

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Oaks Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 University Ave Lubbock, TX 79413	

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. (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 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their own established smoking policy for 1 of 7 residents reviewed for smoking. (Resident #1)The facility failed to ensure Resident #1 followed the smoking policy and did not have smoking supplies (cigarettes and lighter) at his bedside. This failure could place residents at risk of injury or harm.Findings included:Record review of Resident #1's face sheet undated indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses which included Parkinsons (brain disorder), anxiety (feeling of fear and worry), hypertension (high blood pressure) and weakness.Record review of Resident #1's annual MDS assessment dated [DATE], indicated he had a BIMS score of 14, which indicated he had intact cognition. The MDS indicated Resident #1 was independent or needed set-up/clean-up assistance for most ADLs. The MDS indicated Resident #1 was using tobacco at the time of the assessment.Record review of Resident #1's Care Plan Report dated 09/12/25 indicated he enjoys smoking at times. The goal was Resident #1 will keep all cigarettes and lighters locked at the nurse's station and will only smoke during scheduled smoke times with a staff member present. Record review of Resident #1's Safe Smoking assessment dated [DATE] indicated Resident #1 had demonstrated the ability to safely smoke with other interventions - needs a staff with him to monitor him. During an observation and interview on 11/15/25 at 11:50 am with Resident #1, revealed he was lying in bed with headphones on. An observation revealed there were no smoking supplies seen on bedside table, nightstand or sink counter. Resident #1 stated that he was a current smoker. He stated he did have cigarettes and lighter in his room. He stated he kept his cigarettes and lighter in the black bag on his walker. Observation revealed the walker with black bag was in the room by the sink. He stated he walked to the smoking area to smoke. He stated there were certain smoking times during the day and staff were always present when he smoked. He stated he only went to smoke during smoking times. He stated he was not told he could not keep smoking supplies in his room. He stated he only kept them in his black bag on his walker. During an observation on 11/15/25 at 12:05 pm revealed Resident #1 went to his walker and unzipped the black bag on the walker. Observed in the black bag there was one cigarette pack and one lighter. Resident #1 zipped the bag closed and placed the walker in front of the sink area in the room. During an observation on 11/15/25 at 01:40 pm revealed residents outside in the smoking area smoking. MA A was supervising the residents. Observed a blue smoking supply box sitting on the ground beside MA A. Resident #1 was sitting in a chair smoking with his walker in front of him. During an interview on 11/15/25 at 01:42 pm with the DON, she stated per the smoking policy residents were not allowed to have smoking supplies in their room. She stated she had received training on the smoking policy, and all staff had been trained on the facility smoking policy. She stated she was not aware Resident #1 had smoking supplies in his room. She stated she had not seen any smoking supplies in residents' rooms. She stated she expected staff to follow the smoking schedule and go out with residents to smoke. She stated the purpose of the smoking policy was to keep all residents safe. She stated the potential negative outcome could be a resident starting a fire. During an interview on 11/15/25 at 01:50 pm with MA A, she stated she did not normally supervise residents while smoking but the other staff were busy with resident care. She stated Resident #1 had his cigarettes in his black bag on walker. She stated she had been trained on the smoking policy. She stated Residents were not allowed to keep smoking supplies in room or on person. She stated she did not take smoking supplies from the resident. She stated she had not reported the incident to the ADM or the charge nurse because she had just come in from supervising the residents. During an interview on 11/15/25 at 02:30 pm with the ADM, he stated per the facility policy residents were not allowed to have smoking supplies in their rooms. He stated, I cannot search their room and keep them from going to the store next door. He stated the smoking policy was changing from the old company to the new company. The ADM looked at the smoking policy provided by the DON and stated Yes, that is the new one. He stated the convenience store was so close that the residents signed themselves out and got what they wanted. He stated, I cannot police all that. He stated he was not aware of any residents with smoking supplies in their rooms. He stated he was not aware Resident #1 had smoking supplies in his room. He stated Resident #1 was aware of the smoking policy and items not allowed in resident rooms. He stated no one had reported to him seeing smoking supplies in resident's room. He stated SW kept Resident #1 cigarettes in her office locked up because he bought seven cartons at one time. He stated he was not sure if he got a pack from SW or what. He stated residents were told on admission that</p>		