

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Advanced Rehabilitation and Healthcare of Wichita		STREET ADDRESS, CITY, STATE, ZIP CODE 4810 Kemp Blvd Wichita Falls, TX 76308	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41495</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement care interventions in accordance with each resident's written plan of care for 1 of 3 residents (Resident #s 1) whose care was reviewed in that:</p> <p>The facility failed to implement ADL transfer interventions for Resident #1 as care planned.</p> <p>This failure could affect residents that required assistance with transfers.</p> <p>The findings were:</p> <p>Review of the Resident #1's Facesheet, dated, 05/09/2024, revealed she was admitted on [DATE], with diagnoses that included: hypertension (high blood pressure), Diabetes Melitus (too much sugar in the blood) difficulty in walking, and dementia (loss of memory).</p> <p>Review of Resident #1's Admission MDS, dated [DATE] revealed the following:</p> <p>Section C revealed resident's BIMS was a 06 (severe cognitive impairment).</p> <p>Section GG revealed resident partial/moderate assistance with transfers.</p> <p>Review of the Resident #1's Care plan dated 05/06/2024 revealed the following:</p> <p>-Resident #1 has impaired cognition and is at risk for a further decline in cognitive and functional abilities related to: diagnosis of dementia (loss of memory).</p> <p>- Resident #1 has an ADL self-care performance deficit and is at risk for not having their needs met in a timely manner and will require transfers with extensive assist x 1 staff (help resident).</p> <p>During an observation on 05/09/2024 at 11:30 AM, a video clip that was provided from the facility of Resident #1's room revealed that CNA A placed wheelchair to the left of Resident #1 in a 90-degree angle from the bed. CNA A stepped behind the wheelchair. Resident #1 stood from bed without staff assistance and CNA A could be heard asking Resident #1 to turn a little. Resident began turning to the left and fell to the left between the bed and the wheelchair. CNA A immediately called for help and assisted the resident.</p> <p>(continued on next page)</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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 05/10/2024 at 1:30 PM., Resident #1 was lying in her bed watching TV, she stated that she could transfer without assistance. She stated that, does not remember much but that she lost her balance and fell . She revealed that CNA A was always nice to her and kind and that she liked it when she worked. She stated that she knows how to press her call light, but she does not always press it because she does not always need help.</p> <p>During an interview on 05/10/2024 at 9:00 AM., CNA A revealed that, the day Resident #1 fell the following occurred, the resident had pulled her light, she was sitting up on the side of her bed and was needing to go to the bathroom, the CNA asked if Resident #1 wanted to use her walker or wheelchair. The resident said she wanted to use her wheelchair. CNA A said that she pulled the wheelchair next to Resident #1 and the bed and locked the wheels, but when Resident #1 stood up, she faced the chair. CNA A told Resident #1 that she needed to turn around so she could sit in the chair. She stated that when Resident #1 turned to sit correctly in the chair, that is when Resident #1 fell . She said that after Resident #1 fell , she made sure Resident #1 was okay, and she immediately got the nurse. She said she was sitting with her and making sure she was okay until the nurse got there. CNA A stated that she did not know Resident #1 required assistance with transfers, she thought Resident #1 was supervision because the resident gets up on her own and walks on her own and that is what she was before. She stated that she had not ever looked at her care plan, but she should have. CNA A stated Resident #1 often stands and transfers by herself, so she assumed Resident #1 could still do that. She stated that this failure could result in the resident falling and hurting herself.</p> <p>During an interview on 05/10/2024 at 10:30 AM., CNA B revealed that, Resident #1 had been transferring by herself. Staff had been telling her to call for assistance, but Resident #1 had not been doing that. She stated that the facility staff placed a sign on the resident's wall to even remind her. She stated that she would walk in her room, and Resident #1 would be in her bathroom. She revealed that she often worked the hall that the resident was on, and that Resident #1 thought she was independent. She stated that she knew how to access the care plans for each resident.</p> <p>During an interview on 05/10/2024 at 10:45 AM., CNA C revealed that Resident #1 had been transferring by herself, even though staff asked her not to, she still would. She stated that Resident #1 used to transfer without assistance, and she still thought that she could. She stated that they would take Resident #1 to the bathroom, and she would ask facility staff to leave and then would transfer back to her wheelchair by herself. She stated that she knew how to look up the care plans.</p> <p>During an interview on 05/10/2024 at 11:30 AM., the DON confirmed Resident #1 required assistance x1 with transfers. Her expectations were that all staff review the care plans that are individualized to each resident and that covers their needs. She revealed that this resident was able to transfer with supervision previously, but that she required assistance with transfers at the time of the fall.</p> <p>A copy of the policy related to Care Plans was requested on 05/10/2024 at 1:00 PM, the facility stated that they use the RAI manual for guidance on Care Plans.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of CMS RAI Version 3.0 Manual last revised October 2023 revealed: the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45437</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide supervision to prevent accidents for 1 of 3 residents (Resident #s 1) whose care was reviewed in that:</p> <p>The facility failed to implement ADL transfer interventions for Resident #1 .</p> <p>This failure could affect residents that required assistance with transfers.</p> <p>The findings were:</p> <p>Review of the Resident #1's Facesheet, dated, 05/09/2024, revealed she was admitted on [DATE], with diagnoses that included: hypertension (high blood pressure), Diabetes Melitus (too much sugar in the blood) difficulty in walking, and dementia (loss of memory).</p> <p>Review of Resident #1's Admission MDS, dated [DATE] revealed the following:</p> <p>Section C revealed resident's BIMS was a 06 (severe cognitive impairment).</p> <p>Section GG revealed resident partial/moderate assistance with transfers.</p> <p>Review of the Resident #1's Care plan dated 05/06/2024 revealed the following:</p> <p>-Resident #1 has impaired cognition and is at risk for a further decline in cognitive and functional abilities related to: diagnosis of dementia (loss of memory).</p> <p>- Resident #1 has an ADL self-care performance deficit and is at risk for not having their needs met in a timely manner and will require transfers with extensive assist x 1 staff (help resident).</p> <p>During an observation on 05/09/2024 at 11:30 AM, a video clip that was provided from the facility of Resident #1's room revealed that CNA A placed wheelchair to the left of Resident #1 in a 90-degree angle from the bed. CNA A stepped behind the wheelchair. Resident #1 stood from bed without staff assistance and CNA A could be heard asking Resident #1 to turn a little. Resident began turning to the left and fell to the left between the bed and the wheelchair. CNA A immediately called for help and assisted the resident.</p> <p>During an observation on 05/10/2024 at 1:30 PM., Resident #1 was lying in her bed watching TV, she stated that she could transfer without assistance. She stated that, does not remember much but that she lost her balance and fell . She revealed that CNA A was always nice to her and kind and that she liked it when she worked. She stated that she knows how to press her call light, but she does not always press it because she does not always need help.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/10/2024 at 9:00 AM., CNA A revealed that, the day Resident #1 fell the following occurred, the resident had pulled her light, she was sitting up on the side of her bed and was needing to go to the bathroom, the CNA asked if Resident #1 wanted to use her walker or wheelchair. The resident said she wanted to use her wheelchair. CNA A said that she pulled the wheelchair next to Resident #1 and the bed and locked the wheels, but when Resident #1 stood up, she faced the chair. CNA A told Resident #1 that she needed to turn around so she could sit in the chair. She stated that when Resident #1 turned to sit correctly in the chair, that is when Resident #1 fell . She said that after Resident #1 fell , she made sure Resident #1 was okay, and she immediately got the nurse. She said she was sitting with her and making sure she was okay until the nurse got there. CNA A stated that she did not know Resident #1 required assistance with transfers, she thought Resident #1 was supervision because the resident gets up on her own and walks on her own and that is what she was before. She stated that she had not ever looked at her care plan, but she should have. CNA A stated Resident #1 often stands and transfers by herself, so she assumed Resident #1 could still do that. She stated that this failure could result in the resident falling and hurting herself.</p> <p>During an interview on 05/10/2024 at 10:30 AM., CNA B revealed that, Resident #1 had been transferring by herself. Staff had been telling her to call for assistance, but Resident #1 had not been doing that. She stated that the facility staff placed a sign on the resident's wall to even remind her. She stated that she would walk in her room, and Resident #1 would be in her bathroom. She revealed that she often worked the hall that the resident was on, and that Resident #1 thought she was independent. She stated that she knew how to access the care plans for each resident.</p> <p>During an interview on 05/10/2024 at 10:45 AM., CNA C revealed that Resident #1 had been transferring by herself, even though staff asked her not to, she still would. She stated that Resident #1 used to transfer without assistance, and she still thought that she could. She stated that they would take Resident #1 to the bathroom, and she would ask facility staff to leave and then would transfer back to her wheelchair by herself. She stated that she knew how to look up the care plans.</p> <p>During an interview on 05/10/2024 at 11:30 AM., the DON confirmed Resident #1 required assistance x1 with transfers. Her expectations were that all staff review the care plans that are individualized to each resident and that covers their needs. She revealed that this resident was able to transfer with supervision previously, but that she required assistance with transfers at the time of the fall.</p> <p>A copy of the policy related to Care Plans was requested on 05/10/2024 at 1:00 PM, the facility stated that they use the RAI manual for guidance on Care Plans.</p> <p>Record review of CMS RAI Version 3.0 Manual last revised October 2023 revealed: the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.</p>		