

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  11/18/2025
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 0559  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.  (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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed for 1 of 3 residents (Resident #1) reviewed for room or roommate changes. The facility failed to ensure Resident #1, and her RP received written notice prior to moving Resident #1 to another room. This failure could place residents at risk of having their resident rights violated and being moved into another room without notice. Findings include: Observation on 10/15/25 at 10:45 AM revealed Resident #1 was sitting up in her wheelchair in her room. She was clean and well-groomed, and dressed appropriately for the day. Resident #1's RP was also in her room placing items in her closet. Review of an undated face sheet for Resident #1 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included idiopathic normal pressure hydrocephalus (a neurological disorder primarily affecting older adults, characterized by gait disturbances, cognitive impairment, and urinary incontinence, often treatable through shunt surgery), repeated falls, Alzheimer's disease, adult failure to thrive (a condition characterized by significant decline in physical and emotional well-being, often leading to weight loss, decreased appetite, and inactivity), hyperlipidemia (high levels of fat in the blood), hypertension (high blood pressure), hyperglycemia (low blood sugar) and depression. Record review of Resident #1's Quarterly MDS Assessment, dated 08/31/25, reflected a BIMS Score of 3, which indicated a severe impairment in cognition. The assessment further reflected Resident #1 required partial to substantial/maximal assistance for her activities of daily living. Record review of Resident #1's Care Plan Report, dated 02/14/25, reflected she had a self-care deficit related to generalized weakness and right lower extremity weakness. The goal reflected Resident #1 would maintain or improve her ability to participate in her care with ADLs and experience safe transfers through the next review date by staff assisting with her activities of daily living with one person assisting. Record review of Resident #1's progress notes in the electronic health record, dated 09/22/25, reflected the DON communicated with the RP regarding the room change for Resident #1, and the RP gave verbal approval. The DON requested the RP camera removal to come to the facility to move the camera to the new room on Tuesday, 09/23/25 around 3:30 PM. No other concerns were discussed at that time. Record review of Resident #1's electronic nursing note, dated 09/24/2025 at 4:51 PM, reflected the RP was contacted by the DON and ADM regarding Resident #1's room change. An interview on 10/15/25 at 10:45 AM with the RP revealed on 09/24/25 the RP had a conversation with the ADM that Resident #1 had already been moved. The RP stated the change of rooms was communicated to her, but she was not notified in writing regarding the move and did not see the room before Resident #1 moved there. She further stated on 09/25/25 the camera had been moved along with Resident #1's belongings to the new room. An interview by phone on 10/15/25 at 11:18 AM with the RP revealed the DON informed her they could not move Resident #1's belongings to the new room along with the camera themselves and told her she would need to come and do it. The RP stated the next day when she went to the facility, Resident #1's belongings were moved into the new room, and the ADM stated, I had to move [Resident #1] to prove to the state that we did it. Interview on 10/15/25 at 1:43 PM with the SW, who stated she worked in the facility for 4 months. She stated for a room change they had a team meeting, obtained room numbers of rooms available, then they would reach out to the family, and show the room to the resident. The SW stated she did not remember being involved in a move room/change for Resident #1. The SW stated room changes were communicated to residents and families by verbal consent but not in writing per facility policy. The SW further stated verbal consent from residents and family was written into a progress note in the electronic health record. She stated Housekeepers moved the residents' belongings, and social workers were in charge. An interview on 10/15/25 at 2:05 PM with the AD, who stated they discussed room changes with residents and their families, if residents needed to change rooms. The AD stated they discussed room changes during IDT meetings and saw the availability of rooms in the facility. The AD stated they notified the family and residents verbally, and they asked if families wanted to be in the facility during the move. The AD stated the camera should be removed by the family in person per her understanding to make sure it's not broken and re-installed correctly. She stated the SW was in charge of room changes, but other staff members could be involved in the family notifications. An interview on 10/15/25 at 2:19 PM with LVN A, stated the family must be notified and present during the Residents' move from the other room. An interview on 10/15/25 at 3:30 PM with the ADM stated the bathroom was not working in</p>		