STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675909	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER: Harker Heights Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 415 Indian Oaks Dr, Harker Heights, TX 76548	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 1 (Resident #1) of 5 residents reviewed for pain recognition and management. The facility failed to ensure staff accurately assessed Resident #1's pain levels after falls in January and February 2025. Staff used a numerical pain scale instead of a pain ad assessment on Resident #1, who was unable to verbalize his pain level. This deficient practice could place residents at risk of serious injury, pain, being misdiagnosed , receiving improper care and services, not treated timely, effectively, and consistently. Findings included: Review of Resident #1's Admission Record, dated 02/14/25, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had medical diagnoses that included unspecified cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue to die due to a lack of oxygen and nutrients), unspecified epilepsy (a chronic brain disorder that causes seizures, which are sudden bursts of electrical activity in the brain), repeated falls, and unspecified dementia (a decline in thinking, memory, and reasoning that impacts daily life). Review of Resident #1's Significant Change MDS Assessment, dated 10/29/24, reflected he had BIMS score of 00, which indicated he had severe cognitive impairment. Section J (Health Conditions) reflected he did not have pain within the last 5 days of the assessment. Review of Resident #1's BIMS Evaluation, dated 01/27/25, reflected he had a 3 BIMS, which indicated he had severe cognitive impairment. Review of Resident #1's Care Plan, dated 02/06/25, reflected he had memory problems and was at risk for further decline in his cognition that may affect his ability to communicate his needs/wants. His care plan also noted that he was unable to make even simple decisions without assistance due to his dementia and he was unable to safely make important decisions due to his short- and long-term memory problems. His care plan noted that he was also at risk for experiencing discomfort or pain. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Pain Level Summary, from 01/01/25 through 02/14/25, reflected 21/23 entries were numerical pain assessments, from 01/01/25 at 6:15 p.m. through 01/29/25 at 12:20 a.m., 10/11 entries were numerical pain assessments, from 01/29/25 at 12:35 a.m. through 01/29/25 at 7:25 a.m., 32/34 numerical pain assessments, from 01/29/25 at 7:34 a.m. through 02/06/25 at 11:00 p.m. and 18/20 entries were numerical pain assessments, from 2/07/25 at 1:00 a.m. through 02/14/25 at 10:21 a.m. All numerical pain assessments that were documented indicated Resident #1's pain level was 0/10. Review of Resident #1's Post-Fall Review, dated 01/29/25 at 4:16 a.m., reflected RN A asked Resident #1 how he felt and if he was hurting anywhere after his unwitnessed fall and his response to both questions was good. Review of Resident #1's Neuro Checks, dated 01/29/25 at 7:10 a.m., reflected 2 pain Ad assessments were used and 19 numerical pain assessments were used to measure Resident #1's pain levels. RN A, LVN B, LVN C and other nurses used the numerical pain assessment on Resident #1 and indicated his pain level was 0/10. Review of Resident #1's Lookback Documentation Support by LVN B, dated 01/29/25 at 9:21 a.m., reflected he was severely impaired in decision making skills, forgetful/confused in his memory, and sometimes could make himself understood. Resident #1 was alert and oriented x2 with periods of confusion. Review of Resident #1's Post-Fall Review by LVN C, dated 02/06/25 at 4:45 p.m., reflected he had an unwitnessed fall. Review of Resident #1's Neuro Checks, dated 02/06/25 at 4:45 p.m., reflected 2 pain Ad assessments were used and 25 numerical pain assessments were used to measure Resident #1's pain levels. LVN B, LVN C, and other nurses used the numerical pain assessment on Resident #1 and indicated his pain level was 0/10. Review of Resident #1's Change in Condition Evaluation by LVN C, dated 02/06/25 at 4:47 p.m., reflected he had a fall on 02/06/25 in the morning and he was confused and forgetful. Review of Resident #1's Change in Condition Evaluation by ADON E, dated 02/11/25 at 4:53 p.m., reflected he had a fall on 02/11/25 at night, he had a large hematoma to his right forehead that did not grow, and he had frequent falls due to his impaired memory and safety awareness. ADON E asked Resident #1 if he was in pain and he said, Yes pain. ADON E indicated Resident #1 was also unable to rate his pain scale. Review of Resident #1's Progress Notes reflected fall incidents from 01/01/25 through 02/11/25 noted that he denied pain. A note by ADON D on 02/11/25 at 5:05 p.m. reflected he denied pain, had a laceration to his left eye and hematoma to the right side of his forehead due to a fall, and was sent to the hospital emergency room . During an interview on 02/14/25 at 11:19 a.m., the Regional Nurse stated nurses were responsible for assessing residents' pain. The Regional Nurse stated nurses used the pain ad assessment on a resident who was cognitively unable to tell them that they were in pain. The Regional Nurse stated nurses used the numerical pain assessment on a resident who was cognitively able to tell them that they were in pain and what their pain level was. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/14/25 at 12:32 p.m., LVN C stated nurses were responsible for assessing residents' pain. LVN C stated she was trained and in-serviced on pain recognition and management every 2-3 months by the Regional Nurse or one of the ADONs. LVN C stated she could not remember when she was most recently in-serviced on pain recognition and management. LVN C stated nurses used the numerical pain assessment on cognitive residents and pain ad assessment on cognitively impaired residents. LVN C explained she knew not all residents could tell nurses what their pain level was, nurses could not use the numerical pain assessment on residents who could not tell them what their pain level was, and to use the pain ad assessment and observe for non-verbal pain signs and symptoms on residents who could not tell her what their pain level was. LVN C stated she worked with Resident #1 and knew he could not tell her what his pain level was due to his dementia. When asked why she used a numerical pain assessment on Resident #1, LVN C said, Because it might have been a mistake. LVN C stated she knew it was important to use the proper pain assessment tool on residents and said, Because something could be wrong with the resident and there could be a serious injury because the nurse used the wrong pain assessment tool. During an interview on 02/14/25 at 12:55 p.m., LVN B stated nurses were responsible for assessing residents' pain. LVN B stated she was trained and in-serviced on pain recognition and management by the Regional Nurse about 3 weeks ago or 1 month ago. LVN B stated nurses used the numerical pain assessment on residents who were alert, oriented, and could verbalize what their pain level was. LVN B stated nurses used the pain ad assessment and observed for nonverbal cues, such as facial grimacing, touching, and moaning, and vitals on residents who could not verbalize what their pain level was. LVN B stated she worked with Resident #1 and knew Resident #1 could tell her if he was in pain. When asked why she used a numerical pain assessment on Resident #1, LVN B stated she did not know and that she believed his electronic health record prompted her to use the numerical pain assessment on him. LVN B stated she knew it was important to use the proper pain assessment tool on residents and said, Because it determined how much pain a resident was in. An attempt to call RN A was made on 02/14/25 at 1:18 p.m. for an interview. A voicemail and call back number were left. RN A did not return the call before exit. During an interview on 02/14/25 at 1:27 p.m., CNA F stated nurses were responsible for assessing residents' pain. CNA F stated she was not trained and in-serviced on pain recognition and management. CNA F stated she knew to report to a nurse whenever a resident expressed they were in pain. CNA F stated she also knew to observe for injuries, tenderness and nonverbal pain signs and symptoms and notify a nurse whenever a resident could not express they were in pain. CNA F stated she worked with Resident #1 and knew he required a pain ad assessment because he could not verbalize what his pain level was. CNA F stated she knew it was important to use the proper pain assessment tool on residents and said, Because some residents could verbalize pain and some residents could not verbalize pain. Residents could receive the wrong care if nurses did not use the proper pain assessment tool. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/14/25 at 1:51 p.m., CNA G stated nurses were responsible for assessing residents' pain. CNA G stated she was not trained and in-serviced on pain recognition and management. CNA G stated she knew to report to a nurse whenever a resident expressed they were in pain. CNA G stated she also knew to observe for facial expressions, grunting, and sounds and notify a nurse whenever a resident could not express they were in pain. CNA G stated she worked with Resident #1 and knew he required a pain ad assessment because he could not verbalize what his pain level was. CNA G stated she knew it was important to use the proper pain assessment tool on residents and said, Because to determine the accurate pain levels and if a resident needed to be sent out to the physician. Residents could still be in pain, misdiagnosed and have further complications if the improper pain assessment tool was used. During an interview on 02/14/25 at 2:00 p.m., ADON E stated floor and charge nurses were responsible for assessing residents' pain. ADON E stated she was trained and in-serviced on pain recognition and management. ADON E stated she could not remember when she was most recently in-serviced on pain recognition and management. ADON E stated floor and charge nurses used the pain ad assessment and observed for grimacing, crying and behaviors on residents who could not verbalize what their pain level was. ADON E stated floor and charge nurses used the numerical pain assessment on residents who could verbalize what their pain level was. ADON E stated she worked with Resident #1 and knew at times he was verbal and could have minor conversations. ADON E stated Resident #1 could tell her if he was in pain, but he could not express or identify where the pain was and what his pain level was. ADON E stated she knew Resident #1 required a pain ad assessment. ADON E stated she knew it was important to use the proper pain assessment tool on residents and said, Because staff needed to advocate for residents' pain because some residents could verbalize pain and some residents could not verbalize pain, and to get the correct diagnoses, administer proper medication and determine if the resident needed to be sent out to the hospital. During an interview on 02/14/25 at 3:54 p.m., the Regional Nurse stated she in-serviced staff on several topics and could not remember when she specifically in-serviced staff on pain recognition and management. The Regional Nurse stated Resident #1 could verbalize if he was in pain, but he could not verbalize the severity of his pain due to his dementia. The Regional Nurse stated she knew it was important to use the proper pain assessment tool on residents and said, Because staff would be able to determine the severity of pain and treatment to provide. The surveyor requested a copy of the facility's Accuracy of Assessments policy and procedure. During an interview on 02/14/25 at 4:28 p.m., the Regional Nurse stated the facility did not have an Accuracy of Assessments policy and procedure. Review of Resident #1's Pain Management policy and procedure, revised February 2023, reflected, Compliance Guidelines: To assess the resident pain control and management needs at admission/readmission, quarterly, annual, and when a change in condition indicates a need for initiating or modifying pain management program for residents. The goal of the community Pain Management Program is that pain is identified and treated timely, effectively, and consistently.