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	06/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviews, the facility failed to permit 1 (Resident #1) of 1 resident reviewed for discharge, to remain in the facility and not transfer or discharge the resident from the facility.The facility discharged Resident #1 and did not allow Resident #1 to return to the facility after being denied admittance by an acute care facility on 06/06/2026.This failure could result in residents' needs not being met, decline in resident safety, and a violation of resident's rights.Findings Include: Record review of Resident #1's face sheet, dated 06/29/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnoses include but are not limited to anoxic brain injury (no oxygen to brain for a period long enough to damage brain cells), type 2 diabetes(body is resistant to insulin or when the pancreas fails to produce enough insulin), critical illness myopathy (generalized, symmetrical weakness of skeletal muscles), intermittent explosive disorder (sudden episodes of unwarranted anger), dysphagia (difficulty swallowing), attention-deficit hyperactivity disorder (neurodevelopmental disorder), generalized anxiety disorder (excessive incontrollable worry about every day issues), muscle wasting and atrophy (loss or thinning of muscle mass and strength), and cognitive communication deficit (disruption of mental processes essential for communication). Record review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS of 07 which indicated severe cognitive impairment, suggesting difficulties with memory, orientation, and thinking skills. Section D, Mood, revealed a total severity score of 0. Section GG-functional abilities- revealed resident was substantial/maximal assistance for eating, oral hygiene, toileting, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. Section GG-Mobility- revealed resident was substantial/max assist for toilet transfer, partial/moderate assistance with rolling left to right, and supervision or touch assistance with sit-to-lying, lying to sitting on side of bed, sit to stand, char/bed-to-chair transfer, tub/shower transfer, walk 10 feet, walk 50 feet with two turns, and walk 150 feet. Question Q5 revealed that Resident #1 does not use a wheelchair. Record review of Resident #1's discharge MDS, dated [DATE], revealed with question A0310, question F, that Resident #1 was discharged with return not anticipated. Review of question A0310, section G, revealed the type of discharge was unplanned. Question A2105 revealed code 07 for discharge status which indicated that Resident #1 was discharged to a psychiatric hospital or unit. Section E- Behavior, section E0200 revealed resident had behavior of this type occurred 1 to 3 days for physical behavioral symptoms directed towards others, verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed towards others. Record review of Resident #1's care plan, dated 06/11/2026, revealed a focus of The resident is physically aggressive combative r/t poor impulse control. Resident had an altercation with other resident that took his food; Resident #1 hit the resident; placed on one-to-one and IDT looking for psych hospital placement. Record review of progress note, dated 06/04/2026, revealed residents were heard screaming from the other side of the facility. Resident #1 was screaming and cursing nurses and other residents. Staff members attempted to de-escalate the situation and were able to redirect Resident #1 to his room where he began punching walls. Intervention was initiated and Resident #1 became calm while (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	continuing one-to-one supervision. Record review of progress note, dated 06/05/2026, labeled as a behavioral note indicated that Resident # 1 remains on continuous supervision due to behavioral concerns. Nursing staff notified administration and nursing staff notified administration and local law enforcement after an incident in which the resident struck another resident with a door. Staff supervising resident attempted immediate intervention; however, the door made contact with the other resident's face before staff could prevent the incident. The facility stated they contacted law enforcement who attempted to assist with placement in an inpatient psychiatric facility due to Resident #1's escalating behaviors and several hospitals were contacted where Resident #1 was declined to be admitted . The facility was advised to contact law enforcement if Resident #1's behaviors continued to escalate. Record review of Resident #1's progress note, dated 06/06/2026, revealed the following note, Immediate transfer/discharge pursuant to 42 CFR 483.15(c)(1)(i)(C) due to resident's behavioral status endangering the safety of other residents and staff, Resident physically assaulted another resident and presents an ongoing risk for further harm. Transfer to [name of facility] at [name of local hospital] is necessary to ensure the health and safety of others and provide a more appropriate level of behavioral health care ADM is transporting the patient to [name of local hospital]. Record review of form SNF/NF to Hospital Transfer Form, dated 06/06/2026, revealed transfer to [local hospital named] due to behavioral symptoms (e.g. agitation, psychosis). Form was signed by DON on 06/06/2026 at 12:20 with date transferred to the hospital noted at 06/06/2026 at 12:25. On 06/29/2026 at 11:12 AM, an attempt to contact Resident #1's family members was made with no success. On 06/29/2026 at 11:48 AM, an attempt to speak with [name of behavioral hospital] was attempted with no success. On 06/29/2026 from 1:32 PM to 1:51 PM, a second attempt was made to speak with [name of behavioral hospital] with no success. In an interview on 06/29/2026 at 2:25 PM, the SW stated Resident #1 has not been seen or assessed since discharge by the facility. The SW stated she is unsure if Resident #1 can return. The SW stated she was unsure if Resident #1 had tried to return to the facility. The SW stated that it would be in the best interest for Resident #1 not to return to the facility because there may be triggers that cannot be prevented. When asked for a negative outcome of the resident not being able to return to the facility, the SW stated, I'm not sure, I can find out. In an interview on 06/29/2026 at 2:50 PM, ADON stated that more outbursts, screaming and cussing, and threatening was what led to Resident #1's involuntary discharge. The ADON stated it was the administrator and the doctor who decided if Resident #1 would be readmitted . The ADON stated it was a resident right to return after being discharged . The ADON stated Resident #1 agreed to be discharged to [name of behavioral unit]. The ADON stated she does not feel there were any interventions as Resident #1 was up walking around and fine one minute and then wasn't. In an interview on 06/29/2026 at 3:20 PM, OMB stated Resident #1 was admitted to [name of hospital]. In an interview on 06/29/2026 at 4:03 PM, the CM stated Resident #1 was admitted to [name of hospital] and that she has talked to the facility. The CM stated that Resident #1 was not a safe discharge. The CM stated that the FL stated the facility was not taking Resident #1 back. The CM stated that Resident #1 is very directable and behaviors are minimal. The CM stated Resident #1 would need to be placed on a locked unit. In an observation and interview on 06/29/2026 at 4:15 PM, Resident #1 was observed in a hospital room at [name of hospital]. Resident #1 stated he was kicked out but doesn't remember why he was kicked out. Resident # 1 stated he was ok with [name of facility] but is okay with going to another facility. In an interview on 06/29/2026 at 4:37 PM, the DON stated Resident #1's behaviors started on 06/03/2026 and Resident #1 was discharged on 06/06/2026. The DON stated the facility sent Resident #1 to the hospital, the [name of behavioral hospital] communicated with DON, at an undisclosed day/time, and stated [name of behavioral hospital] were putting Resident #1 on an Uber, and Resident #1 did not come back to the facility. The DON stated the [name of behavioral hospital] had sent Resident #1 to the [name of homeless shelter] instead of the facility. The DON stated local police sent Resident #1 to the hospital. The DON stated MD would not provide care because MD wouldn't take Resident #1 as a (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	patient. The DON stated the facility has not looked at another physician to oversee Resident #1's care. The DON stated a negative outcome was hope the family would take care of him. In an interview via phone on 06/29/2026 at 4:51 PM, the ADM stated she knew Resident #1's agitation was getting worse. The ADM stated Resident #1 agreed to go to [name of behavioral unit]. The ADM stated the facility did do an immediate discharge due to assault on another resident and progression of verbal aggression. The ADM stated the resident has not been assessed after being discharged to return to the facility. ADM stated she knows Resident #1 doesn't belong at the facility. The ADM stated that corporate stated they cannot take him back. The ADM stated MD stated he was not accepting Resident #1 back as a patient. The ADM stated they felt they discharged him to a safe place. The ADM was made aware that the [name of behavioral health hospital] did not admit Resident #1 and they were sending him in a taxi back to the facility. The ADM stated Resident #1 did not return to the facility and was found at [name of homeless shelter] by the police. The ADM stated the police took Resident #1 back to [name of hospital] where he was receiving treatment and medication until placement could be determined. Resident #1 was still admitted to [name of hospital]. The ADM stated a negative outcome would be that the resident must stay in the hospital until placement is found. In an interview on 06/30/2026 at 8:26 AM, FL stated CM called FL asking about discharge. FL stated he communicated about Resident #1's behaviors and discharge. FL stated he does not know if Resident #1 is allowed to return to the facility. In an interview on 06/30/2026 at 8:43 AM, CM stated FL told her that facility was not going to admit Resident #1 back in the facility. In an interview on 06/30/2026 at 8:52 AM, the ADON, DON, and FL were asked if [name of hospital] was to call and discharge Resident #1, would the facility admit. DON stated according to ADM and MD, no. ADON stated she understood Resident #1 was not going to be admitted . In an interview on 06/30/2026 at 9:13 AM, ADM stated if the [name of the hospital] was to send over records today and go through all the avenues, the facility would have to have all those items before the facility can safely say that Resident #1 can be here. Facility stated they can't do 1:1 as it is policy to not take residents back. The ADM stated the immediate discharge was to [name of behavioral unit]. The ADM confirmed they did provide the discharge due to Resident #1 assaulting another resident. The ADM stated MD can't take Resident #1 back as a patient. The ADM stated corporate was standing by to not readmit him because the facility was not able to safely meet his needs. ADM stated there shouldn't be a negative outcome as he was being discharged to a safe place that the facility was aware of which was what the facility did. The ADM stated there were no other aggressive residents in the facility. The ADM stated she was willing to take the tag because she truly felt that what was done was right. In an interview on 06/30/2026 at 10:40 AM, the ADM stated she believed Resident #1 was admitted to behavioral unit. Police called ADM and stated Resident #1 was not going to be allowed to stay at [name of behavioral unit]. ADM stated she did not offer to obtain Resident #1 from behavioral unit. In an interview on 06/30/2026 at 10:35 AM, CM stated called facility and texted with FL. CM asked if Resident #1 was discharged , would Resident #1 be allowed to return to the facility. FL replied with following statement, I'm sorry, but at this time I do not have a medical director with admitting privileges at this facility who is able to accept him due to the risk he may pose to the safety and well-being of our other patients. In an interview via phone on 06/30/2026 at 11:56 AM, the MD stated Resident #1 was a danger to self and other patients. The MD stated he fired him to protect the other residents. The MD stated if [name of hospital] was to call and state they are discharging; he would not readmit him. Record review of flyer titled Your Rights in a Nursing Facility, dated January 2025, stated under heading Transfers and Discharges, revealed a resident has the right to not be discharged from the facility, except in accordance with nursing facility regulations and be readmitted to the facility as provided by nursing facility regulations. Record review of procedure titled, Discharging the Resident, revised December 2016, revealed the purpose of the procedure is to provide guidelines for the discharge process. Facility did not provide a discharge or transfer policy as requested during entrance conference and documented wish list sent by email on 06/29/2026 at 8:27 AM.