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	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 (Resident #30) of 15 residents reviewed for PASRR. The facility failed to perform a new PASRR level 1 assessment on Resident #30 due to diagnoses of bipolar disorder and PTSD. This failure could place residents at risk of not receiving needed services and support. Findings Included: Record review of Resident #30's admission record dated 06/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, bipolar disorder mixed severe (serious mental illness characterized by extreme mood swings such as extreme excitement or extreme depressive feelings) and post-traumatic stress disorder (mental health condition caused by a traumatic event that affects your ability to function normally). The date listed for these two diagnoses was 08/30/24. Record review of Resident #30's MDS completed on 04/08/25 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section I indicated Resident #12 had diagnoses that included Bipolar Disorder and PTSD. Record review of Resident #30's care plan completed on 04/09/25 revealed the following focus areas: The resident has a behavior problem easily agitated, short with staff rt bipolar disorder The resident uses antidepressant medication . r/t bipolar disorder The resident uses psychotropic medications . r/t Bipolar disorder. The resident has a mood problem r/t Bipolar disorder, PTSD Record review of Resident #30's active orders dated 06/10/25 revealed the following orders and start dates: (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aripiprazole Oral Tablet 5 MG . Give 1 tablet by mouth at bedtime related to BIPOLAR DISORDER . 02/26/2025 Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG . Give 1 capsule by mouth at bedtime for antidepressant related to BIPOLAR DISORDER . 08/31/24 Record review of Resident #30's MISC tab in her EHR revealed her most recent psychiatry progress note was dated 06/06/25 and she was being treated for bipolar disorder and PTSD. Record review of Resident #30's PASRR level 1 assessment revealed it was performed on 08/29/24 and she was noted to be negative for mental illness. During an interview on 06/11/25 at 09:20 AM ADM stated not performing a new PASRR level 1 assessment on a resident with a qualifying diagnosis could result in a resident not receiving extra services they need. She stated DON was responsible for PASRR assessments. During an interview on 06/11/25 at 09:40 AM DON stated residents might miss out on services they need if they were not newly assessed based on a qualifying diagnosis. DON stated she thought if Resident #30 was screened as negative for mental illness prior to admission she did not need a new PASRR level 1 assessment despite having a qualifying diagnosis because she presumably had the diagnosis prior to admission and at the time of the original screening. During an interview on 06/11/25 at 10:32 AM DON stated she was responsible for PASRR level 1 screenings. During an interview on 06/11/25 at 10:44 AM with MHAE, whose phone number was provided by DON, she stated a bipolar disorder diagnosis would require the facility to conduct another PASRR level 1 assessment. MHAE stated this time the PASRR level 1 assessment would be positive for mental illness, which would prompt the mental health authority to come to the facility and reassess Resident #30 for eligibility for PASRR services. Record review of facility policy titled admission Criteria and dated March 2019 revealed no mention of re-screening residents based on qualifying diagnoses.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission for 1 (Resident #103) of 15 residents reviewed for care planning. The facility failed to develop a baseline care plan for Resident 103 within 48 hours of her admission. This failure could place newly admitted residents at risk of not receiving effective, person-centered care. Findings Included: Record review of Resident #103's admission record dated 06/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hypertensive heart disease (heart problems that occur due to high blood pressure), vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), epilepsy (disorder that causes abnormal brain function, seizures), malignant neoplasm of nipple and areola of left breast (nipple cancer), Crohn's disease (inflammatory bowel disease resulting in abdominal pain, fatigue, diarrhea, and weight loss), and osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes or deficiency of calcium of vitamin D). Record review of Resident #103's EHR under the MDS tab revealed no comprehensive MDS assessments had been completed. Record review of Resident #103's EHR under the Care Plan tab revealed no care plan had been initiated. Record review of Resident #103's EHR under the Assmnts tab revealed no baseline care plan. Record review of Resident #103's EHR under the MISC tab revealed no baseline care plan. During an interview on 06/11/25 at 08:43 AM DON stated Resident #103 just got here (facility) and would not have a baseline care plan. She stated she would look in Resident #103's EHR. During an interview on 06/11/25 at 09:01 AM DON provided a copy of a baseline care plan for Resident #103 with a completion date of 06/11/25. During an interview on 06/11/25 at 09:20 AM ADM stated a resident not having a baseline care plan completed with in 48 hours of admission negatively impact the care they received. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 09:45 AM ADON stated a resident could be negatively impacted by not having a baseline care plan completed within 48 hours of admission. She stated, How would we care for them and know what baseline is and if they are improving or declining? During an interview on 06/11/25 at 10:02 AM ADM stated DON was responsible for completing baseline care plans. During an interview on 06/11/25 at 10:32 AM DON stated baseline care plans were part of the admission packet and should be completed by the charge nurse or the admitting nurse within 48 hours. She stated she did not know why Resident #103's baseline care plan was not completed within 48 hours of her admission. She stated she had trained the nurses in the facility on completing baseline care plans timely. DON stated staff might not identify needs of residents and residents might not have their needs met or addressed if a baseline care plan was not completed timely. Record review of facility policy title Care Plans-Baseline and dated March 2022 revealed the following: . A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 under proper temperature controls and permit only authorized personnel to have access to the keys for 1 (Resident #40) of 15 residents, 1 (hall 200 medication cart) of 4 medication carts, and 1 (east wing treatment cart) of 2 treatment carts reviewed for medication storage. 1. The facility failed to ensure Resident #40 did not have access to nasal decongestant spray. 2. The facility failed to ensure LVN D locked the hall 200 medication cart when it was unattended. 3. The facility failed to ensure LVN E locked the east wing treatment cart when it was unattended. These failures 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: 1. Record review of Resident #40's admission record dated 06/10/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included age-related cognitive decline. Record review of Resident #40's annual MDS completed on 05/15/25 revealed Resident #40 had a BIMS score of 12 which indicated moderately impaired cognition. Resident #40 was coded as receiving anticoagulant medication while a resident. Record review of Resident #40's care plan completed on 05/15/25 revealed he had impaired cognitive function related to impaired memory. The care plan noted Resident #40 was on anticoagulant therapy, but did not mention nose bleeds or self-administration of medication. Record review of Resident #40's active orders dated 06/10/25 revealed no order to self-administer medication. The following orders were revealed: Order start date of 05/28/24 for Afrin Original Nasal Solution (Oxymetazoline HCl) 2 unit in both nostrils as needed for Uncontrolled nose bleed [sic]. Order start date of 08/21/24 for Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day . Record review of Resident #40's MAR for the last 6 months (from 01/10/25 to 06/10/25) revealed he received Afrin Original Nasal Solution (Oxymetazoline HCl) 2 unit in both nostrils as needed for Uncontrolled nose bleed [sic] two times. Once on 02/11/25 and once on 02/15/25. During an observation on 06/09/25 at 07:07 AM Resident #40 was lying in his bed with eyes closed. A small nasal spray bottle was on the nightstand beside his bed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/09/25 at 09:08 AM Resident #40 was on his back in bed with the HOB raised to seated position watching TV. He stated he was hospitalized twice since his admission to the facility. He stated one of the times he was hospitalized was for a bloody nose that wouldn't stop. He stated he was on anticoagulant medication which contributed to the severity of the nosebleed. Resident #40 stated the nosebleed was stopped by spraying Afrin up both nostrils. He then turned and grabbed the small nasal spray bottle from his nightstand and held it up. Resident #40 stated he kept the bottle near just in case he had a nosebleed because that is what the doctor told me to do. During an interview on 06/11/25 at 08:40 AM LVN A stated only one resident in the facility had one medication (a chewable pill) he was allowed to self-administer. She stated a possible negative outcome of residents having medications in their rooms was other residents could take the medication and that would cause harm to them. She stated nurses were trained on administering medications. She stated the pharmacist came monthly to the facility and would train nurses if anything was noted to be [NAME]. During an interview on 06/11/25 at 09:20 AM ADM stated residents were not allowed to have medications in their rooms. She stated, We give them a list of what is not allowed in their rooms at admission. Medication is one of those things. If we notice meds in their rooms, we talk to them about it and take the meds up. ADM stated family members had been known to bring medications to residents. She stated having medications in their rooms could lead to residents being double dosed and it make them ill. During an interview on 06/11/25 at 09:45 AM ADON stated residents could take too much or not remember the dosage if they had medications in their rooms. During an observation on 06/11/25 at 10:20 AM a bottle labelled Major Brand Nasal Decongestant (Oxymetazoline HCl .05%) was sitting on the Resident #40's nightstand. During an interview on 06/11/25 at 10:32 AM DON stated residents were not allowed to have medications in their rooms because the doctor needs to know everything they are taking, including over the counter medication, because it might interact with other medications they are taking. 2. During an observation on 06/09/25 at 06:53 AM LVN D left the hall 200 medication cart unlocked and unobserved while she went into a resident room. During an interview on 06/09/25 at 12:08 PM LVN D stated residents could be negatively impacted by a medication cart left unlocked in that someone can get into the medication cart that is not supposed to, like one of our residents that wander. 3. During an observation on 06/09/25 at 07:03 AM LVN E left the east wing treatment cart unlocked while he performed a glucose check. During an observation on 06/09/25 at 07:07 AM LVN E left the east wing treatment cart unlocked while he interviewed a resident. During an observation on 06/09/25 at 07:16 AM LVN E left the east wing treatment cart unlocked while he administered an inhaler to a resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/09/25 at 12:13 PM LVN E stated, There really isn't one (a negative impact to residents for a treatment cart left unlocked). He stated, But I guess someone could get into it. During an interview on 06/11/25 at 08:33 AM ADON stated leaving medication and treatment carts unlocked and unsupervised could lead to a resident getting into the cart and taking medication which could lead to an adverse reaction. During an interview on 06/11/25 at 08:48 AM DON stated a negative outcome of leaving medication and treatment carts unlocked and unsupervised was anyone could get into the cart, we do have residents that wander and pick things up. Record review of facility policy titled Storage of Medications and dated November 2020 revealed the following: . The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drug and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. 3. Nursing staff is responsible for maintaining medication storage . areas in a . safe . manner. 6. Compartments (including, but not limited to, drawer, cabinets rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. Record review of facility policy titled Administering Medications and 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. 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Record review of page 35 of the facility's admission packet revealed the following: . AUTHORIZATION OF SELF ADMINISTRATION OF DRUGS Each resident has a right to self-administer drugs if the interdisciplinary team . has determined for each resident that the practice is safe. Record review of an unnumbered, undated page of the facility's admission packet revealed the following: . ITEMS NOT ALLOWED IN RESIDENT ROOMS The following items are not allowed in resident's rooms due to health and safety hazards MEDICATIONS: . No eye, ear, or nasal preparation . No prescription medications of any kind except emergency medication with a [sic] expressed Dr's order that may be kept at bedside .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure foods were properly stored, labeled, and dated. These failures placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings Include: Observation of the walk-in refrigerator on 06/09/2025 at 5:55 AM revealed the following: 1. 2 bags of yellow colored cream, the packaging was not labeled or dated. 2. 10 lbs. of ground beef on a flat pan. The pan was labeled: beef-use by 06/07/2025 3. 2 turkeys on a flat pan. The pan was labeled: turkey- use by 06/07/2025 4. 25 small glasses of milk covered-no label or date 5. 26 small glasses of orange juice covered-no label or date 6. 1 container of open cranberry cocktail juice 1/2 full- no open date Observation of walk-in freezer on 06/09/2025 at 6:15 AM revealed the following: 7. 1 box of biscuit type cookies approximately 24 biscuits, opened to air. 8. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 oblong shaped brown bag with clear wrap-not labeled or dated. Observation of counter in kitchen on 06/09/2025 at 6:20 AM revealed the following: 9. 3 cookies were on the counter in a bag open to air, no date. In an interview on 06/10/2025 at 1:00 PM, the DM stated that all staff were responsible for ensuring items were labeled and dated. The DM stated every item opened, should have an open date in the refrigerator, freezer, and dry storage. The DM stated if food items were not properly labeled and dated, staff may be unaware of when the items were opened, increasing the risk of food spoilage and potential illness for residents. In an interview on 06/10/25 at 1:15 PM, DA B stated that all staff were responsible for ensuring items in the kitchen were covered, labeled, and dated and failure to do so could result in residents being served spoiled food, which could cause sickness. DA B stated the DM was responsible for ensuring staff was doing their job. In an interview on 6/11/2025 at 11:00 AM, DA C stated that all staff were responsible for making sure items in the kitchen were covered, labeled, and dated, and a possible negative outcome would be residents could receive bad food and get sick. Record review of Food Receiving and Storage Policy dated 8/1/2020 revealed the following: Foods will be received and stored by methods to minimize contamination and bacterial growth. Refrigerated foods are properly covered, labeled, and dated with a use by date. [NAME] them clearly to indicate the date by which the food shall be consumed or discarded. The day of preparation or day original container is opened shall be considered day 1, discard after three days unless otherwise indicated. Check expiration dates and use by dates to assure the dates are within acceptable parameters. Place food that is repackaged in a leak proof, pest proof, nonabsorbent, sanitary container with a tight-fitting lid. Label both the container and its lid with the common name of the contents, the date it was transferred to the new container, and the discard date. Record review of FDA Code dated 2022 revealed the following: Pathogens can contaminate and/or grow in food that is not stored properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #26, Resident #45, and Resident #46) of 17 residents reviewed for infection control. -LVN D failed to use the proper disinfecting wipes when disinfecting equipment used on residents. This deficient practice had the potential to place residents at risk by exposing them to care that could lead to the spread of viral infections, secondary infections, communicable diseases. Findings include: During an observation on 06/09/25 at 06:32 AM, LVN D performed a blood glucose check on Resident # 26 and did not clean glucometer after blood glucose check. During an observation on 06/09/25 at 06:36 AM, LVN D performed a blood glucose check on Resident # 46,. LVN did not clean the glucometer before or after blood glucose check for Resident #46. During an observation on 06/09/25 at 06:43 AM, LVN D took the glucometer that she (LVN D) just used with Resident #46 and went to Resident 46's roommate, Resident #45 and perform a blood glucose check without cleaning the glucometer in between the residents. During an interview on 06/09/25 at 12:08 PM, LVN D stated a negative outcome for not disinfecting the glucometer in between residents would lead to cross contamination and increase a risk for infection. During an interview on 06/11/25 at 08:33 AM, the ADON stated a negative outcome for not cleaning the glucometer in between residents could lead to infection control issues. During an interview on 06/11/25 at 08:48 AM, the DON stated a negative outcome would be contamination and an increased risk for infection. Record review of the facility -provided policy, titled, Obtaining a Fingerstick Glucose Level, revised October 2011, revealed the following: .3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. .18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Record review of the facility- provided policy, titled, Blood Sampling-Capillary (Finger Sticks), revised September 2014, revealed the following: .General Guidelines (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. .8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use.