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	09/13/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 (Resident #2 and Resident #3) of 5 resident's reviewed for abuse.1. The facility failed to protect Resident #2 from mental and verbal abuse by Resident #3 when he threatened to cut off her foot with a hand saw and proceeded to saw a groove in the center of her top, front, walker bar.2. The facility failed to protect Resident #3 from neglect when he was able to obtain a hand saw from an unlocked maintenance closet.These failures could place residents at risk of abuse and neglect.An Immediate Jeopardy (IJ) was identified on 09/12/25. The IJ template was provided to the facility on [DATE] at 01:00 PM. While the IJ was removed on 09/13/25 at 12:08 PM the facility remained out of compliance at a severity level of no actual harm potential for more than minimal harm not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. Plan of Removal of IJ will be included in findings.Findings Included:1. Record review of Resident #2's admission record dated 09/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, intermittent explosive disorder (repeated sudden outbursts of anger), psychotic disorder with delusions (severe mental illness including distorted beliefs) due to known physiological condition, and major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities).Record review of Resident #2's admission MDS completed on 06/19/25 revealed a BIMS score of 10 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #2 used a walker. She was noted to require partial/moderate assistance to supervision/touching assistance across all ADLs. Record review of Resident #2's care plan initiated on 06/20/25 revealed she had the potential to be verbally aggressive and yell at other residents and staff related to dementia. Resident #2 was noted to receive antianxiety medication and antipsychotic medication.Record review of Resident #2's active orders revealed the following orders with corresponding start dates:07/30/25 risperiDONE Oral Tablet 0.25 MG (Risperidone) Give1 tablet by mouth at bedtime related to PSYCHOTICDISORDER WITH DELUSIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION06/11/25 traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for Headache related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES09/11/25 Vistaril Oral Capsule 50 MG (Hydroxyzine Pamoate) Give 1 capsule by mouth every 04 hours as needed for anxiety for 14 Days2. Record review of Resident #3's admission record revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement) without dyskinesia (abnormality or impairment of voluntary movement), unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), muscle wasting and atrophy (shrinkage or wasting away of tissue), muscle weakness, and other lack of coordination.Record review of Resident #3's quarterly MDS completed 09/05/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section E Behavior revealed Resident #3 had no behaviors. Section GG Functional Abilities revealed he was independent across all ADLs. Section M Medications revealed he was receiving antidepressant, antiplatelet, and anticonvulsant medication.Record review of Resident #3's care plan completed on 09/08/25 revealed he was resistive to care r/t impaired cognition and he had potential to be physically aggressive throwing objects r/t behaviors. Resident #3 was noted to have potential to be verbally aggressive very rude and demanding r/t cognitive impairment. He had impaired cognitive function r/t dementia. He had a mood problem r/t MDD and declines to see psych. Interventions included administering medications as ordered, explain all procedures and orders prior to starting and allow time to adjust to changes, discuss inappropriate behaviors with resident when reasonable, monitor behavior episodes and attempt to determine underlying causes, and document behaviors and potential causes. Staff were instructed to give the resident 5-10 minutes when resistive to care

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	675336	A. Building B. Wing	09/13/2025

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 (Resident #2 and Resident #3) of 5 residents reviewed for abuse/neglect policy implementation.The facility failed to implement their abuse policy when Resident #3 obtained a hand saw from an unlocked maintenance closet and used it to threaten Resident #2 and to saw a groove into the top, front bar of Resident #2's walker.This failure could place residents at risk of abuse and neglect occurring and/or continuing.An Immediate Jeopardy (IJ) was identified on 09/12/25. The IJ template was provided to the facility on [DATE] at 01:00 PM. While the IJ was removed on 09/13/25 at 12:08 PM the facility remained out of compliance at a severity level of no actual harm potential for more than minimal harm not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. Plan of Removal of IJ will be included in findings.Findings Included:1. Record review of Resident #2's admission record dated 09/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, intermittent explosive disorder (repeated sudden outbursts of anger), psychotic disorder with delusions (severe mental illness including distorted beliefs) due to known physiological condition, and major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities).Record review of Resident #2's admission MDS completed on 06/19/25 revealed a BIMS score of 10 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #2 used a walker. She was noted to require partial/moderate assistance to supervision/touching assistance across all ADLs. Record review of Resident #2's care plan initiated on 06/20/25 revealed she had the potential to be verbally aggressive and yell at other residents and staff related to dementia. Resident #2 was noted to receive antianxiety medication and antipsychotic medication.Record review of Resident #2's active orders revealed the following orders with corresponding start dates:07/30/25 risperiDONE Oral Tablet 0.25 MG (Risperidone) Give1 tablet by mouth at bedtime related to PSYCHOTICDISORDER WITH DELUSIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION06/11/25 traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for Headache related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES09/11/25 Vistaril Oral Capsule 50 MG (Hydroxyzine Pamoate) Give 1 capsule by mouth every 04 hours as needed for anxiety for 14 Days2. Record review of Resident #3's admission record revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement) without dyskinesia (abnormality or impairment of voluntary movement), unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), muscle wasting and atrophy, muscle weakness, and other lack of coordination.Record review of Resident #3's quarterly MDS completed 09/05/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section E Behavior revealed Resident #3 had no behaviors. Section GG Functional Abilities revealed he was independent across all ADLs. Section M Medications revealed he was receiving antidepressant, antiplatelet, and anticonvulsant medication.Record review of Resident #3's care plan completed on 09/08/25 revealed he was resistive to care r/t impaired cognition and he had potential to be physically aggressive throwing objects r/t behaviors. Resident #3 was noted to have potential to be verbally aggressive very rude and demanding r/t cognitive impairment. He had impaired cognitive function r/t dementia. He had a mood problem r/t MDD and declines to see psych. Interventions included administering medications as ordered, explain all procedures and orders prior to starting and allow time to adjust to changes, discuss inappropriate behaviors with resident when reasonable, monitor behavior episodes and attempt to determine underlying causes, and document behaviors and potential causes. Staff were instructed to give the resident 5-10 minutes when resistive to care before trying again and when he became agitated to intervene before the agitation escalated and guide him

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Kirkland Court Health and Rehabilitation Center	1601 Kirkland Dr Amarillo, TX 79106

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #2 and Resident #3) of 5 residents reviewed for reporting of abuse/neglect allegations.The facility failed to report an incident from 09/10/25 when Resident #3 obtained a hand saw from an unlocked maintenance closet and used it to threaten Resident #2 and to saw a groove into the top, front bar of Resident #2's walker.This failure could place residents at risk of continued abuse/neglect.Findings Included:1. Record review of Resident #2's admission record dated 09/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, intermittent explosive disorder (repeated sudden outbursts of anger), psychotic disorder with delusions (severe mental illness including distorted beliefs) due to known physiological condition, and major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities).Record review of Resident #2's admission MDS completed on 06/19/25 revealed a BIMS score of 10 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #2 used a walker. She was noted to require partial/moderate assistance to supervision/touching assistance across all ADLs. Record review of Resident #2's care plan initiated on 06/20/25 revealed she had the potential to be verbally aggressive and yell at other residents and staff related to dementia. Resident #2 was noted to receive antianxiety medication and antipsychotic medication.Record review of Resident #2's active orders revealed the following orders with corresponding start dates:07/30/25 risperiDONE Oral Tablet 0.25 MG (Risperidone) Give1 tablet by mouth at bedtime related to PSYCHOTICDISORDER WITH DELUSIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION06/11/25 traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for Headache related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES09/11/25 Vistaril Oral Capsule 50 MG (Hydroxyzine Pamoate) Give 1 capsule by mouth every 04 hours as needed for anxiety for 14 Days2. Record review of Resident #3's admission record revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement) without dyskinesia (abnormality or impairment of voluntary movement), unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), muscle wasting and atrophy (shrinkage or wasting away of tissue), muscle weakness, and other lack of coordination.Record review of Resident #3's quarterly MDS completed 09/05/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section E Behavior revealed Resident #3 had no behaviors. Section GG Functional Abilities revealed he was independent across all ADLs. Section M Medications revealed he was receiving antidepressant, antiplatelet, and anticonvulsant medication.Record review of Resident #3's care plan completed on 09/08/25 revealed he was resistive to care r/t impaired cognition and he had potential to be physically aggressive throwing objects r/t behaviors. Resident #3 was noted to have potential to be verbally aggressive very rude and demanding r/t cognitive impairment. He had impaired cognitive function r/t dementia. He had a mood problem r/t MDD and declines to see psych. Interventions included administering medications as ordered, explain all procedures and orders prior to starting and allow time to adjust to changes, discuss inappropriate behaviors with resident when reasonable, monitor behavior episodes and attempt to determine underlying causes, and document

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated for 2 (Resident #2 and Resident #3) of 5 residents reviewed for allegation investigation.The facility failed to investigate an incident from 09/10/25 when Resident #3 threatened Resident #2 with a hand saw and then cut a groove in the center of the top, front bar of Resident #2's walker.This failure could place residents at risk of continued abuse or neglect.Findings Included:1. Record review of Resident #2's admission record dated 09/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) with late onset, intermittent explosive disorder (repeated sudden outbursts of anger), psychotic disorder with delusions (severe mental illness including distorted beliefs) due to known physiological condition, and major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities).Record review of Resident #2's admission MDS completed on 06/19/25 revealed a BIMS score of 10 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #2 used a walker. She was noted to require partial/moderate assistance to supervision/touching assistance across all ADLs. Record review of Resident #2's care plan initiated on 06/20/25 revealed she had the potential to be verbally aggressive and yell at other residents and staff related to dementia. Resident #2 was noted to receive antianxiety medication and antipsychotic medication.2. Record review of Resident #3's admission record revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement) without dyskinesia (abnormality or impairment of voluntary movement), unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), muscle wasting and atrophy (shrinkage and wasting away of tissue), muscle weakness, and other lack of coordination.Record review of Resident #3's quarterly MDS completed 09/05/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section E Behavior revealed Resident #3 had no behaviors. Section GG Functional Abilities revealed he was independent across all ADLs. Section M Medications revealed he was receiving antidepressant, antiplatelet, and anticonvulsant medication.Record review of Resident #3's care plan completed on 09/08/25 revealed he was resistive to care r/t impaired cognition and he had potential to be physically aggressive throwing objects r/t behaviors. Resident #3 was noted to have potential to be verbally aggressive very rude and demanding r/t cognitive impairment. He had impaired cognitive function r/t dementia. He had a mood problem r/t MDD and declines to see psych.Record review Resident #3's progress notes from 03/11/25 to 09/12/25 revealed no mention of physical or verbal aggression toward another resident.During an observation and interview on 09/11/25 at 08:23 AM Resident #2 stated a male resident had a saw yesterday and threatened to cut off her feet and then cut on her walker. She gestured to the top, front bar of her walker.During an interview on 09/11/25 at 08:36 AM ADON stated she was just told by Resident#2 about Resident #3 threatening her with a saw on 09/10/25.During an observation and interview on 09/11/25 at 08:41 AM ADM stated Resident #3 had a hand saw on 09/10/25. She stated, He took it out of the maintenance room is the only thing we can figure out. ADM stated CNA A and CNA B were working at the time and took the saw away from Resident #3. When asked if he used the saw to threaten Resident #2 and/or cut on her walker, ADM shook her head and stated, What you are going to find out is [name of Resident #2] doesn't tell the truth.During an interview on 09/11/25 at 08:50 AM CNA A stated regarding Resident #3 on 09/10/25, I mean he did have a saw but as soon as we seen him, we took it from him. He was rolling with the saw down the hall. She stated she did not hear him threaten Resident #2 or see him using the saw on Resident #2's walker.During an interview on 09/11/25 at 08:51 AM CNA B stated Resident #3 had a saw on 07/10/25 and he was using the saw on Resident #2's walker. She stated, You can look at her walker. There is proof. CNA B stated Resident #3 got the saw from the maintenance office. She stated she reported the incident to ADM and ADON as soon as the

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 2 (Resident #1 and Resident #3) of 5 residents reviewed for accidents and hazards.1. The facility failed to ensure Resident #1 did not elope on 08/21/25 in his manual wheelchair 8 days after he had cranioplasty surgery .5 of a mile from the facility on his way to the hospital.2. The facility failed to ensure Resident #3 did not have access to a hand saw from the unlocked maintenance office.These failures could place residents at risk of injury or death.An Immediate Jeopardy (IJ) was identified on 09/12/25 at 01:00 PM. Although the IJ was removed on 09/13/25 at 12:08 PM the facility remained out of compliance at a severity level of actual harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. Plan of Removal of IJ will be included in findings.Findings Included:1. Record review of Resident #1's admission record dated 09/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it, stroke), aphasia (a disorder that affects the ability to communicate, read, write, and understand language caused by damage or injury to the specific area of the brain responsible for language), hemiplegia and hemiparesis following cerebral infarction (partial paralysis following stroke) affecting right dominant side, muscle wasting and atrophy, muscle weakness, and other lack of coordination.Record review of Resident #1's quarterly MDS completed on 08/08/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section GG Functional Abilities revealed he had impairment on one side to both upper and lower extremities and utilized a manual wheelchair. He was noted to require substantial/maximal assistance with toileting, bathing, personal hygiene, and dressing. He was noted to be independent wheeling himself once he was seated in his wheelchair. Section J Health Conditions revealed Resident #1 received scheduled pain medication and PRN pain medications. His pain was noted to be occasional, severe, and rarely interfered with sleep and day-to-day activities.Record review of Resident #1's care plan completed on 08/08/25 revealed he was a wanderer r/t confusion. The goal was, The resident's safety will be maintained through the review date. Interventions included distracting him by offering diversions and identifying if his wandering had a pattern. Resident #1 was noted to have impaired cognitive function r/t CVA. Interventions included asking him yes/no questions to determine his needs and The resident needs supervision with all decision making. He was noted to have a communication problem r/t Aphasia; makes sounds and gestures to communicate. Resident #1 was noted to have poor balance, impaired though process and to be very mobile in wheelchair and require supervision. One of the interventions for this area of the care plan was to ensure he was wearing appropriate footwear with ambulating or mobilizing in his wheelchair. He was noted to need a safe environment with: even floors . Resident #1 slid out of his wheelchair on 03/02/25 and fell on [DATE] during a self- transfer. He was noted to have hemiplegia/hemiparesis r/t CVA. He was noted to have chronic pain. Staff were to evaluate the effectiveness of pain interventions and notify the physician if interventions were unsuccessful or if current complaint was a significant change from his past experience of pain. Resident #1 was able to answer yes/no by nodding or shaking his head and to gesture thumbs up or thumbs down to assist in pain assessment. He was noted to have bladder incontinence.Record review of Resident #1's order summary report dated 09/11/25 revealed the following orders with corresponding order start dates:02/27/25 Gabapentin Oral Capsule (Gabapentin) Give 300 mg by mouth two times a day for pain - Moderate11/17/24 [Brand name of Acetaminophen] Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for PainRecord review of Resident #1's MAR for June 2025 revealed he received Gabapentin as ordered all 30 days of the month. He received 650 mg of acetaminophen on the following dates with corresponding pain levels and the medication was effective: 06/01/25 level 10, 06/04/25 level 9, 06/05/25 level 9, 06/24/25 level 9, 06/25/25 level 3.Record review of Resident #1's MAR for July 2025 revealed his Gabapentin was on hold by the physician from 07/22/25 through 08/01/25. Resident #1 received Gabapentin as ordered from 07/01/25 through the morning dose on 07/22/25. He received 650 mg of acetaminophen on the following dates with corresponding pain levels and the medication was effective: 07/04/25 level 2, 07/05/25 level 7, 07/13/25 level 9, 07/15/25 level 3, 07/16/25 level 3, 07/18/25 level 8, 07/19/25 level 7, 07/19/25 level 3