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	04/17/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47243 Based on observation, interview, and record review, the facility failed to ensure the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 (Resident #63) of 5 residents reviewed for resident rights. The facility failed to offer language assistance services or interventions to communicate with Resident #63 who had limited English proficiency. These failures affected the residents at risk of a lack of a dignified existence, self-determination, and quality of life Review of Resident #63's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of diabetes mellitus (a condition where the body either doesn't produce enough insulin or can't effectively use the insulin it makes) with other diabetic arthropathy (a progressive joint disorder that can occur in individuals with diabetes and peripheral neuropathy), cognitive communication deficit (difficulties with communication caused by problems with underlying cognitive process like attention, memory or reasoning, rather pan problems with language or speech production) and need for assistance with personal care. Review of Resident #63's care plan reflected a problem edited on 10/14/24 category communication, Resident #63 does not speak the dominant language of the facility, Resident #63's dominant language is Spanish, a goal dated 10/14/24 Resident #63 will establish a reliable means of communication as evidenced by visual cues and hand gestures, and interventions date 01/12/24 of encourage resident to use signs/gestures/sounds, and flash cards when expressing self, if a family member or friend is present that speak/understands language, get permission to call them when needed and post names and phone number numbers in front of chart, provide visual cueing, and interpreter to enhance communication. Review of Resident #63's most recent MDS, dated [DATE], reflected a BIMS score of 13, indicating cognition was likely intact and suggested that the person was capable of normal cognition and may have needed minimally tailored support for memory and cognitive tasks. Section A - Identification Information Language response to What is your preferred language? reflected English and response to Do you need to or want an interpreter to communicate with a doctor or health care staff? Reflected no. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/15/25 at 11:50 am of Resident #63 revealed English speaking only surveyor and Spanish speaking Resident #63 were not able to communicate. Resident #63 was speaking in Spanish and did not understand the questions surveyor was asking him in English. No paper or communication board to facilitate translation between English or Spanish was observed next to Resident #63 or on the walls next to Resident #63's bed. Observation at 04/17/25 at 11:05, reflected when Resident #63 was shown the communication board that was given to the surveyor by the Administrator as the tool staff used to communicate with Resident #63, Resident #63 made no sign of comprehension or understanding that surveyor attempted to use the paper to help with communication. Surveyor pointed to the section of the paper that reflected a series of faces beginning with the number 10 and beside it a crying face and ending with the number 0 beside it a happy face. Surveyor pointed to a circle with a face enclosed that said in English ANXIOUS/SCARED and in Spanish ANSIOSO(A)/ASISTADP(A) and Resident #63 made no response and did not point to any other areas on the communication board. Interview on 04/17/25 with CNA A at 11:42 am revealed he did not speak Spanish and had helped Resident #63 a lot using the mechanical transferring lift and revealed he felt that Resident #63 could not do a lot for himself. CNA A said if he needed to tell Resident #63 something, he had a Spanish speaker come in and help him. Interview on 04/17/25 with SC MA at 9:52 am revealed she did not speak Spanish there were no Spanish speaking staff members at night and she did not find Resident #63's communication tool useful. SC MA she said she could understand if Resident #63 was in pain, and she would let the nurse know, but she could not communicate with him his level of pain using the communication board, she said the communication board was useless. Interview on 04/17/25 with CNA C at 9:57 am revealed he was not a Spanish Speaker and when he worked with Resident #63, he always tried get someone who spoke Spanish to help with communication when he assisted Resident #63. CNA C said he had tried using the communication board with Resident #63, but it did not appear to him that Resident #63 understood the communication board and it did not help his communication with Resident #63. He said it was a problem when you could not communicate with Resident #63 because you could not tell explain to him what you were going to do when assisting him and Resident #63 could not express his needs. Interview on 04/17/25 with CNA C at 10:05 am revealed she did not speak Spanish, and Resident #63 was not able to point to the communication board, but she did a lot of pointing and used sign language. She said that if he was hurting, he pointed and pulled at his sock and said, yea, yea, yea and she reported this to the nurse. She said she did not think the communication board was effective because he was not able to communicate his level of pain. She said the communication board was ineffective, when she tried to use it with him, he would stare at her blankly. Interview on 04/17/25 with LVN A at 10:17 am revealed she did not speak Spanish and when she gave Resident #63 medication and he looked like he was in pain, she would find a Spanish speaker to assist with communication. She said there were no Spanish speakers on the night shift. She said she saw the communication board, and it [was] just sitting there and she did not use it because she felt she was sufficiently communicating with him and did not feel the communication board would be effective. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/25 with CNA D at 6:02 pm revealed she worked the evening shift and worked with Resident #63 and did not speak Spanish. She said she used sign language to communicate with Resident #63 she found it very helpful. She said she would point, and he would nod his head. She said there were no bilingual staff members on the evening shift but if she had a problem communicating with him, she would call a Spanish speaking staff member for assistance. She said she has not called a Spanish speaking staff member to help with Resident #63 because she had not needed to. She does not think he has pain, and she has not experienced how she would ask him his level of pain. She said she thought it was important to effectively communicate with residents because it could be a fall risk if you could not communicate with residents effectively. Interview on 04/17/25 with the DOR at 1:45 PM revealed she was responsible for the communication with residents with communication needs and was responsible for Resident #63's communication board, was Resident #63's occupational therapist, and was a Spanish speaker. The DOR said she communicated with Resident #63 fine, because she was a Spanish speaker. She revealed that no one working the evening shift spoke Spanish and this lack of communication concerned her because of the lack of ability to effectively communicate with Resident #63. She said she felt that his needs were being meet because his main nurses knew when he was in pain. Interview on 04/17/25 with the DON at 5:47 PM revealed it was the right of a resident to have communication access to people and services and if there was not a Spanish speaker available for Resident #63 the facility would need to provide a communication board. She said she knew there was no Spanish speaking staff member in the evening but, that they had a bilingual Spanish speaking admission coordinator who, nine times out of 10, they could call if they needed her to translate. She said the negative impact of not being able to understand what Resident #63 was asking would be that he could not communicate his needs and might get up out of bed and fall and have a bad injury. Interview on 04/17/25 with the Administrator at 6:09 PM revealed it was important for the resident to be able to communicate in the language they preferred, it was a resident right. The Administrator said evening staff did have the ability to contact by phone someone who spoke Spanish as well as having the use of the communication board to communicate with Resident #63. The Administrator said, when she was told that Resident #63 was not communicating when the surveyor used the communication board to ask questions, that Resident #63 did not want to participate, and she felt like his needs were being met. She said the negative impact of residents not being about to communicate would that the facility would not be able to meet the residents' care planned needs including communicating about residents' pain levels. Review of facility resident rights policy dated February 2021 reflected: Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guaranteed certain basic rights to all residents of this facility. These rights include the residence rights to; Communication within access to people and services both inside and outside the facility. Surveyor requested facility policy related to residents who are non-English speaking, and no policy was produced.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47243 Based on observation, and interviews, the facility failed to keep residents' information secure. This constitutes a failure to protect residents' personal and medical records and violated HIPAA regulations for 1 of 1 laptop. Because of this the facility was in a deficient practice. facility laptop was left open and unattended on a medication cart in the hallway with residents' personal medical information visible to anyone who passed by on 05/17/2025 while the medication aid was in a resident's room. These failures could place residents at risk of having their private information changed or viewed and not kept secure. Findings included: Observation on 05/17/2025, reflected that a staff member left the medication cart laptop open and unsupervised in a resident care area. The laptop screen displayed confidential resident information, accessible to unauthorized individuals. - Interview on 4/17/2025 at 2:37 PM, MA B stated that if the laptop was left open, residents or others could access information on the resident and possibly change the information. MA B said that this would be a HIPAA violation. MA B has been in-service on resident rights and HIPAA policies. - Interview on 4/17/2025 at 2:43 PM, MA A stated that leaving a laptop open could allow someone to change a resident's information, which could harm the residents. MA A said that this was a HIPAA violation. MA A said that she has seen other staff leave laptops open. MA A said that she has been in-service on resident rights and HIPAA. - 4/17/2025 @ 2:55 PM, RN stated that staff are expected to close the laptop when not near it. RN said leaving the laptop open could result in someone walking by accessing or altering resident information. RN confirmed that this is a HIPAA violation and that he has been trained on residents' rights and HIPAA policy. - 4/17/2025 @ 5:33 PM, DON stated that no staff should leave the laptop open and unattended with residents' information on the screen. DON said that leaving the laptop open is a HIPAA violation. DON said that someone could access or change a resident's information if the laptop is left open. DON reported receiving HIPAA and resident rights in-service training. DON said that she has not seen any staff leaving the tablet open. DON said that if she sees a laptop open, she will correct staff immediately if she sees a laptop left open. - 4/17/2025 @ 5:43 PM, ADM said no staff should leave the laptop unattended with residents' information. The ADM said that if a laptop is left unattended, anyone could access it, allowing resident information to be visible to unauthorized individuals. The Administrator stated she has not personally seen staff leaving laptops open. If ADM sees a laptop open, she will shut the laptop and initiate in-service training for all staff regarding this policy.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47243 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Resident's #13, 14, 17) of five residents reviewed for oxygen use and storage. The facility failed to ensure Resident's #13, 14, 17 nebulizer masks were documented when they were changed. This deficient practice could place residents receiving oxygen therapy at risk for infection. Findings include: Review of Resident #13's Admission Record, dated 04/16/25, reflected a [AGE] year old female who was admitted into the facility on [DATE] with diagnosis including Diabetes Mellitus due to underlying condition with Diabetic Neuropathy (a condition that occurs when the body develops insulin resistance and no longer responds effectively to insulin), Rheumatoid Arthritis (an ongoing, called chronic, condition that causes pain, swelling and irritation, called inflammation, in the joint), Sleep Apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). Review of Resident #13's Annual MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated she was cognitively intact. Review of Resident #13's Care Plan, dated 03/13/25, reflected she had a diagnosis of SOB due to weight related to asthma, oxygen via nasal cannula in use. Problem start date 08/22/2023. Review of Resident #13's Order Summary Report, dated 04/16/25, reflected Resident #13 had the following active orders: Oxygen continuously via Nasal Cannula. May titrate between 2-5 LPM for shortness of breath or pulse oximetry < 90% every shift for SOB and to maintain pulse ox > 90% dated 4/16/2025; Change O2 tubing/water every week and PRN every night shifts every Sun for o2 dated 4/16/2025 to start 4/20/2025; [Oxygen, Nebulizer, CPAP, BPAP] tubing and delivery device (mask, nasal cannula) is to be stored in bag when not in use every shift for sob started 4/16/2025 discontinued on 4/17/2025; Change nebulizer tubing and mask every week every night shift - every night shift every Mon for o2 dated 4/21/2025 ordered 4/16/2025. Review of Resident #14's Admission Record, dated 04/16/25, reflected a [AGE] year-old female who was readmitted into the facility on [DATE] with a diagnosis including: End Stage Renal Disease (a severe condition where the kidneys have lost their ability to filter waste and excess fluid from the blood, necessitating dialysis or a kidney transplant to sustain life), Essential (Primary) Hypertension (high blood pressure where no underlying secondary cause has been identified), Acute on Chronic Systolic (Congestive) Heart Failure (situation where a previously established, chronic heart failure condition (systolic) is suddenly exacerbated by a new event, leading to a worsening of symptoms and heart function). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's Annual MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated she was cognitively intact. Review of Resident #14's Care Plan, dated 04/01/25, reflected she had a diagnosis of Acute on Chronic Systolic (Congestive) Heart Failure, Insomnia, Unspecified, Embolism and Thrombosis of Unspecified Parts of Aorta. Review of Resident #14's Order Summary Report, dated 04/16/25, reflected Resident #13 had the following active orders: Oxygen orders: O2 @ 2 l VIA NC PRN SOB or O2 sat <90% (88% if COPD/emphysema) do not exceed 4 L without physician approval if resident is on continuous O2, check O2 sat q shift. change O2 tubing and humidifier bottle Q WK as needed for SOB dated 4/16/2025; Change O2 tubing/water every week and PRN every night shifts every Sun for oxygen dated 4/16/2025 with a start date 4/20/2025; Oxygen tubing and delivery device (mask, nasal cannula) is to be stored in bag when not in use every shift dated 4/17/2027; Oxygen at 2-4 LPM via nasal cannula as needed for SOB and to maintain pulse ox > 90% Every shift dated 4/17/2025. Review of Resident #17's Admission Record, dated 04/16/25, reflected a [AGE] year-old male who was admitted into the facility on [DATE] with a diagnosis including: Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (a situation where a person has type 2 diabetes and has developed diabetic polyneuropathy, a condition characterized by damage to multiple nerves throughout the body due to long-term high blood sugar levels), Sepsis, Unspecified Organism (a diagnosis where a patient is experiencing the severe inflammatory response to infection (sepsis), but the specific infectious agent (like a particular bacteria or virus) causing the infection has not been identified), Chronic Obstructive Pulmonary Disease, Unspecified (COPD) (a lung disease that makes it difficult to breathe, causing shortness of breath, wheezing, and a persistent cough). Review of Resident #17's Annual MDS, dated [DATE], reflected he had a BIMS score of 14, which indicated he was cognitively intact. Review of Resident #17 's Care Plan, dated 04/01/25, reflected he had a diagnosis of requires oxygen therapy related to Hypoxemia. Change canula or mask and tubing as per facility protocol and prn, also administer oxygen as ordered dated 2/24/2025. Review of Resident #17's Order Summary Report, dated 04/16/25, reflected Resident #13 had the following active orders: Oxygen Orders: O2 @ 2 L Via Nc Prn Sob or O2 Sat <90% (88% If COPD/Emphysema) Do Not Exceed 4 L without Physician approval if Resident is on continuous O2, Check O2 Sat Q Shift. Change O2 Tubing and Humidifier Bottle Q WK as needed for SOB dated 4/16/2025; Check Oxygen Concentrator filter for placement and clean filter every week and PRN every night shift every Sun for O2 dated 4/16/2025; Change nebulizer tubing and mask every week every night shift every Mon for O2 dated 4/16/2025; Oxygen and Nebulizer, tubing and delivery device (mask, nasal cannula) is to be stored in bag when not in use every shift O2 dated 4/17/2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident #13 on 04/16/25 at 10:33 a.m. reflected Resident #13 cannula was dirty and appeared to not have been changed. There was no date on the cannula as it is not required. Per record review of their EHR on 4/17/2025, there was no documentation that reveal the cannula had been changed. Administrative staff stated they were in the process of changing their EHR and they are still carrying over information from their previous system as of 4/17/2025. During an interview on 04/16/25 at 11:45 a.m., Resident #13 was asked when the last time was the cannula changed? Resident #13 stated it was changed it on 4/13/2025. Resident #13 roommate which was also her mother, Resident #6 stated it had been longer than 4/13/2025 since the cannula had been changed but did not have an exact date. During an interview on 04/17/25 at 4:35 p.m. with MA B /Staffing Coordinator when asked who was responsible for changing the nasal cannula and she stated the nurses were responsible. She stated she doesn't know their routine but most places they have to be changed every Sunday. She stated the negative affect could happen if their airway could be blocked and not get proper clean air. During an interview on 4/17/2025 at 4:55 PM with LVN A when asked who was responsible for changing the nasal cannula and she stated all nurses can do it. She stated it should be changed every Sunday or as needed. She stated if it was not changed the cannula can get clogged and particles can accumulate in there. The nursing staff was supposed to rinse them out when done. She stated once it is changed, it should be documented. During an interview on 4/17/2025 at 5:25 with the DON A when asked who was responsible for changing the nasal cannula and she stated it should be changed by the nursing staff. She stated it should be changed every Sunday or as needed. She stated if not changed, it could cause infection or death. She stated once it is replaced, it should be documented in the MAR. During an interview on 4/17/2025 at 5:40 p.m. with RN A when asked who was responsible for changing the nasal cannula and he stated the nursing staff. He stated all CNA's, LVN's, and RNs could change them. He stated there was a pop up now in the EHR for a task for the nurses. He stated it should be changed every Sunday. It could get dirty and cause an infection, cause skin breakdown of the skin, get clogged and dirty. If it was clogged, the Residents would not breathe clean air. He stated once they change them, they just throw them away and attach a clean nasal cannula. He stated once it popped up, they perform the duty and document. He stated it was a weekly task for the nurses. Review of the facility's Oxygen Therapy Administration policy, undated, reflected: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration .Weekly documentation. 1. Oxygen/nebulizer tubing/masks to be changed by nursing department, weekly, and documented in the electronic health record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on observation, interview, and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for one (Resident #63) of four residents reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #63 received his Acidophilus (bacterium found in the mouth) on 04/11/25, 04/12/25, and two times on 04/15/25. This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements, could result in worsening or exacerbation of medical conditions. Findings included: Review of Resident #63's face sheet reflected an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of diabetes mellitus (a condition where the body either doesn't produce enough insulin or can't effectively use the insulin it makes) with other diabetic arthropathy (a progressive joint disorder that can occur in individuals with diabetes and peripheral neuropathy), cognitive communication deficit (difficulties with communication caused by problems with underlying cognitive process like attention, memory or reasoning, rather pan problems with language or speech production) and need for assistance with personal care. Review of Resident #63's care plan problem dated 10/14/24 reflected category pain Resident #63 is at risk for alteration in comfort and or pain related to chronic pain with a goal dated 10/14/24 of Resident #63 will be able to verbalize pain and or discomfort at an acceptable level on a daily basis and interventions dated 10/12/24 of administer medications as ordered and monitor for side effects and effectiveness, assess characteristics of pain (location, duration, quality, radiation, intensity) and document, and reposition frequently as needed to promote comfort. Review of Resident #63's most recent MDS, dated [DATE], reflected a BIMS score of 13, indicating cognition was likely intact and suggested that the person was capable of normal cognition and may have needed minimally tailored support for memory and cognitive tasks. Review of Resident #63's MAR for April 2025 Acidophilus (bacterium found in the mouth) oral capsule give 1 capsule by mouth three times a day for balance bacteria was not administered on PM on 04/11/25, 04/12/25, 04/15/25, and HS on 04/15/25. On 04/17/25 at 3:45 PM attempted to interview MA A who worked the PM 04/11/25, 04/12/25, 04/15/25, and HS on 04/15/25 for an interview regarding Resident #63's medication administration for Acidophilus by leaving voices mails, no response was received from MA A. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/17/25 with MA B at 5:30 PM she said she, as a medication aide, had the responsibility to document when medications were given to residents. She said that the rule was, if you did not chart in the MAR that you dispensed the medication to a resident, it was considered that the medication was not given to the resident. The negative effect of not charting that medication was administered would be that you don't know if the medication was given and if the resident was sent to the hospital and it was not documented, and the resident was administered the medication again, the resident might overdose. She stated it was the responsibility of the person who administered the medication to make sure it was documented in the MAR. In an interview on 04/17/25 with RN A at 5:55 PM he stated, after he was shown Resident #63's MAR for April 2025 it did not look like the Acidophilus (bacterium found in the mouth) oral capsule give 1 capsule by mouth three times a day for balance bacteria was administered on PM 04/11/25, 04/12/25, 04/15/25, and HS on 04/15/25. RN A said he followed the rule that if you did not chart it in the MAR, the medication was not administered. He said the negative impact of not charting medication administration was that you had nothing to show that you administered the medication to the required resident and did not give it to someone else. He said it was not good practice not to chart when you give medication, and it was the responsibility of the medication aide and the nurses to chart when medication was given to a resident. In an interview on 07/17/24 with the DON at 5:47 PM she stated, after she was shown Resident #63's MAR for April 2025, it did not look like Resident #63 received the Acidophilus (bacterium found in the mouth) oral capsule give 1 capsule by mouth three times a day for balance bacteria on PM on 04/11/25, 04/12/25, 04/15/25, and HS on 04/15/25. She said it was the ADON's responsibility to make sure that medications are charted by the staff who administer medications and a possible negative affect of not administering medication is that a medication could be given too soon, or a double dose of the medication could be administered if it was not documented that the resident received the medication. Review of facility administering medications policy dated April 2019 reflected medications are administered in a safe and timely manner as prescribed. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frames. Medication errors are documented, reported and reviewed by the QAPI committee to inform process changes and/or the need for additional staff training. Medications are administered within one hour of their prescribed time, unless otherwise specified. As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered, the dosage, the route of administration, and the signature and title of the person administering the drug.