

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 08/11/2025
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)
<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure that the resident environment remained safe, clean, comfortable, and homelike including keeping the facility comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, must maintain a temperature range of 71 to 81 F; for 1 of 1 memory care unit. The facility failed to maintain comfortable and safe temperature levels in the memory care unit when the local temperatures were at 97 Degrees Fahrenheit (F) and the temperature inside the memory care unit was 93 degrees (F) on 08/09/2025. An IJ was identified on 08/09/2025. The IJ template was provided to the facility on [DATE] at 8:47pm. While the IJ was removed on 08/11/2025, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because (e.g.) all staff had not been trained on temperatures and hydration. This failure could affect residents result in discomfort, hyperthermia, a decline in health and/or death. Findings Included: Resident #1 Record review of Resident #1's face sheet dated 08/09/2025 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnosis included cerebrovascular disease (a range of conditions that affect the blood flow to the brain), dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), vascular dementia (lack of blood that carries oxygen and nutrients to a part of the brain), Seizures, hypertension (high blood pressure), and history of falling. Resident #2 Record review of Resident #2's face sheet dated 08/09/2025 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2's diagnosis included hyperlipidemia (high cholesterol), dementia (memory, thinking, difficulty), need for assistance with personal care, unsteadiness on feet, muscle weakness and hypertension (high blood pressure). Observation of memory care 600 hall dining room on 08/09/2025 at 4:51pm revealed there were 16 residents sitting in the dining room eating dinner. Some residents appeared to be hot (skin flushed and sweating). The residents were eating their dinner none were complaining at the time of being hot. The temperature in the room was 93 degrees according to the thermostat. Observation of the 700-hall memory care dining room on 08/09/2025 at 4:53pm revealed there were 10 residents sitting in the dining room and Resident #1 was in the hall with no pants on sitting in his wheelchair. The residents appeared to be warm (skin flushed and sweating) staff were providing the residents drinks. Staff said they were not giving residents coffee since it was hot. The temperature in the dining room was 87 degrees according to the thermostat. An interview with the LVN G on 08/09/2025 at 4:50pm revealed the air conditioner had been out since this morning. She said that none of the resident have become sick due to the heat. She said they were giving the residents fluids. She said that she did notify MAIN but was not sure when she notified him. She said MAIN brought fans and was in the process of getting portable AC's. She said it had been hot in the facility since the morning time. An interview with CNA A on 08/09/2025 at 4:54pm revealed that the air conditioner had been out since 5:00 am. He said Resident #2 had said his room was hot and wanted the air conditioner turned on. He said as far as he knows none of the resident have gotten sick. He said MAIN was aware and that the DON also was aware. He said that the residents were complaining that it was hot in the facility. He said it was hot. An interview with the MAIN on 08/09/2025 at 4:56pm revealed that he got the call that the air conditioner was out at 2:17pm. He said that the air conditioner company was on their way. He said he was going to get four more emergency air conditioners. He said he did not have a log of the temperature. An interview with the DON on 08/09/2025 at 5:26pm revealed that the facility has a plan in place, and they were going to move residents. She said the staff moved the resident to the common area in the main building. She said that staff were positioned all around them so they could not leave the facility. She said that the MAIN should be there soon with the other air conditioners. An interview with the On-Call Doctor on 08/09/2025 at 7:58pm revealed that with the temperatures 93 degrees it could cause the residents dehydration if the staff were not monitoring the residents' fluids. She said the most that could happen that would be concerning was the residents getting dehydrated. Record review of the Weather Channel App on 08/09/2025 revealed the local temperature in [NAME] Heights was 97 degrees Fahrenheit. Record Review of the Extreme or Dangerous Temperature Levels Policy dated 11/2021 revealed Federal and Texas state standards for nursing centers require heating systems to be capable of maintain a minimum temperature of 71 F degrees and cooling systems to maintain a maximum temperature of not greater than 81 degrees F. Record Review of form 671 Long Term Care Facility Application for Medicare and Medicaid dated 8/9/2025 revealed a census of 24 residents in memory</p>		