean with NS, pat dry, apply collagen powder, alginate calcium, cover with foam border dressing daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/22/2024 at 2:15 pm, CNA B did not wear an isolation gown while performing incontinent care for Resident #2. CNA B donned clean gloves, rolled Resident #2 on her right side, removed soiled brief and put in the unlined trash can. CNA B stated to perform incontinent for Resident #2 and put the soiled wipes in the unlined trash can, wounds at the back of Resident #2's thigh were exposed. CNA B then walked to the light switch, used soiled gloved hand to turn the light brighter, touching the privacy curtains with gloved hands thereby contaminating the curtains and the light switch. CNA B was also observed wiping Resident #2 and soiled wipes were also put in the unlined trash can. CNA B repositioned Resident #2 on her back, same gloved hands, touching Resident #2's blanket to cover her, removed gloves, performed hand hygiene and walked out of the room to call the nurse. Later, CNA B returned to Resident #2's room followed by LVN C, both staff don gown and gloves, no hand hygiene. LVN C did not have a clean field for wound care set up, not bag for soiled dressings. LVN C put wound care supplies on Resident #2's bed, removed soiled dressing and put in the unlined trash care, did not change gloves or perform hand hygiene cleaned wound with normal saline, pat dry while wearing same soiled gloves. LVN C applied collagen to wound bed wearing same soiled gloves, then changed gloves after applying the medication to the wound bed, LVN C then reached in her pocket for sharpie by lifting up her isolation gown there by contaminating the gloves. It was observed Resident #2 started to have a bowel movement, LVN C then started to cleaned Resident #2's bowel movement and put the soiled wipes in the unlined trash can. LVN C then changed her gloves, no hand hygiene, applied clean dressing on Resident #2's wound while LVN C hands were touching the inner portion of the dressing. CNA B removed gloves, no hand hygiene, stepped out of Resident #2's room while wearing the isolation gown, stepped back in the room, removed isolation gown and provided trash bag to CNA B to empty the trash in it. LVN C then left the room without hand hygiene. During an interview on 11/22/2024 at 3:00 pm, CNA B stated she was trained and in-serviced on enhanced barrier precautions. She stated she should have donned PPE when providing peri care for Resident #2. She also stated Resident #2's wound dressing always came out during incontinent care. CNA B said PPE is to protect the residents and the staff from bodily fluids from infection due to opened wounds. CNA B also stated hand hygiene is performed before and after care and also with glove changes. She stated she did not think touching a light switch would warrant a glove change and hand hygiene before going back to providing care. During an interview on 11/22/2024 at 3:18 pm, LVN C stated she worked with the facility before through agencies and that was her first day as facility staff. She stated she had not yet done training at the facility. LVN C stated enhanced barrier precautions was infection control for residents with wounds, and the gloves and the gowns were to protect herself (LVN C). LVN C stated hand hygiene is done before care for a resident and that she did not perform hand hygiene because there was no sanitizer machine in the room like she was used to. LVN C stated when she started to clean Resident #1's wound she noticed there was no trash bag in the room, that is a huge infection control issue . She also stated she should have had a bag to place soiled dressing in. She said she should have had a clean field for wound care supplies and that was double infection control problems, and a risk for cross contamination. LVN C also stated she did not perform hand hygiene with glove changes because her hands were not visibly soiled. LVN C stated putting the wipes with bowel movement in the unlined trash can, and touching the inside of clean dressing were all infection control issues. LVN C stated there was no sanitizer machine in the room and that is why she did not perform hand hygiene before she left Resident #2's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 11/25/24 at 10:58 AM, the DON stated gloves and a gown must be donned before wound care for a resident on EBP to prevent transmitting anything to the resident or vice versa. She stated there should absolutely be a trash bag in the trash can to prevent infection control issues. She stated gloves should be changed when they were soiled or before touching any clean areas. She stated hand hygiene should be done after changing gloves or when they were physically soiled. She stated a negative outcome of not following infection control precautions would be infection control concerns. Review of facility's policy titled Handwashing/Hand Hygiene dated October 2023 reflected: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene is indicated: --immediately before touching a resident. --before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device). --after contact with blood, body fluids, or contaminated surfaces. --after touching a resident. --after touching the resident's environment. --before moving from work on a soiled body site to a clean body site on the same resident and --immediately after glove removal. Review of facility's policy titled Enhanced Barrier Precautions dated 2001 reflected: Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing. b. bathing/showering. c. transferring. d. providing hygiene. e. changing linens. f. changing briefs or assisting with toileting. g. device care or use and h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. a. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. Review of facility's policy titled Infections-Clinical Protocol dated March 2018 reflected nothing to do with infection control issues during wound care, trash can lining .