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	12/17/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 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 interview and record review the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #1) of 5 residents reviewed for advanced directives. Resident #1 had a DNR in her record that was not dated by the physician. The facility's failure could place residents at risk for not receiving healthcare as per their or their legal representatives' wishes.Findings included: Record review of Resident #1's face sheet printed 12/17/2025 revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), atherosclerotic heart disease of native coronary artery with unstable angina pectoris (narrowing and hardening of the arteries due to buildup of plaque) and an aneurysm of the ascending aorta, without rupture (weak spot on aorta). The face sheet reflected that Resident #1 had a Do Not Resuscitate (DNR) order under Advance Directives Record review of Resident #1's Quarterly MDS Assessment completed 10/29/2025 indicated a Brief Interview of Mental status (BIMS) score of 12, reflecting moderately impaired cognition, and documented that the resident required supervision or touching assistance with activities of daily living. Record Review of Resident #1's care plan, most recently revised on 10/29/2025, included the following problem statement: Resident had an order for Do Not Resuscitate. Date initiated: 07/11/2025 Resident had a terminal prognosis and was admitted to hospice dated 07/29/2025 Record review of the clinical record printed on 12/17/2025, revealed an order summary that listed: DNR-Active - 07/11/2025. Resident was admitted to Hospice on 7/17/2025.Record review of the electronic medical record revealed no DNR document uploaded or maintained in the system Record review of a paper DNR located at the nurses' station for Resident #1 revealed the DNR form was signed and dated by the resident and signed by two witnesses on 07/11/2025. Review further revealed the physician had signed the DNR; however, the signature was not dated. During an interview on 12/17/2025 at 7:45 AM, LVN A (the nurse responsible for Resident #1 this shift) reviewed the paper DNR and stated the document was incorrect because the physician had not dated the signature and the physician should be responsible for ensuring the DNR was completed correctly. During an interview on 12/17/2025 at 8:25 AM, the ADON reviewed the DNR and stated the document was not valid because the physician had not signed and dated it, and that honoring the DNR in its current state would be against the resident's' wishes. The ADON stated the SW was responsible for ensuring DNR documents were completed correctly. During an interview on 12/17/2025 at 8:40AM, the SW reviewed the DNR and said she was unsure whether the document was completed correctly. The SW stated she believed the form appeared acceptable but indicated she was not responsible for DNR completion and that responsibility belonged to the DON. During an interview on 12/17/2025 at 8:45 AM, the DON reviewed the DNR and stated the document was incomplete and not filled out correctly. The DON stated that, due to the incomplete DNR, the resident would need to be coded, which would be against the resident's expressed wishes.During an interview and observation on 12/17/2025 at 9:00 AM, Resident #1 was observed sitting in bed eating breakfast. The resident stated she was on hospice services and that her wish was to be a DNR.During an interview and observation on 12/17/2025 at 9:50AM, the SW and ADM presented a second DNR obtained from the hospice agency. Review of this document revealed it was signed and dated by Resident #1, and two witnesses on 07/15/2025, with RN and LVN written after the witness signatures and signed and dated by the physician on 07/16/2025. During the discussion the ADM stated that both witnesses were employed by the facility at the time the DNR was signed. After reviewing the DNR instructions, the ADM acknowledged the DNR was not valid because both witnesses were direct care staff at the time of execution. The ADM who was aware the SW was responsible for the DNRs stated she would get with SW and conduct an audit of all DNR documents.Record review of the facility provided policy titled Advanced Directives updated December 2016, revealed the following: Policy Statement: Advanced Directives will be respected in accordance with state law and facility policy.Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, revealed the following:-The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to review the risks and benefits of bed rails with 1 of 5 (Resident #1) residents or their resident representatives and obtain informed consent prior to installation of bed rails, in that:Resident #1 had (1) one-half length bed rail installed on the right side of her bed without a physician order, without documented informed consent from the resident or resident representative and without inclusion of bed rail use in the resident's comprehensive care plan. This failure placed the residents at risk for injury, including entrapment of bedrails, hindered the resident's' ability to independently exit the bed and could negatively impact the resident's' ability to engage in activities of daily living.Findings included:Record review of Resident #1's face sheet printed 12/17/2025 revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), atherosclerotic heart disease of native coronary artery with unstable angina pectoris (narrowing and hardening of the arteries due to buildup of plaque) and an aneurysm of the ascending aorta, without rupture (weak spot on aorta). Unspecified fracture of sacrum, subsequent encounter for fracture with routine healingRecord review of Resident #1's Quarterly MDS Assessment completed 10/29/2025 indicated a Brief Interview of Mental status (BIMS) score of 12, reflecting moderately impaired cognition, and documented that the resident required supervision or touching assistance with activities of daily living. Record review of Resident #1's care plan, most recently revised on 10/29/2025, did not have any documentation relating to bed rail use. Care plan also indicated resident was a high risk for falls, with a history of falls prior to admission.Record review of Resident #1's active physician orders on 12/17/2025 did not include a physician order authorizing bed rail use.Record review of Resident #1's electronic medical record under consents on 12/17/2025 did not include documented informed consent for bed rail use. Record review of Resident #1's Bed Rail Safety Review dated 12/10/2025 reflected the bed rails will promote mobility.During an interview and observation on 12/17/2025 at 7:45 AM, LVN A (the nurse responsible for Resident #1 this shift) was observed reviewing Resident #1's orders and did not find an order for bed rails and stated she was new and unsure if orders were required for bed rails. During an interview and observation on 12/17/2025 at 8:25 AM, the ADON reviewed Resident #1's electronic medical record and could not find an order or consent in the record and stated she would look through her paper files to see if it did not get put in the system. The ADON said a possible negative outcome for having bed rails without orders or consent could cause harm.During an interview on 12/17/2025 at 8:45 AM, the DON stated she was responsible for documenting the use of bedrails in the care plan but stated since there was no physician order for the bed rail it did not alert her to add it to the care plan. The DON stated a possible negative outcome for bed rail use without an order, informed consent, and care plan intervention could result in harm.During an interview and observation on 12/17/2025 at 9:00 AM, Resident #1 was observed sitting in bed watching tv, head of bed raised, she was eating breakfast. The Resident stated she liked the bed rail on her bed because it made her feel safe and helped with her mobility. During an interview on 12/17/2025 at 9:50AM, the ADON stated she could not find the consent and reported contacting the resident's representative to obtain consent. Record review of the facility's policy Proper Use of Side Rails dated December 2016 reflected the following: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. The use of side rails as an assistive device will be addressed in the resident care plan Consent for the side rail use will be obtained from the resident or legal representative