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	06/27/2026

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the menus were followed for 1 of 1 facility for food and nutrition services.The facility failed to follow the meal posted for lunch or dinner. The facility failed to post and follow the current week's menu in the dietary department.The facility failed to post the current week's menu where the residents can see it.This failure could result in the lack of knowledge and lead to nutritional, physical, and psychosocial upset. Findings included:In an observation on 6/27/2026 at 9:11 A.M., the menu was posted on the wall outside of the dining room and reflected as the week 4 menu. The menu showed today's lunch as cheese quesadillas, garden blend vegetables, refried beans, sugar cookies and dinner as hamburger on a bun, tossed salad, lettuce, tomatoes, pickle, potato wedges, and peach cobbler. The menu reflected today's dinner as hamburger on a bun, tossed salad, potato wedges, and peach cobbler. Record review of Resident #2's electronic health record revealed a [AGE] year-old male, admission date 01/20/2025, Diagnoses: chronic ischemic heart disease (heart damage caused by narrowed heart arteries), adult failure to thrive (state of decline that is multifactorial and may be caused by concurrent diseases and functional impairments), neoplasm of uncertain behavior of meninges (tumor that arises from the protective membranes covering the brain and spinal cord), unspecified severe protein-calorie malnutrition (imbalance between the nutrients your body needs to function and the nutrients it gets), generalized anxiety disorder (excessive, ongoing worry that is difficult to control), heart failure (heart muscle weakens or stiffens and cannot pump enough oxygen-rich blood to meet the body's needs), bipolar disorder (lifelong mental health condition that causes extreme shifts in mood, energy, activity levels, and concentration).In an interview on 6/27/2026 at 10:03 A.M. with Resident #2, he stated that sometimes the facility staff gave the wrong thing (food item) or was out of what he wanted. Resident #2 stated he ate in his room and staff come in every day to write down what he wanted for meals. Resident #2 stated he eats everything they give him or can request an alternative meal.In an interview on 6/27/2026 at 10:58 A.M. with LVN D, she stated that every morning staff take menus to the residents and let them choose their meal because the posted menu is hardly ever right. She stated the residents do not complain about the posted menu not matching the meals but do get upset if what staff tell them the morning of gets messed up.In an observation on 6/27/2026 at 12:30 P.M., the lunch plates contained lasagna, roll, cake, and salad instead of the posted cheese quesadillas, garden blend vegetables, refried beans, and sugar cookies.In an interview on 6/27/2026 at 3:51 P.M. with DC E, he stated that today's lunch was Mexican lasagna, roll, salad, and yellow cake. He stated he did not know who was responsible for posting the menu for residents. DC E stated he cooks what is posted in the kitchen by his manager to cook and he did not know what week it should be. He showed the current menu he used in the kitchen as week 3. DC E stated he had not heard any complaints from residents about the menu not being correctly posted. DC E stated dinner was polish sausage, capri vegetables, and fried potatoes. In an observation on 6/27/2026 at 3:51 P.M., the menu provided by DC E revealed week 3 menu with lasagna for lunch and polish sausage for dinner on Saturday of week 3.In an observation on 6/27/2026 at 3:51 P.M., the food being prepared was polish sausage and mixed (continued on next page)

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vegetables. In an interview on 6/27/2026 at 5:13 P.M. with ADON C, she stated it was the responsibility of the kitchen staff to update and post the menu. She stated a possible negative impact on the residents could be they stop eating if it is not what they were expecting.In an interview on 6/27/2026 at 7:36 P.M. with DON B, she stated that the facility's dietary department is contracted. She stated she did not think there were any negative resident effects from the menu not being posted because staff go into their rooms daily to inform them.In an interview on 6/27/2026 at 7:36 P.M., DON B was asked for a dietary policy regarding menus. The policy was not provided prior to exit.

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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 0844 Level of Harm - Potential for minimal harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Based on observation, interviews, and record review, the facility failed to provide written notice to the State Agency responsible for licensing the facility at the time of change, for a change in the facility's administrator for 1 of 1 facility reviewed for administration.The facility failed to notify the State Agency of a change in the facilities administrator within 30 days.This failure could result in the lack of knowledge and inability to connect with the appropriate leadership of the facility.Findings included:In an observation on 6/26/2026 at 3:03 P.M., the name of the administrator in TULIP during offsite preparation showed a different name than ADM A. In an interview on 6/27/2026 at 10:58 A.M. with LVN D, she stated that ADM A was the administrator and she was not sure how long he had been but a while. In an interview on 6/27/2026 at 11:30 A.M. with DON B, she stated that ADM A was the administrator and had been for more than 30 days. In an interview on 6/27/2026 at 5:13 P.M. with ADON C, she revealed that ADM A was the administrator and had been for at least a couple of months, maybe even 10 months or longer. ADON C stated that ADM A was on vacation and not available. She stated that DON B was completing her administrator in training and who everyone went to in his absence. In a follow-up interview on 6/27/2026 at 7:36 P.M. with DON B, she revealed that ADM A had completed the name change in TULIP she thought because that is what he told her, but that he is not currently available. DON B stated she did not think there was any negative resident impact because they all came to her with anything and she addressed any concerns or needs. She stated that ADM A had been at the facility long enough that all staff and residents knew him and went to him, as well. Record review of the Facility Summary Report reviewed on 6/26/26 at 3:03 P.M. revealed the name of the administrator did not match ADM A.