

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 12/03/2025
NAME OF PROVIDER OR SUPPLIER Killeen Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of resident property for Resident #2 reviewed for misappropriation. The facility failed to ensure Resident #2 was protected from the AC accessing her bank account, leading to 4 unauthorized transactions totaling \$10,250 from Resident #2's account between 10-18-2025 and 10-29-2025. This failure could place residents at risk of decreased quality of life, property misappropriation, and financial hardship. Findings included: Record review of Resident #2's admission record, dated 12-03-2025, indicated an [AGE] year-old female admitted to the facility on [DATE] with primary diagnoses of cerebral infarction, unspecified (blood flow to the brain disrupted due to issues with the arteries that supply it), and secondary diagnosis of Alzheimer's disease Resident #2 was her own responsible party, Record review of Resident #2's Quarterly MDS Assessment, dated 11-05-2025, revealed Resident #2 had a BIMS score of 12, indicating impairment, 8 - 12 = moderate cognitive. Record review of Resident #2's Care Plan, dated 05-08-2025, indicated Resident #2 was impaired mobility, and used psychotropic medications r/t Alzheimer's disease process. Record review of Resident #2's bank statement revealed the following: 10/10/2025 for \$1,300 cash withdrawal 10/18/2025 for \$3,600 for a charge to loan company 10/28/2025 for \$2,000 cash withdrawal 10/29/2025 \$3,350 cash withdrawal Record review of the facility's residents' safe survey, in-service training on misappropriation of funds, and staff questionnaire completed on 11-20-2025. In an interview with Resident #2 on 12-03-2025 at 1:15 p.m., Resident #2 stated AC talked her into putting AC on her bank account. Resident #2 stated the AC told her she could help her with her finances because she had taken Resident #2 to the bank. Resident #2 stated she did not know the AC would take money without her knowing or she would not have put AC on her bank account. Resident #2 stated she did not know the AC was stealing money from her and did not know the total amount taken. Resident #2 stated only \$3,500 was returned to her. Resident #2 could not remember the exact amount that AC had taken. In an interview on 12-03-2025 at 2:00 pm the CMA stated on 11-19-2025 while she passed medications, she heard the AC telling Resident #2 in Spanish not to tell anybody about the money. The CMA did not know the amount of money. The CMA stated she reported what she heard to the ADM the same on 11-19-2025. CMA stated she was in-serviced on abuse, neglect, and exploitation, and the last time was a couple of weeks ago. The CMA stated if she saw abuse, neglect or exploitation, she reported it to the ADM. In an interview on 12-03-2025 at 3:10 pm, the ADM stated Resident #2 told her on 11-19-2025 Resident #2 put AC on her bank account and then taken money from the account without Resident #2 permission. The money that was taken out was supposed to be for Resident #2's friend, but AC did not bring the money to Resident #2. The ADM talked to AC on 11/19/2025. The ADM stated on 11/20/2025, Resident #2's bank statements, dated 09/26/2025 to 10/25/2025 and 10/26/2025 to 10/29/2025, had both the AC's and Resident #2's names on the bank account. The transaction summary for money withdrawn from residents account were as follows: On 10/10/2025 for \$1,300 cash withdrawal, 10/18/2025 for \$3600 for a charge to a loan company 10/28/2025 for \$2,000 cash withdrawal, and 10/29/2025 \$3,350 cash withdrawal. On 11/21/2025, a certified letter was mailed to the address on file for AC, requesting the money be returned to Resident #2, but there was no response from AC. In-services on misappropriation were started for all staff, residents were offered psychiatric services, safe survey questions on residents' employee transported places conducted and no trends of abuse or neglect were found. Employee questionnaires were also conducted, and no trends of abuse or neglect found. ADM said Resident #2 took care of her own finances, so they did not know AC had taken the money. ADM stated that when they found out AC took money from Resident #2 they started their investigation and did a self report. Record review of AC employee file showed that AC was terminated from her employment at the facility on 11-20-2025. Record review of the facilities investigation report for their investigation of the misappropriation of funds. Record review of Resident #2 financial records that showed the withdraws of the funds from residents account, Record review of facility policy, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, revealed, 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including, but not necessarily limited to: facility staff. 2. Develop and implement policies and protocols to prevent and identify: Theft, exploitation or misappropriation of resident property. 4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: Been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; Had a finding entered into the</p>		