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	02/28/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure drugs were stored properly and only authorized persons had access for 1 (MC #1) of 3 med carts reviewed for drug storage and labeling. The facility failed when MC #1 was in an unsecured location, unlocked, and was accessible to staff, residents and passers-by. This failure could place residents at risk of ingesting medications that was not prescribed to them leading to sickness.During an observation of MC #1 on 2/28/26 at 10:00 AM, revealed it was unattended, unlocked and accessible to staff, residents, and passers-by in the main lobby area. The locking mechanism was protruding outward on the medication cart. Neither the RN, nor the LVN saw the surveyor open the drawers and take pictures. During an interview with the RN on 02/28/26 at 10:23 AM, she stated the cart belonged to the LVN who was working the 300 hall. The RN stated staff were trained a couple of weeks ago on med cart storage. She stated residents could get into the cart and take medications that were not intended for them, leading to harm or sickness. She stated as the charge nurse and supervisor on duty, she was responsible for ensuring med carts remained locked. During an interview with the DON on 02/28/26 at 03:00 PM, she stated med carts were supposed to be locked at all times with no exception. She stated all nurses should have known that practice. She stated she was sure there was a facility policy related to med cart security. The DON stated an in-service was started 02/28/26. During an interview with the LVN on 02/28/26 at 03:32 PM, she stated she worked with the facility 15 or 16 years. She stated she was responsible for the 300-nurse cart. When asked about it being left unlocked, she stated she could not say about that. The LVN stated the policy said carts were to remain locked at all times because there was a possibility someone could go into it. The LVN stated residents were at risk of taking medication that was not prescribed to them and could cause sickness. The LVN stated the facility held regularly scheduled in-services about the med carts., The LVN stated the most recent was a couple of weeks ago. She stated she could not recall the date. During an interview with the ADM on 02/28/26 at 05:45 PM, he stated med carts were to be locked at all times when not in use. He stated whichever nurse was assigned to the specific cart was responsible for ensuring security. He stated any staff member, or member of management, who saw it unlocked was also responsible for ensuring security. He stated the facility policy was for med carts to be locked at all times. Record review of facility policy titled, Medication Cart Use & Storage, dated 01/2023, reflected, Responsible Disciplines: Licensed nurses, C.M.A.'s Guidelines: 1. Security: The medication and its storage bins should be kept closed, secured and/or in the line of sight when not in use. If an emergency occurs during a medication pass, the nurse/medication cart should be closed, secured and/or in the line of sight before attending to the emergency. During administration of medications, the cart may be positioned in the doorway of the resident's room with drawers unlocked and facing inward, and within sight. Record review of in-service dated 02/28/26 reflected:02/28/26 Medication Cart: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: To reinforce the importance of keeping medication carts locked at all times when not in direct attendance to prevent medication errors, diversion, theft, resident harm, and regulatory violations; Regulatory & Policy Basis; Medication carts must remain locked when unattended per: Facility Policy & Procedure, State Regulations (including Texas HHSC standards), CMS F-Tag Requirements (Tag #: Labeling, Storage, and Security of Drugs), Medication Safety Best Practices. Failure to comply may result in: (blank) (the LVN's signature included).