| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675909 | A. Building<br>B. Wing | 06/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Harker Heights Nursing & Rehabilitation | 415 Indian Oaks Dr<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 1 of 18 residents (Resident #1) reviewed for ADL care. The facility failed to ensure Resident #1 was provided incontinent care from 11:30 p.m. until 5:50 a.m. on 06/11/2026. This failure could place residents at risk of infection, skin breakdown and diminished quality of life.Findings include: Record review of Resident #1's face sheet, dated 06/11/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental function), dementia (memory, thinking, difficulty), bipolar (extreme mood swings), history of malignant neoplasm of bladder (cancer of the bladder), hypertension (high blood pressure), and protein-calorie malnutrition (inadequate intake of both protein and calories).Record review of Resident #1's quarterly MDS assessment, dated 03/15/2026, reflected a BIMS score of 0, which indicated severe cognitive impairment. [Resident #1] was dependent on staff for toileting hygiene (helper does all of the effort. Resident does none of the effort to complete the activity). [Resident #1] was always incontinent of bowel and urine.Record review of Resident #1's care plan, dated 05/12/2026, reflected the following: Focus: Baseline / Initial Care Plan: [Resident #1] may be at risk for: self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress. Cognition Impairment, Resident has difficulty communicating her needs/wants, Weakness and debility.Goals: [Resident #1] condition will be stable and his/her needs will be anticipated and met as indicated. Resident will not experience a health decline.Interventions: Provide ADL care as indicated. See nurse for any care related questions or concerns. *Interview Patient/Resident/Representative regarding: ADL & care needs/preferences.During an interview with Resident #1's FM on 06/11/2026 at 11:35 a.m., she said Resident #1 did not get incontinent care from 11:00 p.m. when she changed Resident #1 until 5:00a.m. on 06/11/2026 by CNA A. She said she had other days Resident #1 did not get changed on camera. She said she talked to the facility about Resident #1 not getting changed at night and nothing had been done about it. She said she would provide the camera footage.During an interview with CNA B on 06/11/2026 at 2:05 p.m., she said she had been trained on incontinent care. She said the policy for changing the residents was to change them every two hours. She said the CNAs were responsible for changing the residents. She said if staff did not change the resident regularly the resident could have skin breakdown. She said the CNAs monitored to ensure the residents were changed. She said the CNAs monitored by checking the residents. She said she did not know why Resident #1 was not changed all night. During an interview with CNA C on 06/11/2026 at 2:19 p.m., she said she was trained on incontinent care. She said the policy was that staff must round on the resident every two to three hours and change the resident. She said the CNAs were responsible for changing the residents. She said if the resident did not have brief changes the resident could have skin break down. She said the DON monitored to ensure staff were changing the residents. She said the DON monitored by checking on the residents. She said she did not know why CNA A did not provide Resident #1 was not changed all night.Interview attempted with CNA A on 06/11/2026 at<br>(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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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 02:49p.m., was unsuccessful. Interview attempted with DON on 06/11/2026 at 3:56 p.m., revealed she had to leave the facility. During an interview with the ADON on 06/11/2026 at 4:01p.m., she said she was trained on incontinent care. She said the policy for changing the residents was to check and change the resident every two hours. She said the licensed nursing staff and direct care staff were responsible for changing the residents. She said if a resident was not changed regularly it could cause skin breakdown and could also lead to other issues. She said the Nurses, DON and ADON monitored to ensure staff were changing the residents. She said the nurses, DON and ADON monitored by doing rounds on the residents. She said she had one complaint recently about Resident #1 not being changed. She said she had not done anything yet. She said she did not know why Resident #1 did not get changed. During an interview with the ADM on 06/11/2026 at 4:12 p.m.,. He said his expectation was to change the residents if the resident needed to be changed. He said the CNAs, nurses, and medication aides were responsible for changing the residents. He said if the resident was not being changed regularly it could affect their skin integrity. He said the nurse monitored to ensure staff were changing the residents. He said the nurse monitored through rounds. He said he did not know why the staff did not change Resident #1. Record review of video footage dated 06/11/2026 from midnight to 5:58am revealed no staff entered the room to change Resident #1.Record review of the Activities of Daily Living Policy, dated 1/2023, revealed Each resident's abilities to perform activities of daily living will not diminish unless the individual's clinical condition demonstrates that diminution was unavoidable. Activities of daily living include personal hygiene, and toileting. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 3 medication carts (MC #1) reviewed for drug storage and labeling.The facility failed to ensure MC #1 was locked, medications secured, and not accessible to other staff, residents, or visitors.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings include:During an observation of the nurses station on 06/11/2026 at 12:35 p.m., revealed LVN D was down one of the halls and the medication cart was up against the nurses station unattended and unlocked. MC #1 contained residents prescription medications, narcotics, antibiotic ointment, and over the counter medications. Staff and residents were observed walking past the unlocked medication cart.During an interview with LVN D on 06/11/2026 at 12:37 p.m., she said she was trained on medication storage. She said the policy was staff must lock the medication carts any time the nurse/medication aide walked away from the cart. She said the nurse or whoever was working on the cart was responsible for locking the medication cart. She said if staff left the medication cart unlocked and unattended a resident or someone else could get into the medication cart and take medications. She said management monitored to ensure the medication carts were locked. She said management monitored the medication carts through observation. She said she had two residents who wanted their nails cut and she was looking for her nail stuff and she forgot to lock the medication cart.During an interview with the ADON on 06/11/2026 at 04:05 p.m., she said she was trained on medication storage. She said the policy was the medication cart was to be locked at all times. She said whoever was on the medication cart was responsible for ensuring the medication cart was locked. She said if the medication cart was left unlocked and unattended someone could get into the medication cart and take medications. She said the ADON and RNs monitored to ensure staff locked the medication cart. She said the ADON and RNs monitored through observations. She said she did not know why LVN D left the medication carts unlocked.During an interview with the ADM on 06/11/2026 at 04:16 p.m., revealed his expectation for the medication cart was the nurses locked the medication carts when they were not in them. He said the person who was using the medication cart was responsible for ensuring the medication cart was locked. He said if the medication cart was left unlocked and unattended someone could get into the cart and take medication. He said everyone monitored to ensure the staff were locking the medication cart. He said everyone monitored by doing rounds. He said he did not know why LVN D left the medication cart unlocked.Record review of the Medication Cart Use and Storage Policy, dated January 2023, reflected The nursing Team Members (Nurses & CMA's) use the medication cart to systematically distribute physician ordered medications to residents. he medication cart 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 aide should be closed, secured and/or in the line of sight before attending to the emergency. |