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	08/11/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each 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

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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 0558 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 observations, interviews, and record review, the facility failed to accommodate the needs and preferences for one of seven residents (Residents #1) reviewed for accommodation of needs, in that:The facility failed to ensure that Resident #1 had his call light in reach on 8/8/2025. This deficient practice could place residents at risk of injury, for not receiving timely care and nursing interventions.Findings included: Review of Resident #1's Face sheet dated 8/8/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Hemiplegia (paralysis of one side of the body, Chronic Kidney Disease, Heart Failure, Obstructive Uropathy (disrupted urine flow) and, Atrial Fibrillation (irregular heart rhythm). Review of admission MDS dated [DATE] for Resident #1 reflected a BIMs of 14 suggesting no cognitive impairment. Review of Resident #1's Care plan dated 8/8/2025 for Resident #1 reflected the focus I am at risk for falls [related to] impaired mobility, with the Intervention: Evaluate, interview and document my physical condition and cognitive status. Observe environment to identify any potential factors that could contribute to a fall, such as lighting, uneven/slippery/cluttered floor surfaces, improper footwear, failure to use assistive devices, etc. Remove any potential causes or hazards, if possible. Educate me of potential fall hazards. An observation of Resident #1's room on 8/8/2025 at 11:18 am revealed resident was lying in bed on his back, face up and was awake and alert. Further Observations revealed resident's call light was laying on the floor behind the head of his bed and out of his reach. During an interview on 8/8/2025 at 11:15 am, Resident #1 stated he did not know his call light was laying on the floor behind the bed as he could not see it. He stated he was partially paralyzed and needed his call light to call staff for assistance as he needed assistance for his activities of daily living. Resident #1 stated he would not be able to call for help if he needed to because he could not reach his call light. Resident #1 stated he did not know how the call light got on the floor behind his bed, but he did not put it there. During an interview on 8/8/2025 at 11:21 am, RN A noted that Resident #1's call light was on the floor the call light was not quite where he [Resident #1] could reach it without it being a risk to him. He further stated if Resident #1 attempted to reach for the call light on the floor, he could fall out of bed and get injured. During an interview on 8/8/2025 at 2:42 pm, the Regional Nurse stated the call lights should always be within reach so that residents can get staff when they really needed them. She stated her concern with the call light not being in reach would be that residents would not be able to get the assistance they needed. During an interview on 8/8/2025 at 2:46 PM, LVN C stated she had seen Resident #1 earlier that morning when making her hospice rounds. She stated, at that time, the call light was in reach. She stated she would have safety concerns for Resident #1's call light not being in reach, because he would not be able to get help if he needed it, and could possibly fall out of bed while trying to reach his call light. During an interview on 8/11/2025 at 3:30 pm, the ADM stated any staff that went in a resident's room could have made sure the call light was in reach. She stated her concern with a call light being on the floor would have been that the patient would not be able to make their needs known which could lead to a failure of care. Review of the facility's policy Call System, Residents updated January 2025, reflected the following: Residents are provided with a means to call staff for assistance through a communication system that directly callsa staff member or a centralized work station.Policy Interpretation and Implementation1. Each resident is provided with a means to call staff directly for assistance from his/her bed, fromtoileting/bathing facilities and from the floor. Review of the facility's policy Resident Rights, revised February 2021, reflected the following: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 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 observation, interview, and record review, the facility failed to establish and 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 diseases and infections for 1 of 7 residents (Resident #1) reviewed for Infection control. The facility failed to ensure Resident #1's catheter bag was not laying on the floor on 8/8/2025. This failure could result in the spread of diseases to residents which could result in decreased quality of life, illness, and hospitalization.Findings included: Review of Face sheet dated 8/8/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Hemiplegia (paralysis of one side of the body), Chronic Kidney Disease, Heart Failure, Obstructive Uropathy (disrupted urine flow) and Atrial Fibrillation (irregular heart rhythm). Review of admission MDS assessment dated [DATE] for Resident #1 reflected a BIMS score of 14 suggesting no cognitive impairment. Review of MDS section H - Bladder and Bowel - reflected Resident #1 had an indwelling catheter. Review of Care plan dated 8/8/2025 for Resident #1 reflected the focus The resident has an indwelling catheter for [Benign Prostate Hyperplasia] with Intervention: Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. An observation of Resident #1's room on 8/8/2025 at 11:17 am revealed his urinary catheter bag was hanging off the side bed rail with the bottom of the bag sitting on the ground. During an interview on 8/8/2025 at 11:15 am, Resident #1 stated he did not know his catheter bag was laying on the floor because he could not see it from where he was laying. He stated he would be worried about a possible infection from the bag laying on the dirty floor. Resident #1 stated he did not know who put his bag on the floor. During an interview on 8/8/2025 at 11:21 am, RN A stated that Resident #1's catheter bag was on the floor, and the bag laying on the floor was a trip hazard as well as an infection control issue as germs could get into the catheter making Resident #1 very sick. During an interview on 8/8/2025 at 1:23 pm, NP B stated, we need to get it [catheter bag] off the floor so bacteria can't be introduced She stated the catheter bag is a controlled environment, but it still needs to be off the floor. She stated she would have concerns about infection control with the catheter bag laying on the floor. During an interview on 8/8/2025 at 1:53 pm, Branch Manger RN stated she would have concerns from an infection control standpoint for a catheter bag laying on the floor. She stated she would have concerns about bacteria getting in there - looking at potential infections - the floor is not any environment to have access to an internal entrance. She stated the catheter bag being on the floor was an infection risk and Resident #1 was more at risk because he was immunocompromised (having a weakened immune system). During an interview on 8/8/2025 at 2:46 PM, LVN C stated she had seen Resident #1 earlier that morning when making her hospice rounds. She stated, at that time, the catheter bag was hooked to the bed rail and she did not notice it on the floor. She stated her concerns with a catheter bag being on the floor would be an infection control issue. She stated she would worry about germs and infections. She stated Resident #1 was a higher risk for infection due to being immunocompromised and being on hospice. During an interview on 8/8/2025 at 3:30 pm, Regional Nurse stated a catheter bag on the floor would be an infection control issue including exposure of urine or bag to bacteria on the floor. During an interview on 8/11/2025 at 3:30 pm, the ADM stated nursing staff was responsible for making sure catheter bags are off the floor. She stated a concern would be an infection of some sort. Review of the facility's policy Catheter Care, Urinary updated July 2024, reflected the following: PurposeThe purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control1. Use standard precautions when handling or manipulating the drainage system.2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.a. Do not clean the periurethral area with antiseptics to prevent catheter-associated UTIs while the catheteris in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) isappropriate.b. Be sure the catheter tubing and drainage bag are kept off the floor.