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	06/26/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 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 interviews and record reviews, the facility failed to notify the resident and resident's representative(s) of the discharge, reasons for the move, and right to appeal in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 2 (Resident #1 and Resident #2) of 10 residents reviewed for discharge planning. A) 1. The facility failed to notify Resident #1 and Resident #1's RP of Resident #1's discharge, reasons for the move, and right to appeal in writing, in a language and manner they understand, and at least 30 days before Resident #1 was discharged from the facility on 05/25/25 in a facility-initiated discharge to another skilled nursing facility.2. The facility failed to send a copy of the notice to the facility's Ombudsman before Resident #1 was discharged from the facility on 05/25/25. B) 1. The facility failed to notify Resident #2 of a reason for his discharge from the facility, an effective discharge date , a location to which he would discharge to, his right to appeal, and the facility Ombudsman's contact information in writing, in a language and manner he understood and at least 30 days or as soon as practicable before he was required to discharge from the facility. 2. The facility failed to send a copy of the Resident #2's notice of discharge to the facility's Ombudsman. This failure could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. Findings included:A)Review of Resident #1's face sheet dated 06/25/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (neurodegenerative disease primarily of the central nervous system, affecting both motor and non-motor systems) with Dyskinesia (uncontrolled, involuntary movements), Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), mood disorder due to known physiological condition with depressive features, and neurocognitive disorder with Lewy bodies (aka Lewy body dementia, is a type of dementia caused by protein deposits in the brain cells affecting thinking, memory, movement, sleep, and behavior). The face sheet reflected Resident #1 was discharged [DATE] at 2:09 PM after a 13-day length of stay. Review of Resident #1's discharge MDS assessment return not anticipated dated 05/25/25 reflected section A discharge status which was marked as Resident #1 being discharged to a long-term care facility with a discharge date of 05/25/25. Section C cognitive patterns reflected a BIMS score of 04 indicating severe cognitive impairment. Review of Resident #1's progress notes reflected the following notes:- A nursing progress note dated 05/25/25, a family member of one of our patients alerted us to Resident #1 being in the road on [main road off property] we immediately went and got the resident and brought him back in the facility. We brought him back in the facility and placed him on 1 on 1 family member is currently here now and I informed her of his elopement and also that we are trying to find placement for him at a memory care facility. We cannot meet his needs since we are not a lock down facility or have wonder guards to prevent resident from getting out the facility and getting hurt [receiving SNF] has accepted resident and will be transporting him to their facility. - A social services progress note dated 05/25/25, Resident will be transferred to [facility] today due to his need for a secured memory care unit. He will be transported there around 02:00 PM today. [Resident #1's family member] is aware of this plan and that she can later transfer him to another facility later on if she wishes to. - A nursing progress note dated 05/25/25, d/c'd to another facility. Record review of Resident #1's Discharge summary dated [DATE] reflected:- discharge date : [DATE].- Expected return? No. - Released to other facility.- Reason for discharge: needs a secure memory care unit.- Final summary: Resident is transferring to [facility] a secured memory care unit.Review of Resident #1's discharge planning review record dated 05/25/25 reflected: Who initiated discharge? Facility. If facility, if this was a facility initiated discharge, was advance notice given (either 30 days or as soon as practicable on the reason of the discharge) to the resident, resident representative, and a copy to the Ombudsman; Did the notice include all the required components (reason, effective date, location, appeal rights, Ombudsman, ID, MI info as needed) and was it presented in a manner that could be understood; and if changes were made to the notice, were recipients of the notice updated? Signatures of facility staff included SW and ADON A dated 05/25/25.In an interview on 06/25/25 at 10:10 AM with Resident #1's family, she stated ADON A approached her after she arrived to the facility at approximately 10:00 AM on 05/25/25 and told her they needed to leave and should have never been admitted due to the condition of Resident #1 and his elopement risk. Resident #1's family stated this was sudden and it was a result of an elopement Resident #1 had earlier that morning. She stated she was not

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision for 1 of 10 residents (Resident #1) reviewed for accidents and supervision.The facility failed to ensure Resident #1 did not exit the facility without staff's knowledge and ambulate approximately 100 yards down their driveway to a busy street with a speed limit of 65 MPH on 05/25/25. The facility failed to ensure staff were knowledgeable on how to properly secure the doors using the door security box located at 2 of 2 nurses' stations (both the skilled nursing and long-term care sides of the facility). Staff were identified by ADON B pressing the door release button with a key emblem instead of the round door secure button resulting in the doors not being secured. An Immediate Jeopardy (IJ) was identified on 06/25/25. The IJ Template was provided to the facility on [DATE] at 05:10 PM. While the IJ was removed on 06/26/25, the facility remained out of compliance at a scope of isolated and a severity with no actual harm with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of harm and/or injury due to elopement. Findings included:Review of Resident #1's face sheet dated 06/25/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (neurodegenerative disease primarily of the central nervous system, affecting both motor and non-motor systems) with Dyskinesia (uncontrolled, involuntary movements), Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), mood disorder due to known physiological condition with depressive features, and neurocognitive disorder with Lewy bodies (aka Lewy body dementia, is a type of dementia caused by protein deposits in the brain cells affecting thinking, memory, movement, sleep, and behavior). The face sheet reflected Resident #1 was discharged [DATE] at 2:09 PM after a 13-day length of stay. Review of Resident #1's discharge MDS assessment return not anticipated dated 05/25/25 reflected section A discharge status which was marked as Resident #1 being discharged to a long-term care facility with a discharge date of 05/25/25. Section C cognitive patterns reflected a BIMS score of 04 indicating severe cognitive impairment. Review of Resident #1's baseline care plan dated 05/12/25 reflected safety risks- is the resident an elopement risk? was not marked yes or no. Review of Resident #1's care plan last revised 05/25/25 reflected a focus initiated on 05/25/25 the resident is an elopement risk/wanderer related to disoriented to place. History of attempts to leave facility unattended, impaired safety awareness. Resident wanders aimlessly, significantly intrudes on privacy or activities. The care plan reflected there was no focus or interventions prior to 05/25/25 the date of the elopement. Review of Resident #1's progress notes reflected the following notes related to wandering/exit seeking behavior: - Nursing note dated 05/14/25 resident on follow up day 3/3 of new admit. He seems to be adjusting to being at facility. Does continue to wonder around. Alert to self but pleasantly confused. - Nursing advanced skill evaluation dated 05/15/25 resident wanders at night. - Nursing note dated 05/15/25 resident observed making multiple attempts to exit the facility through the secure doors. When redirected resident expressed confusion stating, I don't know what I am doing here. This nurse provided reorientation and education regarding his current medical condition and reason for admission. Resident has a feeding tube, medications and nutritional feeding were administered via tube as ordered. Despite tube feeding, resident was observed attempting to consume food from other residents' tray and requesting coffee. Staff have been providing frequent redirections and reassurance. Resident was brought to nursing station for closer observation; however, he is unable to remain seated for prolong period and frequently attempts to stand and ambulate unsafely. This nurse has made several multiple interventions to promote safety including verbal redirections. - Nursing note dated 05/15/25 Resident found in room packing his clothes and personal belongings which were laid out on his bed. When asked what he is doing he states that he is going home, and his family member is coming to pick him up. Resident educated and redirected but resident remains insistent on leaving. This nurse attempted to contact family member , resident in his room alert and verbal still expressing desires to go home.- A nursing note dated 05/17/25, Resident up in his wheelchair at this time wheeling around everywhere trying to get into other residents' rooms and trying to eat and drink everyone's food and drinks. Resident has to be reminded that he cannot eat or drink anything at this time as he is strictly to not have anything by mouth and that he has a feeding tube that hives him the foods and fluids he needs. Resident stares at nurse and just wheels off. He is very confused, but it is a pleasant confused. Resident attempting to go towards the doors and staff again has to redirect him that he cannot go out of the