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	02/26/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse and neglect are reported immediately, but not later than 24 hours if the events that cause the allegation involve abuse and do not result in serious bodily injury for 1 of 3 residents (Resident #1) reviewed for abuse and neglect.The facility failed to ensure that CNA A reported allegation of abuse immediately, but no later than 24 hours to the ADM when Resident #1 reported that her roommate slapped her on her thigh to CNA A.This failure could result in continued abuse or neglect of residents, injury, and/or psychosocial harm.Findings included:Record review of Resident #1's face sheet dated 02/26/26 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of type 2 diabetes, mild protein-calorie malnutrition, hypertension, cerebral infarction (stroke) , monoplegia of upper limb (paralysis of arm), muscle weakness, unsteadiness on feet and lack of coordination.Record review of Resident #1's care plan dated 02/25/26 reflected Resident #1 experiences loneliness and /or isolation and the relevant intervention was, encouraging resident to express feelings of loneliness and isolation.Record Review of Resident #1's quarterly MDS dated [DATE] reflected BIMS score of 15 which indicated there was no cognitive impairment. Further review reflected Resident #1 had no physical, verbal or other behavioral symptoms directed towards others. Record review of the FRI dated 02/17/26 indicated that the SW reported to the ADM that, during a session on the same date, the LPC conveyed that Resident #1 had disclosed that her roommate had slapped her in the face approximately two weeks prior. However, when the ADM subsequently interviewed Resident #1, she stated that her roommate had hit her on the thigh several weeks earlier.Record review of the Provider Investigation Report dated 02/24/26 revealed that, during the facility investigation, it was documented that Resident #1 had reported to CNA A on 02/07/26 that she did not like her roommate because she had hit her in the past and CNA A had not reported the allegation to the AC at the facility.During an interview on 02/26/26 at 12:30 PM, the SW stated that on 02/17/26, the LPC informed him that Resident #1 had reported her roommate had hit her in the face. The SW also noted that the LPC mentioned Resident #1 had reported to her that she had informed CNA A and other staff members about the incident. The SW stated that he immediately reported the allegation to the ADM, who served as the AC at the facility.During an observation and interview on 02/26/26 at 12:30 PM, Resident #1 was observed lying in bed. She reported that she was satisfied with her current room and her new roommate. Resident #1 indicated that her previous roommate had been unkind and had taken her belongings, primarily food items brought in by her FM, without her permission. She stated that approximately a few weeks prior, when she confronted her former roommate about her behavior, the roommate responded by slapping her on the right thigh. Resident #1 reported that she disclosed the incident within a few days to multiple CNAs who worked with her; however, she did not recall their names. Resident #1 stated that she immediately reported the incident to the FM and further recalled informing CNA A about the incident several (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days afterward. She noted that, although no further incidents occurred, she did not feel safe remaining in the same room with her previous roommate. Resident #1 expressed that she felt more comfortable after moving to her current room.During a telephone interview on 02/26/26 at 1:34 PM, the FM reported that Resident #1 disclosed the incident to her the day after it occurred, during a visit. The FM stated she had reported the incident to a staff member working on the floor on the same day but was unable to recall the staff member's name or role within the facility. She further indicated that the ADM recently discussed the incident with her and instructed her to report any complaints, preferably directly to the administrator rather than to other staff members on the floor. The FM expressed that this approach was new to her, as she previously believed she could report concerns to any staff member. She noted that no injuries or visible harm resulted from the incident and expressed satisfaction that the facility took steps to relocate Resident #1 away from the alleged perpetrator. She added, however, it would have been better if the roommate was removed from the room rather than Resident #1 moving to a different room. The FM stated she was generally satisfied with the care and services provided to Resident #1 at the facility thus far.During an interview on 02/26/26 at 11:10 AM CNA A stated that approximately few weeks prior, while changing Resident #1, the resident indicated that her roommate had hit her at some point in the past. CNA A stated that she did not inquire about the specific timing of the incident, nor did she ask the resident for more details. She said that she initially took the report lightly, as Resident #1 was discussing other topics and laughed it off. She stated that Resident #1 reported to her that she had previously reported the incident to other staff members at the time that had occurred, though she did not disclose their names. CNA A explained she had chosen to not to report the incident to AC because of Resident #1's statement that she reported about the incident to other CNAs, also it was in the past, and the resident did not appear to be upset about it at the time. CNA A recognized the ADM as the AC and acknowledged that she later received a one-on-one in-service from the AC. She stated she understood that her failure to report the allegation was a mistake. CNA A stated she learned that any allegation of abuse, regardless of when it occurred, should be reported to the AC.During an interview on 02/26/26 at 2:30 PM, the DON reported that she learned of the allegation through the SW. The DON stated, the LPC had informed the SW that, on 02/17/26, during a session with Resident #1, the resident disclosed that her roommate had assaulted her approximately two weeks earlier by smacking her in the face. However, upon further inquiry by the ADM, Resident #1 clarified that her roommate had hit her on the thigh and not on the face, several weeks prior. The DON said, since the roommate did not want to move out of the room, they asked if she wanted to move rooms, Resident #1 expressed a desire to do so and was promptly relocated. The DON stated Resident #1 reported feeling safe at the facility and was satisfied with the room change. The DON said when the roommate was interviewed, she denied ever hitting Resident #1, stating that although they had disagreements, she had never physically assaulted her. She said, both residents were under psychiatric care, with no prior documentation of such incidents in their sessions. The DON stated, the psychiatric team continued to monitor and followed up with both residents and during a follow-up psychiatric assessment on 02/19/26, Resident #1 was specifically asked about the alleged assault. The DON said, Resident #1 did not confirm any physical aggression and instead focused on property disputes and reported feeling happier and safer in her new room. The DON said on 02/17/26 the FM of Resident #1 was contacted and informed of the incident and room change. The FM acknowledged that Resident #1 had previously mentioned being hit in the face but explained she did not report it because she was not hurt. The FM was advised of the importance of reporting such incidents promptly and verbally committed to doing so in the future, even for minor concerns. The DON stated, staff (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	questionnaires completed after the incident revealed that CNA A had briefly mentioned that Resident #1 had reported the incident weeks earlier to her, noting it as a distant past event. The DON stated that CNA A said she did not report this incident to anyone in the facility as the incident had happened in the past. A one-on-one in-service was conducted with CNA A emphasizing the necessity of reporting all potential abuse, regardless of timing, to ensure proper documentation and investigation per facility policy. The DON stated she performed a comprehensive skin assessment on both residents, confirming no abnormalities from baseline. The DON said she conducted resident safety surveys to all residents in the 800 hall, including Resident #1, which showed no concerning trends. Additionally, staff training sessions on abuse, neglect, reporting procedures, and de-escalation techniques for residents with behavioral issues were implemented to improve staff awareness and response. When the investigator clarified that the FM was instructed by the ADM to report incidents directly to the administrator rather than to floor staff, the DON stated that this was inappropriate. She emphasized that residents and their families had the right to report concerns to any staff member, and it was the staff member's responsibility to escalate and report such complaints to the appropriate authority.An interview with ADM on 02/26/26 at 2:30pm was unsuccessful as she was on leave and was not accessible via mobile phone.Record review of in-service dated 02/17/26 reflected in-service was conducted with all staff over topic of Reporting abuse and neglect when anyone reports abuse or neglect regardless of time frame. All incidents should be reported to abuse coordinator. De-escalation techniques for residents with behaviors. It was also revealed that CNA A received a separate 1:1 in-service on the same subject on 02/17/26, from the AC.Record review of facility policy Abuse, Neglect, Exploitation and Misappropriation prevention program revised in April 2021 reflected: Reporting Allegations to the Administrator and Authorities:If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 3.Immediately is defined as:n. within two hours of an allegation involving abuse or result in serious bodily injury; orb. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.