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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harker Heights Nursing & Rehabilitation	415 Indian Oaks Dr Harker Heights, TX 76548

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with the comprehensive person-centered care plan and the residents' choices for 5 of 13 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for quality of care. The facility failed to implement interventions, according to the comprehensive plan of care, to check and change on rounds and as needed to keep Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5's skin clean and dry. The failure placed residents with self-care deficit, falls, and skin concerns at risk of decline or decrease in their quality of life and quality of care. Findings included: Record review of Resident #2's face sheet, dated 1/26/2026, revealed an 81-years-old female, admitted on [DATE] and readmitted [DATE] with diagnosis hemiplegia (severe paralysis affecting one side of the body, often caused by brain injury) and hemiparesis (weakness or partial paralysis affecting one side of the body, commonly caused brain injuries) following cerebral infarction (a type of stroke caused by a blockage of blood flow to the brain resulting in brain tissue death) affecting left non-dominant side, dementia (a progressive syndrome, not a normal part of aging, characterized by cognitive decline), type 2 diabetes mellitus (a chronic metabolic disorder characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar) and anxiety disorder. Record Review of Resident #2's quarterly MDS, dated [DATE], revealed BIMS score of 3, severe cognitive impairment. The MDS indicated occasional incontinence and occasional bowel incontinence with need for assistance with personal care. Record review of Resident #2's care plan, dated 10/27/2025, revealed the risk for self-care deficit, falls, skin concerns, pain, infection, nutrition/hydration concerns and emotional distress. Personal hygiene x1 person assist, turning and repositioning: on rounds and as needed, transfer and toilet transfer x2 person assistance. Fall risk was identified with interventions: routine rounds to help with safety checks by all team members. She has incontinence related to dementia diagnosis with interventions in place to check and change on rounds and as needed. Record review of nursing notes for Resident #2, dated 3/23/26, revealed that resident family call for resident perineal (around genitals and bottom region) care. The note reflected, Resident's family proceeded to make a complaint that resident was not changed for hours and was soaking wet with urine. CNA went into resident room to perform perineal care on resident. Resident brief is noted to be dry and free from urine and BM by this nurse, CNA and DON.Observation on 3/26/2026 at 10:15 a.m. revealed Resident #2 was lying in bed and crying for help. When the call light button was pushed, nobody answered Resident #2's call light for 14 minutes and 9 seconds until a surveyor went to the nursing station and brought it to the nursing staff's attention. No nursing staff was visible in the 500 hall. The housekeeper was cleaning a room across the hall and did not attempt to answer the light. The sound of the call light system was heard through the hallway, but nobody came to Resident #2's room to assist her. The DON was walking by the nursing station and was informed about the call light going on for 14 minutes and 9 seconds. The DON found CNA C who was in another resident's room to answer the call light. Attempted to interview Resident #2 on 3/26/2026 at 10:21 a.m. and Resident #2 could not provide the comprehensive information about help she needed. She stated she had pain pointing to her stomach and needed her (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	family member. During interview on 3/26/2026 at 2:27 p.m. with RP E for Resident #2, she stated the care for Resident #2 was not too good. The RP E said nursing staff left Resident #2 wet and soiled when she was sleeping. The RP E said there was a brown stain on her brief a few days ago. Th RP said it was not all the time and it's just with some nurses. The RP E said they say they've already changed her and it's brown, it happens about once a week. During interview on 3/26/26 at 11:05 a.m. with CNA C, she stated she was occupied in a different room with another resident. She stated that answering call lights was everybody's responsibility and if not answered promptly that could lead to residents' falls and skin breakdown. She stated that she had training on answering call lights in the last two months. CNA C stated that there were two CNAs per hallway, but she was the only one during lunch time. She stated that they supposed to round on residents every two hours and change briefs at that time if it was wet or soiled. She did not remember specifically when she changed Resident #2 last time during her shift. CNA C stated she tried to answer the call lights promptly when she was not busy with other residents. She stated with 28 residents on 500 hall, she was responsible for 14 residents. Record review of Resident #1's face sheet, dated 3/26/2026, revealed a 78-years-old male, originally admitted [DATE] and readmitted [DATE], with diagnosis of type 2 diabetes mellitus (a chronic metabolic disorder characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar), epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain), and chronic obstructive pulmonary disease (a progressive, treatable lung disease, commonly caused by smoking, that makes breathing difficult due to airflow blockage). Record Review of Resident #1's quarterly MDS, dated [DATE], revealed BIMS score of 14, intact cognition. The MDS indicated Resident #1's had incontinence of bowel and bladder with need for assistance with personal care. Record review of Resident #1's care plan, dated 10/03/2025, revealed Resident #1 has bowel incontinence and interventions to check and change on regular rounds and as needed. Incontinence care assistance should be provided every shift and as needed. No current skin issues were identified. Interview and observation of Resident #1 on 3/26/2026 at 10:48 a.m. revealed resident lying in bed stating he had concerns that staff did not check on him every two hours as they needed to. He said sometimes nobody checked on him all night. He stated that he wanted to be checked on more often. Resident #1 stated that he needed to be changed and repositioned in bed. He stated that he told nursing staff regarding his concerns before, but nothing changed. Record review of Resident #3's face sheet, dated 3/26/2026, revealed a 78-years-old female, originally admitted [DATE] and readmitted [DATE], with diagnosis of type 2 diabetes mellitus (a chronic metabolic disorder characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing brain cells of oxygen), hypertension (high blood pressure), and depression. Record Review of Resident #3's quarterly MDS, dated [DATE], revealed BIMS score of 8, moderate cognitive impairment. The MDS indicated the resident had frequent bladder incontinence and occasionally bowel incontinence with a need for assistance with personal care. Record review of Resident #3's care plan, dated 09/21/22, indicated Resident #3 was incontinent of bowel and bladder, required assistance with toileting with interventions to monitor for incontinence every 2-3 hours and as needed, apply skin protective barrier. Record Review of Resident #3's progress notes indicated maximum assistance with ADLs. No skin issues were identified. Interview and observation of Resident #3 on 3/26/2026 at 11:07 a.m., revealed Resident #3 was sitting in a wheelchair and stated that she had been in the facility for three years. She stated that it took staff 30-45minurs on different shifts to answer call lights to assist her with being changedInterview on 3/26/2026 at 1:25 p.m. with RP D for Resident #3 revealed it took too long for staff to respond to requests like warming the food or changing her. She stated that Resident #3 felt uncomfortable asking for help because most of the time staff said they would be right back and then don't end up coming back. The RP D said one hour was nothing, but every time she was the facility she witnessed staff not answering call lights or not coming back. She stated typically (continued on next page)

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