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 01/07/2025

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 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** 48161 Based on observation, interview and record review, the facility failed to ensure in accordance with accepted professional standards and practices, the facility maintained medical records on each resident that were complete, accurately documented, and readily accessible for 2 of 5 residents (Residents #1 and #2) reviewed for clinical records. The facility failed to ensure the altercation that occurred on 12/4/2024 between Resident #1 and Resident #2 was documented in their clinical records. This failure could place residents at risk for incorrect or omitted treatment, duplicated treatments, poor self-esteem and self-worth, and a failure to ensure continuity of care. Findings included: 1. Record review of Resident #1's face sheet, dated 01/07/2025, reflected a [AGE] year-old-female who was admitted to the facility on [DATE]. Resident #1's current diagnoses included but were not limited to cerebral infarction (stroke), vascular dementia (impaired blood flow to the brain/brain damage), major depressive disorder and generalized anxiety disorder . Record review of Resident #1's quarterly MDS Assessment, dated 11/07/2024, reflected Resident #1 had a BIMS score of 00 out of 15, which indicated her cognition was severely impaired. Record review of Resident #1's care plan, dated 11/11/2024, reflected Resident #1 had a behavior problem with interventions to intervene as necessary to protect the rights and safety to others, divert attention and remove from situation and take to alternate location as needed. No documentation of incident that occurred on 12/4/2024 was noted in care plan. Record review of Incident Report dated 12/4/2024 reflected Resident #1 was getting a cup of juice off the table in the dining room. Because the cup did not belong to Resident #1, Resident #2 attempted to get the cup back from the resident. The Incident Report reflected both residents were assessed, residents families were notified, and physician notified. The residents were separated. Record review of Resident #1's progress notes reflected no documentation of the incident that occurred on 12/4/2024 between Resident #1 and Resident #2. (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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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 01/07/2025
NAME OF PROVIDER OR SUPPLIER Kirkland Court Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #2's face sheet, dated 01/07/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2's current diagnoses included but were not limited to paranoid schizophrenia (delusion of paranoia), unspecified dementia (decline in cognitive function), and cognitive communication deficit (problems with communication). Record review of Resident #2's annual MDS Assessment, dated 12/10/24, reflected Resident #2 had a BIMS score of 12 out of 15, which indicated his cognition was intact. Record review of Resident #2's care plan, dated 12/12/2024, reflected Resident #2 had behavior problems with interventions to intervene as necessary to protect the rights and safety of others, monitor behavior episodes and attempt to determine underlying causes and provide opportunity for positive interaction, attention-stop and talk to Resident #2. Record review of Resident #2's progress notes reflected no documentation of the incident that occurred on 12/4/2024 between Resident #1 and Resident #2. During an observation and interview on 01/07/2024 at 10:03 AM, Resident #2 was in his room watching television. When asked about the incident, Resident #2 stated he did not remember the incident. During an observation and interview on 01/07/2024 at 10:05AM, Resident #1 was observed sitting in a recliner in the common area and she did not answer any questions that were presented to her. During an interview on 01/07/2025 at 1:10 PM, the ADM stated the incident should be documented in the progress notes. The ADM stated there would be no negative outcome for not having documentation in the progress notes due to the incident being on the incident report. During an observation and interview on 01/07/2025 at 1:12 PM, the ADON was looking through Resident #1's clinical record and could not find the documentation of the incident. The ADON stated the incident should have been documented in the progress notes in the clinical record and the charge nurse involved should have documented it. The ADON stated she was responsible for ensuring documentation was complete and accurate and a possible negative outcome would be staff would not know about the incident and would not be aware of what to look for in resident behavior. During an observation and interview on 01/07/2025 at 1:20 PM, LVN A stated she was the charge nurse on duty during the incident. LVN A attempted to find the documentation in the EMHR but could not find it. LVN A stated she must have forgotten to document it because she was overwhelmed that day and was concentrating on ensuring the residents were ok. LVN A stated a possible negative outcome for not documenting incidents would be the records would not be accurate. Record review of the Resident-to-Resident Altercations Policy, dated December 2016, reflected the following: If two residents are in an altercation the staff will: Complete a Report of Incident/Accident form and document the incident, finding and any corrective measures taken in the resident's medical/clinical record.