STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675852	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation and Healthcare of Wichita	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641 Based on interview and record review, the facility failed to ensure the right to be free from verbal abuse for 1 of 1 resident reviewed for mistreatment, (Resident #1). On 02/02/25 at 1:00 pm, LVN A began arguing with Resident #1. LVN A continued arguing after being asked to stop by other staff repeatedly, and continued to anger and upset Resident #1. This failure could place residents at risk for resident mistreatment. Findings included: Record review of Resident #1's Face Sheet dated 2/27/25 revealed a [AGE] year-old female, admitted to facility on 5/23/22 with diagnoses that included Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems without behaviors),); Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), obesity, generalized anxiety disorder (worry, excessively and feel nervous or restless for no obvious reason). Record review of Resident #1's MDS assessment dated [DATE], revealed Resident #1 had BIMS score of 15 (cognitively intact). Record review of Resident #1's Care Plan dated 12/4/24 indicated Resident #1, schizophrenia, ADL deficit-forgetfulness, confusion, behaviors-sexual comments with males, history of false allegations, trauma while in state facility, verbally abusive behaviors, anxiety, anti-psychotic med, psychotropic medications (antidepressants, antipsychotics, anxiolytics, or hypnotics) related to depression, generalized anxiety disorder, schizophrenia- Has EPS from antipsychotic usage-tremors of hands. Interventions are to calm voice when speaking to resident and redirect when resident agitated. Record review of intake On 02/02/25 around 1:00 pm Resident #1 and LVN A had a verbal altercation where Resident #1 called LVN A fat and then LVN A told Resident #1 that she was Fat and Ugly. LVN A was suspended and after facility investigation terminated. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of statement provided by LVN A to Administrator dated 02/02/25, LVN A stated that resident called me fat, I did say she was ugly, referring to her calling me fat. I told her God does not like ugly, resident said I bet you and your wife do it doggy style you son of a bitch. Interview on 02/27/25 at 10:00 am, Resident #1 stated she was talking to RN B at nurse's station and LVN A started running his fat mouth. She stated that she said he was a [NAME] and fat, and she called him a bastard. LVN A said she was ugly and flipped me the bird. RN B told him to stop but LVN A kept on talking and calling her ugly, RN B and Resident #1 left. She was so upset, she was shaking. Resident #1 stated that she was doing well since the Administrator got rid of LVN A. Resident stated that she knows her rights and staff are not allowed to call residents names. Interview on 02/27/25 at 10:20 am, RN B stated she was witness to incident on 02/02/25. RN B stated she was at the nurse's station when Resident #1 came up and started taking to RN B. RN B stated all was fine just a general conversation. RN B stated that LVN A just butted in on conversation and that upset Resident #1. She told Resident #1 not to worry about LVN A and then Resident #1 called LVN A a fat [NAME]. LVN A said Resident #1 was ugly, and they both started bickering at one another very loudly. RN B stated she stepped in, tried to redirected Resident #1, and told LVN A to stop, but LVN A continued bickering with Resident #1 even after RN Basked LVN A many times to stop. RN B stated she was able to separate Resident #1 away from LVN A and started walking away, stating LVN A continued bickering and upsetting Resident #1 further. RN B stated protecting resident was her only concern and to stop the bickering. RN B stated it was very loud and disruptive. RN B stated once Resident #1 was calm and safe, RN B stated she immediately reported the incident to Administrator. Interview on 02/27/25 at 10:55 am, CNA C witnessed incident on 02/02/25. CNA C stated she was not positive on how conversation started between LVN A and Resident #1. CNA C stated she heard Resident #1 raising her voice towards LVN A and LVN A raising his voice. CNA C stated she heard LVN A say that Resident #1 was fat & ugly, and Resident #1 called LVN A fat and that he'eats four meals a day CNA stated that RN B was separating Resident #1 and LVN A. RN B asked LVN A several times to stop, but LVN A did not, and keep arguing with Resident #1. CNA C stated Resident #1 was clearly upset and LVN A should have stopped aggravating her. Several attempts made to contact LVN A was unsuccessful. 2/27/25 at 4:15pm, no voice mail, 2/28/25 at 8:55am, no voice mail. 2/28/25 at 2:10pm, no voice mail. Interview on 02/27/25 at 11:50am, Administrator stated that he is the facility's Abuse Coordinator, and the facility does not tolerate staff getting into verbal arguments with residents. Administrator stated his expectation that always for staff to be respectful and professional. Administration stated that LVN A was aggravating Resident #1 with little regards to Resident #1's mental diagnosis. Administrator stated that LVN A was terminated for Verbal Abuse. Record review of LVN A employee file revealed he was hired 4/23/21. There was a disciplinary write-up dated 3/3/23 for 'Speaking to resident in stern voice'. LVN A's annual background check dated 04/03/24 training for Abuse, neglect and Resident's Rights were up-to date. Review of the facility's Abuse, Neglect and Exploitation policy., dated 10/24/22, revised 9/6/24 Reflected, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641 Based on interviews and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 of 1 resident (Resident #2 reviewed for discharge requirements. The facility failed to readmit Resident #2 after being admitted to the hospital, while facility initiated discharge was Pending Appeal. This failure placed residents at risk of not receiving necessary care and services. . Findings included: Record review of Resident #2's Face Sheet dated [DATE], reflected Resident #2 was a [AGE] year-old female, admitted to facility on [DATE]. Diagnoses included aftercare following surgical amputation below right knee, hemiplegia and hemiparesis following cerebral infraction affecting right dominant side (weakness and/or loss of strength to one side), type 2 diabetes (insulin resistance and high blood sugar levels), major depressive disorder (mood disorder that causes persistent feeling of sadness and loss), cerebral infraction (stroke), pressure ulcer of sacral region stage 3 (deeper involvement of underlying tissue with more extensive destruction spine tissue). Record review of Resident #2's MDS assessment dated [DATE] revealed Resident #2 has BIMS score of 15 (cognitively intact). Resident #2 needs extensive assistance with bed mobility, transfers, toileting, and dressing. Record review of Resident #2's Care Plan dated [DATE] revealed the resident had an indwelling catheter, ADL Self Care Performance Deficit, diagnosis of major depressive disorder, diagnosis of diabetes, fall risk, right heel MRSA, Enhanced Barrier Precautions d/t Urinary catheter, psychotropic medications antidepressants, anxiolytics related to depression. Record review of Resident #2's medical record revealed that Resident #2 fell in her room on [DATE], resident was assessed by facility staff and sent to hospital for further evaluation. Resident #2 did not suffer any injury due to fall but was diagnosis with pneumonia. On [DATE] hospital contacted nursing facility stating resident was ready for discharge back to the nursing facility. Facility refused to accept resident back due to non-payment for care at facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:40 am, BOM stated that Resident #2 admitted to facility on [DATE] from LTAC. Resident #2 had Blue Cross Blue Shield (BCBS) Cobra insurance. Facility was notified by BCBS in September that Resident #2's coverage had expired; Resident #2 had run out of covered days before admitting to facility. Resident #2 and Resident #2's POA were informed that her stay would be private pay until Medicaid, or another payor source was found. BOM stated that POA stated will apply for Medicaid. Resident #2 was denied Medicaid due to 'not meeting eligibility'. BOM stated that Resident #2 must apply for SSI before being approved for Medicaid. BOM stated resident had not applied for SSI and is not MCD pending. BOM stated that the facility does not take SSI pending residents and that BOM informed Resident #2 and POA. BOM stated on [DATE], Resident #2 paid $5456 for [DATE] stay, and on [DATE] paid $4,752 for [DATE] stay. BOM stated that Resident #2 had an outstanding balance of $44, 572.82, which Resident #2 and POA stated they cannot pay. Interview [DATE] at 10:30 am, Resident #2's POA stated that Medicaid was applied for, but was denied on [DATE] due to Medicaid saying Resident #2 owned two houses; one in Dallas and one in Wichita Falls. POA stated the house in Dallas was sold in [DATE], and the money was used to buy house in Wichita Falls. POA stated that Resident #2 did not have Social Security, but they are applying for disability (SSI). POA was informed by facility that resident must have SSI before applying for Medicaid, and that the facility does not take SSI pending, and that the resident must be private pay. POA stated that Resident #2 cannot pay private, that was why they are trying to get Medicaid. POA stated that she and Resident #2 received a 30-day Notice of Discharge from facility on [DATE], with effective discharge date of [DATE]. POA stated an appeal of discharge was made on [DATE], and the Fair Hearing was set for [DATE]. POA stated that the facility has refused to readmit Resident #2 back from the hospital. POA stated they have no place for Resident #2 to go. Interview on [DATE] at 1:20 pm, Administrator stated on [DATE], he issued a 30-Day Discharge Notice to Resident #2, Resident #2 's POA, Resident's primary physician, and Ombudsman. Administrator stated that Resident #2 had an outstanding bill of $44,572.82, has no coverage days with his medical insurance, and is not MCD eligible. He stated Resident #2 is applying for SSI, and they do not accept SSI pending. Administrator stated he was notified that the Discharge Notice was appealed and that the Fair Hearing was set for [DATE] and that he plans to attend hearing. Administrator stated the facility was contacted by the hospital and he refused to readmit Resident #2 back in facility. Administrator stated his reason for denial was Resident #2 has no payor source, an outstanding bill of $44,572.82, and Resident #2 and her POA have stated they cannot pay. Record review of facility's Admission Policy dated [DATE], revised [DATE], revealed: Policy Explanation and Compliance Guidelines, 5). When a resident exercises his or her right to appeal a transfer or discharge. That facility will not transfer or discharge the resident while the appeal is pending unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.