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	04/16/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 2 of 2 dumpsters reviewed for garbage disposal. The facility failed to ensure the dumpsters were free from debris on 4/14/26 and on 4/15/26. The facility failed to ensure that 2 dumpsters were closed/covered on 4/14/26, 4/15/26 and 4/26/26.CK H failed to close/cover the dumpster after using it on 4/15/26. These failures placed residents at risk of being exposed to rodents and pests.Findings included: During an observation of the facility's dumpsters on 4/14/26 at 11:45 AM, three plastic gloves and one metal can were observed between the two dumpsters and the dumpster on the left was open. During an observation interview on 4/14/26, a rodent trap was observed outside of the kitchen's back door. The Dietary Supervisor stated no the facility had not had any problems with rodents. During an observation on 4/15/26 at 10:16 AM, CK H put a bag of trash in the dumpster and walked away without closing it. An observation of the dumpster area on 4/15/26 at 10:18 PM revealed the three gloves and tin can from the previous day (4/14/26) were gone, and a resident's walker was observed behind the dumpster on the left. Both sliding doors on the left dumpster were open and the left-hand door on the dumpster on the right was open. An observation on 4/16/26 at 9:16 AM revealed the dumpster on the left had its left-hand door open and the dumpster on the right had both doors open. The resident's walker observed the previous day (4/15/26) was still sitting behind the dumpster on the left. During an interview on 4/16/26 at 4:55 PM, the ADM stated that everybody was responsible for keeping the dumpsters clean and covered. The ADM stated if they were not maintained that way, it could attract pests and odors. A record review of the facility's policy titled Garbage Receptacles titled 10/1/2018 reflected the following: Outdoor receptacles: Outdoor storage surfaces for refuse shall be constructed of nonabsorbent material such as concrete or asphalt and shall be smooth, durable, and sloped to drain. It shall be constructed to have tight fitting lids, doors or covers and stored in a manner that is inaccessible to insect and rodents with doors/lids kept closed and no waste outside of the receptacle.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the need of each resident for 2 of 6 medication carts (*the medication cart designated for use on the 100 Hall and the medication cart designated for use on the 200 Hall) reviewed for pharmacy services.The facility failed to establish a system of record of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation at each shift change for the medication cart designated for use on the 100 Hall and the medication cart designated for use on the 200 Hall. This failure could place residents at risk of drug diversions and could result in diminished health and well-being.Findings Included: Record review of the Change of Shift Narcotic Count Sheets revealed missing signatures for the following: 100 Hall Medication Cart04/03/2026 1st Shift Nurse Oncoming04/03/2026 2nd Shift Nurse Off going04/04/2026 2nd Shift Nurse Off going04/04/2026 2nd Shift Nurse Oncoming04/05/2026 1st Shift Nurse Off going04/05/2026 1st Shift Nurse Oncoming04/05/2026 2nd Shift Nurse Off going 200 Hall Medication Cart04/03/2026 1st Shift Nurse Oncoming04/03/2026 2nd Shift Nurse Off going04/04/2026 2nd Shift Nurse Off going04/04/2026 2nd Shift Nurse Oncoming04/05/2026 1st Shift Nurse Off going04/052026 1st Shift Nurse Oncoming04/05/2026 2nd Shift Nurse Off going04/11/2026 2nd Shift Nurse Off going04/14/2026 1st Shift Nurse Oncoming04/14/2026 2nd Shift Nurse Off going During an interview with LVN C on 04/15/2026 at 2:46PM, she stated it was required for the off going and oncoming staff to count narcotic medications and sign the Narcotic Count Sheet. She stated they received training on the process for change of shift narcotic count and documentation at new hire and then every year. She stated a possible negative outcome for failure to do the count would be drug diversion or a possible delay in care. During an interview with MA A, on 04/15/2026 at 3:00PM, she stated it was required for the off going and oncoming staff to count narcotic medications and sign the Narcotic Count Sheet. She stated they received training on the process for change of shift narcotic count and documentation at new hire and then every year. There are also in-services at different times, the last one being about 2 weeks ago. During an interview on 04/15/2026 at 3:05PM during an interview with MA B, she stated it was required for the off going and oncoming staff to count narcotic medications and sign the Narcotic Count Sheet. She stated she was trained on this process at new hire. During an interview on 04/16/2026 at 10:50AM with the DON she stated it was her expectation that the off-going nurse and the on-coming nurse counted the narcotics together at the change of shift. The DON stated a negative outcome of not consistently following the narcotic count expectations was a possibility of drug diversion. The DON stated the staff are trained at New Hire and annually thereafter. She stated there are also in-services throughout the year on this topic, the last one being two weeks ago. During an interview on 04/16/2026 at 3:20PM with the Administrator, he stated it was his expectation that the oncoming and off going shift count the narcotics together and then document the inventory on the Change of Shift Narcotic Count Sheet. A possible negative outcome of not performing the count would be a possible drug diversion. Record review of the Medication: Controlled Drugs Policy dated January of 2023 was performed. The Policy stated, Reconcile the narcotic count inventory at least at the beginning and end of each shift. Reconciliation should be performed by a visual count of the remaining narcotic medications comparing the actual count to the narcotic drug count sheet. This should be conducted by two persons who are legally authorized to administer medications.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately after the allegation was made for 1 of 5 (Resident #131) reviewed for resident abuse in that: RN E failed to report an allegation of verbal abuse made by Resident #131 on 4/03/2026. This failure could place residents at risk for on-going abuse.Findings included: A record review of Resident #131's face sheet dated 4/16/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of diabetes mellitus (uncontrolled blood sugar), intervertebral disc degeneration (gradual breakdown of spinal discs), end stage renal (kidney) disease, obesity class 3, paraplegia (paralysis of lower half of the body), heart failure, and hypertension (high blood pressure). A record review of Resident #131's MDS assessment dated [DATE] reflected a BIMs score of 15, which indicated no cognitive impairment. A record review of Resident #131's care plan last revised on 3/04/2026 reflected that she had cognitive communication deficit and self-care deficit. Interventions included a one-person assist with most ADLs and referral to the SW as needed. A record review of Resident #131's progress note dated 4/03/2026 authored by RN E reflected the following: Resident said to this nurse that she was threatened by her roommate saying she will kill her. Social worker [name] and administrator was made aware. 2.A record review of Resident #31's face sheet dated 4/16/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of type 2 diabetes (uncontrolled blood sugar), dementia (neurocognitive disorder), unstable angina (chest pain), schizoaffective disorder, bipolar type (mental disorder including mania), major depressive disorder (depression), cognitive communication deficit, difficulty in walking, and anemia. A record review of Resident #31's MDS assessment dated [DATE] reflected a BIMS score of 00, which indicated severely impaired cognition. A record review of Resident #31's care plan last reviewed on 4/15/2026 reflected that she was at risk for psycho-social issues and required psychotropic medications. Interventions included to administer medications as ordered and attempt non-pharmacological interventions to promote calming. During an interview and observation on 4/16/2026 at 1:25 PM, Resident #131 was observed lying in bed. Resident #131 stated that her roommate threatened her a few weeks ago but she was not sure exactly when. Resident #131 called her family member and placed her on speaker phone. Resident #131's family member stated that the incident was on 4/02/2026. Resident #131 stated she told a nurse who told the DON, but the DON did not do anything about it. During an observation on 4/16/2026 at 1:27 PM, Resident #31 was observed walking towards the sink in her room. Resident #31 was non-interviewable. During an interview on 4/16/2026 at 2:15 PM, the DON stated she had not been notified about an allegation of verbal abuse. During an attempted interview on 4/16/2026 at 2:28 PM, RN E was contacted and a voicemail was left but she did not return the call. During an interview on 4/16/2026 at 2:56 PM, the SW stated that RN E had not reported an allegation of abuse to her. The SW stated, the roommate doesn't even talk. The SW stated that Resident #131 had never brought it up with her. The SW stated that she would have moved Resident #131 if she had known. During an interview on 4/16/2026 at 3:40 PM, the DON stated that if an allegation of abuse were reported to a person, that person needed to make a report to the ADM within two hours. The DON stated that staff were trained on reporting allegations of abuse with in-services and that they would start one that day (4/16/2026). The DON stated she would have to check if RN E was trained on reporting allegations of abuse. The DON stated that if allegations of abuse were not reported timely, the situation could escalate. During an interview on 4/16/2026 at 4:17 PM, the ADM stated that the allegations of abuse were reported to him and he reported them to the State. The ADM stated that many things could happen if allegations were not reported and investigated including someone else being abused. A record review of RN E's training record dated 2/10/2026 reflected that she had been trained on reporting abuse. A record review of the facility's (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy titled Abuse, Neglect and Exploitation dated 7/02/2025 reflected the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.VII. Reporting/ResponseA. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have evidence that all allegations of abuse were thoroughly investigated for 1 of 5 (Resident #131) residents reviewed for resident abuse. The facility failed to investigate an allegation of abuse made by Resident #131 on 4/03/2026. This failure could place residents at risk for on-going abuse.Findings included: A record review of Resident #131's face sheet dated 4/16/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of diabetes mellitus (uncontrolled blood sugar), intervertebral disc degeneration (gradual breakdown of spinal discs), end stage renal (kidney) disease, obesity class 3, paraplegia (paralysis of lower half of the body), heart failure, and hypertension (high blood pressure). A record review of Resident #131's MDS assessment dated [DATE] reflected a BIMs score of 15, which indicated no cognitive impairment. A record review of Resident #131's care plan last revised on 3/04/2026 reflected that she had cognitive communication deficit and self-care deficit. A record review of Resident #131's progress note dated 4/03/2026 authored by RN E reflected the following: Resident said to this nurse that she was threatened by her roommate saying she will kill her. Social worker [name] and administrator was made aware. During an interview and observation on 4/16/2026 at 1:25 PM, Resident #131 was observed lying in bed. Resident #131 stated that her roommate threatened her a few weeks ago but she was not sure exactly when. Observed Resident #131 call her family member and place her on speaker phone. Resident #131's family member stated that the incident was on 4/02/2026. Resident #131 stated she told a nurse who told the DON, but the DON did not do anything about it. During an interview on 4/16/2025 at 2:15 PM, the ADM stated that he would report the allegation of verbal abuse that Resident #131 made to HHSC and he would start investigating. During an interview on 4/16/2026 at 3:40 PM, the DON stated that the allegation of verbal abuse made by Resident #131 was not investigational because we were not aware. The DON stated that since she became aware, Resident #131 was moved. The DON stated she would suspend RN E pending their investigation. During an interview on 4/16/2026 at 4:17 PM, the ADM stated that he had not started an investigation because he just found out. The ADM stated no RN E had not been notified him about the allegation that Resident #131 made. The ADM stated that RN E would be suspended pending his investigation. The ADM stated that many things could happen if allegations were not reported and investigated including someone else being abused. A record review of the facility's policy titled Abuse, Neglect and Exploitation dated 7/02/2025 reflected the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.V. Investigation of Alleged Abuse, Neglect and ExploitationA. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include:1. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, ,and cause; and6. Providing complete and thorough documentation of the investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's psychosocial needs for 1 of 5 (Resident #130) reviewed for care plans.The facility failed to ensure that Resident #130's care plan included interventions to address her psychosocial behaviors.This failure placed residents at risk of dwelling in a disruptive environment.The findings include: A record review of Resident #130's face sheet dated 4/16/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of anxiety disorder, cerebral vascular disease (condition affecting blood vessels), and altered mental status. A record review of Resident #130's MDS assessment dated [DATE] reflected that she had a BIMS score of 13, which indicated minimally impaired cognition. A record review of Resident #130's care plan last reviewed on 3/09/2026 reflected that she had anxiety, required anti-depressant medication, and chose not to follow recommendations made by the physician and/or clinical team related to care, services, and medications. Interventions included to administer medications as ordered and provide education on options for care and reassure resident that choices will be respected. A record review of Resident #130's POC Response History report with a 30-day lookback period dated 4/16/2026 reflected the following behavioral symptoms: Yelling/Screaming: 3/18/2026, 3/25/2026, 3/27/2026, 3/28/2026, 3/29/2026, 3/30/2026, 3/31/2026, 4/01/2026, 4/02/2026, 4/03/2026, 4/04/2026, 4/05/2026, 4/06/2026, 4/07/2026, 4/08/2026, 4/09/2026, 4/10/2026, 4/11/2026, 4/12/2026, 4/14/2026, and 4/15/2026. During an interview on 4/14/2026 at 3:05 PM, Resident #130 stated she came from the hospital and she was not sure why she was there. During an observation on 4/15/2026 at 11:00 AM, Resident #130 was observed in the hallway yelling you never push me. Observed the DON assist the resident in the hall. During an interview on 4/15/2026 at 11:17 AM, CNA F stated that Resident #130 was always yelling and if staff did not do what she wanted, she yelled and screamed. CNA F stated that residents complained that they could not sleep because they could hear Resident #130. CNA F stated that Resident #130 yelled in the morning, afternoon, and night. CNA F stated that Resident #130 was at the end of the hall and when she screamed, she could be heard at the front of the hall. CNA F stated that staff tried to anticipate her needs and redirect her. CNA F stated I don't know if the interventions were working. During an interview on 4/16/2026 at 1:42 PM, CNA G stated that Resident #130 had been there for a few months and she did a lot of attention-seeking behavior. CNA G stated, she hoops and hollers all the time and a lot of residents complained about the noise. CNA G stated that Resident #130's behavior of yelling should be in her care plan. During an interview on 4/16/2026 at 3:40 PM, the DON stated that MDS Nurse A and MDS Nurse B were responsible for updating care plans and yes she would expect to see a history of yelling in a resident's care plan. The DON stated she was not familiar with Resident #130's behavior of yelling and did not know if it was care planned. The DON stated she did not know which interventions were in place for Resident #130's behavior without looking into her chart. The DON stated she would go to the care plan first to look. The DON stated that residents could be disturbed and their behaviors could be exacerbated by Resident #130's yelling. During an interview on 4/16/2026 at 4:55 PM, the ADM stated that MDS Nurse A, MDS Nurse B, the SW, and the IDT were responsible for revising care plans. The ADM stated yes he would expect to see a history of yelling behaviors to be care planned. The ADM stated he was familiar with Resident #130 and said that she yelled for help and wanted things right away. When asked what could happen if behaviors were not care planned, the ADM stated, it could get worse. A record review of the facility's policy dated February 2017 reflected the following: Care Plans The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, preventative measures. The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 2 of 7 residents (Resident #26 and Resident #107) reviewed for grooming. The facility failed to provide showers to Resident #26 in compliance with his shower schedule.The facility failed to provide ADL facial hair care to Resident #107. This deficient practice could place residents at risk of decline in skin integrity and psychological well-being. Findings included: 1.Record review of Resident #26's admission record, dated 04/16/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #26 had diagnoses which included: osteomyelitis (infection in a bone), diabetes (condition where the body has trouble controlling blood sugar, morbid obesity(having very high amount of body fat that significantly increases health risk), end stage renal disease (the final stage of chronic kidney disease), hypertension (high blood pressure), anemia in chronic kidney disease (your body doesn't have enough healthy red blood cells because your kidneys aren't working properly. Record review of Resident #26's care plan, dated 03/30/2026, reflected Resident #26 was care planned for ADL self-care performance deficit and had an intervention of bathing/shower: to be showered 2-3 times weekly and as needed on 2-10 shift and requires staff x1 for assistance. Review of Resident #26's task sheet Bathing dated 04/16/2026, reflected Resident #26 was scheduled for a bath on Tuesday, Thursday, and Saturdays during the evening shift. There was no documentation reflecting Resident #26 received a bath on the following dates: 03/27/2026, 03/28/2026, 03/29/2026, 03/30/2026, 04/01/2026, 04/04/2026, 04/07/2026, 04/09/2026, 04/11/2026. Reviewed shower sheet dated 04/14/2026 reflected at 2:20 pm, 5:00 pm, and 6:30 pm Resident #26 did not have clothes and did not want a shower. During an interview on 04/14/2026 at 2:43 pm, Resident #26 stated he had not received a bath in two weeks from the facility staff. He stated he was supposed to receive a bath today. He stated he does not like or want to smell bad. He did not report refusing a shower or bath on his scheduled days. During an interview on 04/16/2026 at 10:30 am, CNA D stated she was not aware that Resident #26 had not been receiving showers as scheduled. CNA D stated that resident's bath/shower schedule was located on the EMR. CNA D stated that if a resident did not receive scheduled a bath/shower they would smell bad and cause the resident not to feel well. 2.Record review of Resident #107's admission record indicated an [AGE] year-old male resident who admitted to the facility on [DATE]. Resident #107 had diagnoses of other cerebral infarction (specific types of ischemic strokes caused by blocked blood flow to the brain that do not fit into common categories like thrombosis or embolism), unspecified dementia (cognitive decline that prevents a definitive diagnosis of a specific type), and hyperlipidemia (a common, often inherited or lifestyle-driven condition characterized by excess fat in the blood). Record review of Resident #107's care plan record dated 06/21/2024, indicated Resident #107 had a self-care deficit related to a diagnosis of cognitive impairment, weakness and debility. Resident #107 required 2 person assist with ADL self care. During an observation on 04/14/2026 at 11:45AM, Resident #107 was observed to have long facial hair, which appeared to not be maintained. During an interview on 04/16/2026 at 10:15AM, Resident #107 stated that the facility had not offered to shave his face. Resident #107 stated he would like his face shaved. He stated that because the facility had not offered to shave his face, it made him feel bad about himself. During an interview with the DON on 04/16/2026 at 10:44 am, the DON stated CNAs were responsible for giving the residents a bath/shower. The DON stated if a resident did not receive their scheduled bath/shower they could develop an odor or a skin issue. The DON stated her expectation was for all residents to receive a bath/shower as scheduled. During an interview with the ADM on 04/16/2026 at 10:58 am, the ADM stated the CNAs were responsible for giving the residents a bath/shower. The ADM stated that residents would develop an odor if they were not receiving a bath/shower per the residents' bath/shower schedule. ADM stated that he expected all residents to (continued on next page)

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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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive a bath/shower as scheduled. The ADM stated that residents should be offered to be shaved every time they have a shower, which should be 3 times a week. He stated that a resident could not feel good if the residents are not offered to be shaved. A record review of the facility's Routine resident care policy, dated, 3/14/19, revised date 01/2024 reflected Residents should receive the necessary assistance to maintain good grooming, personal/oral hygiene and safety. Steps are taken to provide that a resident's capacity for self-performance of these activities does not diminish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable. Care is taken to maintain resident safety at all times. Responsible Disciplines:License nurses and non-licensed direct care team membersGuidelines.2. Showers, tub baths, and/or shampoos should be scheduled at least twice weekly and more often as needed or per residents' preference. Shower schedules should be geared to resident preference and scheduled as such.3. Daily personal hygiene minimally includes assisting or encouraging residents with washing their faces and hands and combing their hair.