STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675909	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harker Heights Nursing & Rehabilitation	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 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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also took into account nonsmoking residents for 1 (Resident #1) of 25 residents reviewed for smoking.The facility failed to implement their policy that smoking for team members was permitted only in approved designated areas. This failure could place residents at risk of an unsafe smoking environment, accidents, harm and long-lasting health concerns centered around secondhand smoke. Findings include:Record review of Resident #1's face sheet, dated 01/16/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had the following diagnoses which included normal pressure hydrocephalus (cerebrospinal fluid builds up in the ventricles), Alzheimer's(a progressive disease that destroys memory and other important mental functions), adult failure to thrive (when a person's dependence declines) , hyperlipidemia (a condition in which there are high levels of fat particles) , hypertension(condition in which the force of blood against the artery) and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). Record review of Resident's #1's cognitive intact GG functional section of the quarterly MDS, dated [DATE], reflected a BIMS score 03, which indicated cognitive impaired cognition. Record review of Resident #1's care plan, dated 01/21/2025, reflected Resident # 1 had a self-care deficit of generalized weakness & R lower extremity weakness. Resident #1 was a gait belt x2 transfer, toileting x2, and was at risk of falls due to unsteady gait & poor balance. The care plan reflected the following interventions: Keep call light within reach and encourage use for assistance. Respond promptly to all requests for assistance.An observation of an, undated, video recording provided by FM, revealed CNA A and CNA B provided care for Resident #1, CNA B was observed providing care for the resident in the restroom. CNA A stood by the bathroom door, she removed something from her pocket, put it to her mouth and put it back in her pocket.During an interview on 09/16/2025 at 11:15 AM with the Admin, he revealed the FM of Resident #1 told him she saw CNA A on camera smoking what appeared to be a vape while she and another caregiver cared for Resident #1. He informed her he would look into the situation and follow up with her. He reveled he reviewed the camera footage and did in fact see CNA A with what appeared to be a vape to her mouth and then put it in her pocket. The admin stated he and the DON both provided CNA A with in-services as well as a verbal warning. During an interview on 09/16/2025 at 12:37 PM with the DON revealed she was made aware of the situation when the admin made her aware of the incident involving CNA A vaping. She said when she was made aware she interviewed CNA A who admitted she abruptly took her vape pen from her pocket, quickly inhaled it and returned it to her pocket. The DON revealed CNA A was very apologetic and she had only did it one time. She said CNA A was a good worker, and she felt as if this was a one-time mistake. The DON revealed she coached CNA A on her behavior. She said she also reminded CNA A there was a designated smoking area outside of the facility. During an interview on 09/16/2025 at 05:09 PM with Resident #1 revealed she had only been at the facility since January of 2025. She stated she felt safe at the facility and felt the staff treated her with respect. She revealed she was not aware CNA A was smoking a vape while in her presence. She said she was made aware when her FM, came to visit her one day and she told her she saw CNA A on camera bring what appeared to be a vape to her mouth, then put it back in her pocket. Resident #1 revealed she was surprised when her family member told her because she had never seen CNA A do anything like that before. During a phone interview on 09/16/2025 at 5:45 PM with CNA A, she revealed on 09/09/2025 while she was caring for Resident #1, she was told she was seen on camera smoking a vape. She said she was unsure if it was a vape, she said she had several pens that she kept in her pocket that had lights on them. CNA A stated it could have been mistaken for a vape. CNA A revealed she did smoke vapes when she took residents out to smoke in the designated smoking area. CNA A revealed she was coached on her behavior and how it could have a harmful outcome on the residents. A record review of the facility's grievance log reflected CNA A had never had a grievance filed on her before. A record review of CNA A's employee file reflected she only had this one write up. A conduct and workplace expectation notice dated 09/12/2025 was signed by CNA A. A record review of the facilities seniority date/rehire date reflected Team members smoking is permitted only in approved designed areas. Smoking will be prohibited in all other areas including but not limited to any areas where oxygen, flammable liquids, and/or combustible gases are being used or stored, in any area that would