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	05/17/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 7 residents (Resident #1) for medical records.The facility failed to ensure Resident #1's skin tear cleaning was documented completed in the electronic medical record for 04/07/2026, 04/08/2026, and 04/13/2026.These failures could place residents at risk for the possibility of not verifying the needed care and services to meet their needs.Findings included:A record review of Resident #1's face sheet, dated 05/16/2026, reflected a [AGE] year-old male, admitted [DATE]. Resident #1's diagnoses included unspecified dementia (cognitive decline), Alzheimer's disease (progressive irreversible brain disorder that slowly destroys memory and cognitive skills), and hypertension (high blood pressure).A record review of Resident #1's care plan, dated 03/10/2026, reflected Resident #1 was at risk for skin impairment (diminished, weakened, or damaged).A record review of Resident #1's Quarterly MDS assessment, dated 04/16/2026, reflected Resident #1 had a BIMS score of 12, indicating moderate cognitive impairment. Resident #1 was at risk of developing pressure ulcers/injuries and had one unhealed pressure ulcers/injuries.A record review of Resident #1's physician's order, dated 04/06/2026, reflected cleanse skin tear to LLE (lower left extremity) with wound cleanser, pat dry with 4x4 gauze, apply hydrogel (advanced water based dressing that mimics the body's natural moisture), cover with Xeroform (sterile, non-adhering petrolatum dressing), cover with dry dressing qd (everyday) until resolved, once daily, starting 04/06/2026.A record review of Resident #1's TAR, dated 04/07/2026, 04/08/2026, and 04/13/2026, reflected to cleanse skin tear to LLE (lower left extremity) with wound cleanser, pat dry with 4x4 gauze, apply hydrogel (advanced water based dressing that mimics the body's natural moisture), cover with Xeroform (sterile, non-adhering petrolatum dressing), cover with dry dressing qd (everyday) until resolved, once daily,was not signed off completed in the electronic medical record by LVN A.Attempted an interview and observation with Resident #1 on 05/15/2026 but Resident #1 had transferred out of the facility on 04/28/2026.During an interview with Resident #1's RP on 05/15/2026 at 12:37 PM, stated Resident #1 was transferred to another nursing facility in another town. Resident #1's RP stated the facility did not meet her expectations of what they had agreed to and she transferred Resident #1 out because she wanted what was best for Resident #1 and she was the only family that Resident # 1 had.During an interview on 05/17/2026 at 1:33 PM, LVN A stated she was responsible for signing off in the electronic medical record when she completed Resident #1's skin tear cleansing treatment on the leg. LVN A stated that she failed to sign off in the electronic medical recorc after she had completed the treatment on 04/04/2026, 04/08/2026, and 04/13/2026. LVN A stated she was assisting with other job duties and did not sign off in the electronic medical record that the treatment was completed. LVN A stated if treatment was not signed off on in the electronic medical record it would look like the skin tear treatment did not happen.During an attempted telephone interview on 05/17/2026 at 2:00 PM, 2:35 PM, and 2:55 PM, the Wound Care Nurse did not answer. Voice messages were left and no return calls were received by exit (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
	675909	A. Building B. Wing	05/17/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/17/2026 at 4:30 PM or after.During an interview on 05/17/2026 at 3:25 PM, the DON stated it was LVN A's responsibility to have documented in electronic medical record on 04/07/2026, 04/08/2026, and 04/13/2026 that the skin tear treatment to leg of Resident #1 was completed. The DON stated that she would have been responsible for double checking to make sure the documentation was in the electronic medical record. The DON stated she failed to double check. The DON stated if documentation was not signed off on, it would indicate the treatment did not happen.During an interview on 05/17/2026 at 3:40 PM, the ADM stated LVN A was responsible to have signed off in the electronic medical record that Resident #1's treatment was completed for 04/07/2026, 04/08/2026, and 04/13/2026. The ADM stated it was expected for LVN A to have documented in the electronic medical record once the treatment was completed. The ADM stated that without documentation in the electronic medical record it would not show the treatment was completed.Record review of the facility's, revised 01/2024 , policy titled, Professional Standard of Care, reflected, Nurses should conduct assessments or evaluations and document within the medical record in the following instances:admission, re-admission and as clinically indicated.at the time of accidents, incidents or change in conditionswhen exceptions are identifiedas otherwise directed.