STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkland Court Health and Rehabilitation Center	1601 Kirkland Dr Amarillo, TX 79106

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491 Based on interview and record review, the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representatives when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention or a significant change in the resident's physical, mental, or psychosocial status for 1 (Resident #1) of 5 residents reviewed for notification. The facility failed to ensure Resident #1's resident representative was immediately notified when the resident had a change in condition that required he be transported via ambulance to the hospital. This failure could result in residents not having the comfort and company of their families during traumatic times. Findings included: Record review of Resident #1's face sheet revealed that Resident #1 was a [AGE] year-old male, who was originally admitted into the facility on [DATE], with an updated admitted [DATE]. Resident #1 had diagnoses that included but were not limited to: cellulitis of unspecified part of limb (common, potentially serious bacterial skin infection), repeated falls, muscle weakness, and reduced mobility. Updated diagnoses on 07/01/2024 documented encounter for other orthopedic aftercare. The admission record further revealed Resident #1's family member was his emergency contact. Record review of Resident #1's quarterly MDS completed on 05/10/24. Section C revealed a BIMS of 13 which indicated cognition was intact. Record review of Resident #1's care plan completed on 05/22/24 revealed resident was a risk for falls, with unsteady gait balance and required moderate assistance with his personal needs. Record review of Provider Investigation Report dated 06/28/24 revealed Resident #1 had an unwitnessed fall in the front lobby of the facility on 06/21/2024 which required x-rays and resulted in Resident #1 having a displaced sub capital femoral neck fracture of right hip (hip fracture). Record review of Resident #1's progress note dated 06/21/24 revealed Resident #1 left the facility by ambulance on the same day in stable condition. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note dated 06/26/24 and written by LVN B revealed that an attempt to contact Resident #1's family member, regarding resident's fall and transfer to hospital was unsuccessful. During a phone interview on 07/11/24 at 12:38 PM, emergency contact/family member stated that he was not contacted by the facility that Resident #1 had fallen or that he was transferred to the hospital due to the fall. He stated that he found out Resident #1 was in the hospital 2 days later, on his usual weekly visit to the facility when a nurse told him what had happened. When he got to the hospital, he found out Resident #1 had undergone surgery for the broken hip. Emergency contact/family member stated he was very upset that the facility had not contacted him about the fall or notified him that Resident #1 had been transferred. During an interview on 07/11/24 at 2:26 PM, LVN A stated that she was trained to immediately call the physician and family after a fall occurred and the resident was stable. She stated a possible negative outcome for not calling the family or the physician would be that if something happened to the resident, and the family was not notified, staff could be written up and the family could be upset, not knowing what was happening to their loved one. During an interview on 07/11/24 at 2:37 PM, LVN B stated that she was responsible for calling Resident #1's family after the fall. She stated that she called Resident #1's emergency contact/family member 2 times on the day of the fall, but that she was unable to talk with the family member and that she forgot to document it on the day of the fall, so she did a late entry on 06/26/24 in the progress notes. LVN B stated a possible negative outcome for not calling the family immediately after a significant change or transfer could be horrific and detrimental for family members. During an interview on 07/11/24 at 3:17 PM, DON stated that it was the charge nurses responsibility to contact the family and physician after a resident has had a change in condition. She stated that it was documented in either the progress notes or assessments. DON stated she could not find any documentation in assessments but found an entry in Resident #1's progress notes dated 06/26/24, 5 days after fall happened, that an unsuccessful attempt was made to contact family. DON stated a possible negative outcome for not contacting emergency contact/family member could be care at hospital might be bad if resident were to arrive confused and that family would not be aware of what was happening. Record review of facility policy titled Change in a Resident's Condition or Status and dated 02/21 revealed the following: .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status . .4. a nurse will notify the resident's representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of unknown source. b. There is a significant change in the resident's physical, mental, or psychosocial status. e. It is necessary to transfer the resident to a hospital/treatment center . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, Assessing Falls and Their Causes, dated 3/18 revealed the following: .After a fall: 5. Notify the resident's attending physician and family in an appropriate time frame . .Reporting: 1. Notify the following individuals when a resident falls: a. The resident's family