STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675336	A. Building B. Wing	06/04/2025

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 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 observations, interviews, and record reviews, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 (Residents #1) of 6 residents reviewed for care plans. The facility failed to implement Resident #1's care plan to ensure Resident #1 was transferred and toileted with the assistance of 2 staff in order to ensure resident's safety. Resident #1 was transfered from her bed to wheelchair using a gait belt with the assistance of one person. This failure could place residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing. The findings included: Resident #1 was a 69-y o female admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis, kidney failure and muscle wasting. Record review of Resident #1's comprehensive care plan dated 5/6/25 reflected Resident #1 was at risk for falls, required 2 persons assist for toileting, transfers and bed mobility. The goal of the care plan reflected The resident will maintain current level of function in ADLs through the review date. Interventions listed revealed: The resident required extensive assistance of 2 staff for toileting, bed mobility, and transfers. Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 12 out of 15 which indicated cognition was moderately impaired. Section GG of the MDS documented transfers, toileting and bed mobility for Resident #1 was dependent- Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. persons on 2 staff required maximum assistance with ADLs of toileting, bed mobility and transfers. Resident had 2 staff required for transfers, and toileting. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/4/25 at 10:10 am, the DON stated she expected all staff to review and follow the care plan recommendations. She stated the care plans were accessible on the front of each resident's chart. She stated if a resident could bear weight the resident was considered a 1 person assist and a one-person transfer. She stated that was how the MDS was scored and how the care plans reflected the MDS. She stated the MDS was scored after the nurses and CNAs provided the information on the resident and then the MDS calculated how much assistance the resident needed. She stated a resident was considered a one person transfer because the resident could bear weight and could participate or assist in helping with the transfers. The DON stated the consequences of not transferring residents correctly using the recommendations of the care plan would be injuries to the resident. In an observation and interview on 6/4/25 at 10:39 am, CNA A transferred Resident #1 from her bed to a wheelchair using a gait belt. CNA A toileted Resident #1 with no other staff assistance. Resident #1 was observed with left sided weakness of her arm. Resident #1 did not assist CNA A with the transfer. CNA A stated Resident #1 was a one-person transfer. CNA A stated she had always transferred Resident #1 by herself. CNA A stated Resident #1 was a left sided weakness so she could use her good side to assist with transfers. She stated Resident #1 did not weigh much so she could complete the transfer by herself. In an interview on 6/4/25 at 11:00 am, PTA B stated the facility had several residents who needed to be a 2 person transfer that were not a 2 person transfer at the present time. In an interview on 6/4/25 at 1:10 pm Resident #1 stated since she had been admitted to the facility, she had always been transferred with one person for the bathroom and getting out of the bed. She stated, It had always been with just one person. Resident #1 stated she had to go to the bathroom at least once every hour since she had been on dialysis. She stated when she needed to go, she had to go right then and could not wait. She stated she could not move her left side or assist at all. In an interview on 6/4/25 at 4:30 pm, CNA A stated Resident #1had been a one person transfer and a one person assist for toileting. She stated Resident #1 had left sided weakness, but she could use her right side to assist with the transfers. CNA A stated she had not been aware Resident #1 's care plan revealed she was a total dependence x's 2 and a two-person transfer and toilet. CNA A stated she had always transferred and toileted Resident #1 by herself. She stated all the facility staff only transfer Resident #1 as a one-person transfer. She stated she did not look at the care plan. She stated the care plan was available on the computer, but she had not looked at it. She stated when she was hired, she had been trained by the facility staff and had in-services on transfers since her hire. She stated the consequences of Resident #1 being transferred with only one person would be she could get hurt. In an interview on 6/4/25 at 5:00 pm, the DON stated she was not sure what Resident #1's assistance level would be, but it should be in the care plan. She stated the care a resident had gotten was driven by the lookback of 7 days in the MDS and the care level of residents could change every time the MDS was redone. She stated the nursing staff used the care plans to know how to care for resident. She stated the MDS drove the care plans and the care plans would change with every look back period. During exit conference on 6/4/25 at 6:45 pm, the ADM stated she had scheduled a training for facility staff for transfers with the therapy department and all care plans would be reviewed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy Care Plans, Comprehensive Person -Centered, dated March 2022, reflected. A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive care plan describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. Services provided for or arranged by the facility and outlined in the comprehensive service plan are provided by qualified persons. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem area s and their causes, and relevant clinical decision making.