

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 12/01/2025
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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review the facility failed, in accordance with State and Federal laws, to store all drugs and biologicals in locked compartments for 1 (west wing medication cart) of 4 medication carts reviewed for medication storage. The facility failed to ensure RN locked the west wing medication cart when it was unattended. This failure could place residents at risk of injury due to ingesting non-prescribed medications and/or ingesting prescribed medications at incorrect doses or times. Findings included: During an observation on 12/01/2025 at 8:43am the west wing medication cart was unlocked and unattended. Unidentified residents were walking about freely around the medication cart. During an observation on 12/01/2025 at 8:45am the RN for the west wing of the facility came back to the medication cart and locked it. During an interview on 12/01/2025 at 8:49am RN stated the reason she did not lock the west wing medication cart was because she just forgot. RN stated that a negative outcome for the residents was They might take something out of it. During an interview on 12/01/2025 at 9:30am ADON stated that the negative outcome for not locking medication carts would be that other residents could get into the cart and take medications that were not theirs. During an interview on 12/01/2025 at 10:42am ADM stated that the negative outcome for residents getting into an unlocked medication cart would be that other residents could get into the cart and take medications that did not belong to them. Record review of facility policy titled Administering Medications, dated April 2019 revealed the following: . 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.</p>

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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