

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 12/06/2024
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>50133</p> <p>Based on interviews and record review, the facility failed to implement its policies and procedures to prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property for 4 of 4 staff members (ADM, DON, ADON and CNA B) reviewed for abuse protocol.</p> <p>The facility failed to complete annual Criminal Background Checks for the ADM, DON, ADON and CNA B.</p> <p>This failure could place residents at risk for abuse, neglect, and exploitation.</p> <p>Findings included:</p> <p>Record review of the ADM personnel file revealed no annual criminal background check completed for 2024. The ADM had a hire date of 5/9/2016.</p> <p>Record review of the DON personnel file revealed no annual criminal background check completed for 2024. The DON had a hire date of 1/19/10.</p> <p>Record review of the ADON personnel file revealed no annual criminal background check completed for 2024. The ADON had a hire date of 06/23/04.</p> <p>Record review of CNA B personnel file revealed no annual criminal background check completed for 2024. CNA B had a hire date of 12/19/20.</p> <p>In an interview on 12/6/24 at 3:26 PM, ADM stated that annual background checks for 2024 were not completed on any employee with a hire date prior to 1/1/24 by the Human Resources Manager. He stated that he was not aware the checks were not being run and that the Human Resources Manager would run them 12/6/24. He stated that employees hired within year 2024 had background checks completed.</p> <p>In an interview on 12/6/24 at 5:10 pm, the Human Resources Manager stated, I ran them, but I cannot find them referring to annual criminal background checks for year 2024. She stated that it was her responsibility. She stated, I don't know when asked about adverse outcome of checks not being run. She also stated that she was not aware that she needed to keep previous checks on file. She stated that she ran them in January of 2023, but was unsure of the exact date .</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/6/24 at 5:23 PM, the ADM stated that criminal background checks should be ran annually in January per policy and completed before hire. He further stated that an adverse outcome of not running employee background checks could lead to having staff with felonies.</p> <p>Record review of facility policy Policy and Procedures: Abuse, Neglect and Exploitation dated 10/24/22 revealed the following [in-part]:</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>.3. The facility provides ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.</p> <p>The components of the facility abuse prohibition plan are discussed herein:</p> <p>I. Screening:</p> <p>A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property.</p> <p>1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.</p> <p>3. The facility will maintain documentation of proof that the screening occurred.</p> <p>Record review of facility Human Resources Policies and Procedures Manual revised 07/09, section 7. Safety and Health, Subject-Applicant and Employee Screening revealed the following [in-part]:</p> <p>Policy: All current employees will have annual employee screening conducted.</p> <p>2. Criminal history check will be completed.</p> <p>Criminal History: Criminal history checks must be completed prior to employment and annually, each January thereafter for all staff and volunteers.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133</p> <p>Based on observation, interview, and record review, the facility failed to ensure it was free of medication error rates of five percent or greater. There were 4 medication errors out of 28 opportunities, resulting in a medication error rate of 14% involving 4 of 10 residents (Resident #s #151, #113, #39, & #80) reviewed for medication errors.</p> <p>A. On 12/4/24 at 11:29 am, LVN A administered Micafungin Sodium IV to a Resident #151 at the incorrect physician ordered administration time.</p> <p>B. On 12/4/24 at 11:38 am, LVN A failed to prime the insulin needle prior to administering Novolog 100 units/ml via a Flex Pen to Resident #113.</p> <p>C. On 12/4/24 at 11:44 am, LVN A failed to prime the insulin needle prior to administering Humalog 100 units/ml via a Flex Pen to Resident #39.</p> <p>D. On 12/4/24 at 11:51 am, LVN A failed to prime the insulin needle prior to administering Novolog 100 units/ml via a Flex Pen to Resident #80.</p> <p>These deficient practices could place residents at risk of not receiving their medications according to physician's orders and cause a physical decline in health.</p> <p>The findings included:</p> <p>1. Record review of Resident #151's Admission Record dated 12/06/2024 revealed she was a [AGE] year-old-female admitted to the facility on [DATE] with the following diagnoses: Aftercare Following Joint Replacement Surgery, Unspecified Asthma Uncomplicated (airway restriction), Multiple Sclerosis (breakdown of the protective covering of nerves), Other Migraine, Intractable Without Status Migraineurs (severe headaches), Presence of Right Artificial Hip Joint, Other Idiopathic Peripheral Autonomic Neuropathy (nerve pain), Herpes viral Vesicular Dermatitis (skin inflammation), Vitamin Deficiency, Attention Deficit Hyperactivity Disorder (attention difficulty), Gastro Esophageal Reflux Disease without Esophagitis (heart burn), Muscle Spasms, Anemia (low red blood cells), Depression, Anxiety, Insomnia (difficulty sleeping), Hypertension (high blood pressure), and Age Related Osteoporosis Without Current Pathological Fractures (weak and brittle bones).</p> <p>Record review of Residents #151's Physician orders revealed the following medication orders, dated 12/06/2024 revealed:</p> <p>1. Micafungin Sodium IV Solution 100 mg use 10 mg IV one time a day at 7:00 PM</p> <p>In an observation on 12/4/24 at 11:29 am, LVN A administered Micafungin Sodium IV to a Resident #151.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #113 Admission Record dated 12/06/2024 revealed that she was an [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Fracture with Routine Healing, Type II Diabetes Mellitus Without Complications (diabetes), Asthma (difficulty breathing), Zoster Without Complications (shingles), Hypothyroidism (underactive thyroid), Hyperlipidemia (elevated lipids in blood), Major Depressive Disorder (chronic depression), Generalized Anxiety Disorder (anxiety), Hypertension (high blood pressure), Allergic Rhinitis (seasonal allergies), Gastro Esophageal Reflux Disease Without Esophagitis (heart burn), and Urinary Tract Infection (infection of the bladder).</p> <p>Record review of Resident #113's physician orders dated 12/06/2024 revealed the following medication orders:</p> <ol style="list-style-type: none"> NovoLOG FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML Inject 2 unit subcutaneously with meals for diabetes NovoLOG FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML Inject as per sliding scale: if 150 - 224 = 1 unit; 225 - 299 = 2 units; 300 - 374 = 3 units; 375 - 449 = 4 units; 450 - 500 if >450, give 5 units and notify the physician, subcutaneously before meals. <p>In an observation on 12/4/24 at 11:38 am, LVN A failed to prime the insulin needle prior to administering Novolog 100 units/ml via a Flex Pen to Resident #113.</p> <p>Record review of Resident #39's Admission Record dated 12/06/2024 revealed that she was a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses: Depressed (depression), Unspecified Systolic Congestive Heart Failure (heart failure), Hypokalemia (low potassium), Non ST Elevation NSTEMI Myocardial Infarction (heart attack), Mixed Hyperlipidemia (elevated lipids in the blood), Polyneuropathy (nerve pain), Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris (plaque buildup in arteries), Peripheral Vascular Disease (narrowed blood vessels), Complete Traumatic Amputation At Level Between Knee and Ankle Left Lower Leg Initial Encounter (left leg amputation), Hypertension (high blood pressure).</p> <p>Record review of Resident#39's physician orders dated 12/06/2024 revealed the following medication orders:</p> <ol style="list-style-type: none"> HumaLOG Injection Solution 100 UNIT/ML 2 unit subcutaneously before meals HumaLOG Injection Solution 100 UNIT/ML as per sliding scale: if 150 - 189 = 1 unit; 190 - 229 = 2 units; 230 - 269 = 3 units; 270 - 309 = 4 units; 310 - 349 = 5 units if BBG IS GREATER OR EQUAL TO 350, GIVE 5 UNITS AND ALERT MD, subcutaneously before meals and at bedtime <p>In an observation on 12/4/24 at 11:44 am, LVN A failed to prime the insulin needle prior to administering Humalog 100 units/ml via a Flex Pen to Resident # 39.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #80's Admission Record dated 12/06/2024 revealed that he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Sepsis Unspecified Organism (blood infection), Insomnia (difficulty sleeping), Iron Deficiency Anemia (low iron), Type II Diabetes Mellitus Without Complications (diabetes), Vitamin D Deficiency (low vitamin D), Hyperlipidemia (elevated lipids in the blood), Hypertension (high blood pressure), Heart Failure, Peripheral Vascular Disease (narrowed blood vessels), Chronic Pulmonary Disease (blocked airflow in the lungs), Gout (arthritis in joints), and COVID -19.</p> <p>Record review of Residents #80's physician orders dated 12/06/2024 documented the following medication orders:</p> <ol style="list-style-type: none"> 1. NovoLOG FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML 5 unit subcutaneously with meals 2. NovoLOG FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML as per sliding scale: if 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400 - 450 = 12 units if BBG >400, give 12 units and notify physician, subcutaneously before meals and at bedtime. <p>In an observation on 12/4/24 at 11:51 am, LVN A failed to prime the insulin needle prior to administering Novolog 100 units/ml via a Flex Pen to Resident # 80.</p> <p>In an interview on 12/6/24 at 8:30 AM regarding Residents #113, 39, and 80, LVN A stated, I take off the primed needle then put on a new needle. You prime the needle to make sure the pen is good. There is not insulin in the new needle . She was unable to explain correct medication administration of priming needle with insulin prior to administering. She did not acknowledge that replacing the primed needle with a new needle, and failing to prime that needle, can cause any adverse reactions or that failure to do so, prevents the resident from receiving the entire dose of insulin. She acknowledged that the nurse is responsible for ensuring insulin administration is conducted properly.</p> <p>In an interview with LVN A 12/06/2024 at 11:15 am, when asked if she reviewed the MAR prior to administrating Resident #151's IV on 12/04/2024 at 11:29 am, she stated the medication was on the MAR but had a time order change the day previous. She stated that upon review the medication was scheduled at 7:00 PM. LVN A stated lack of checking orders and following rights of medication administration could cause someone to get something they aren't supposed to get. She further stated to prevent medication errors in the future, you should check the order before giving it. She stated, The nurse who passes the medication are responsible for checking medication and that, missing that final check caused that error.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/6/24 at 3:50 pm, the DON stated, My expectation is for them (staff) to follow their MAR and go by their MAR which is time limit is specific . She further stated that she does acknowledge that the nurse administered the Micafungin at 11:29 am and that the physician order at that time was for 7:00 PM. She stated an adverse outcome of not following a physician's order could lead to anaphylaxis, renal failure, or heart failure. She stated the administering nurse is responsible for checking the MAR and administering medications. The DON stated, The nurses should prime the needles prior to administration. She stated that primed needles should not be replaced prior to injection. They have skills check offs and annual checks off for all of that. She continued to say that she spoke with the nurse who removed the primed needle and replaced it with a non-primed needle and educated her on how to properly prime an insulin needle. She stated hyperglycemia (high blood sugar) could be a result of not priming the insulin pen needle.</p> <p>Record review of the facility's policy and procedure guide labeled Administration of IV Fluids and Medications, dated April 2014, revealed the following [in part]:</p> <p>.Procedure:</p> <p>1. Verify label on IV bag with prescriber's order .</p> <p>Record review of the facility's policy and procedure labeled License Skill Review for Administration of SQ Insulin via Insulin Pen provided by the DON on 12/6/2024 revealed the following [in part]:</p> <p>.5. Prepares injection:</p> <ul style="list-style-type: none"> o Attaches the needle o Remove the needle cap o Check the flow of delivery device (air shot) o 2-unit PRIIME every time o Select the dose prescribed . 		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>41871</p> <p>Based on observation, interviews, and record reviews, the facility failed to provide an appetizing temperature meal for 3 of 3 residents reviewed for meal palatability.</p> <p>The facility failed to serve meals at palatable, attractive, and at an appetizing temperature for residents #105, #25 and #27 served their meals in their rooms.</p> <p>This failure could affect the residents by placing them at risk for malnutrition due to not providing appetizing temperature meal.</p> <p>Findings included:</p> <p>An observation and interview with the Dietary Manager on 12/05/24 at 11:58 AM, in the Satellite Kitchen on the 2nd floor revealed:</p> <p>A. The holding temperatures were as follows: Turkey Entree 169.2 Fahrenheit and Carrots 174.1 Fahrenheit.</p> <p>B. At 11:59 AM, the sample tray was placed on the food cart.</p> <p>C. At 12:07 PM, the food cart left the kitchen.</p> <p>D. At 12:12 PM, the last tray was delivered to the resident.</p> <p>E. At 12:15 PM, the sampled tray was tested with the Dietary Manager. The temperature of the food was as followed: Turkey entree 100 Fahrenheit and the carrots 104 Fahrenheit. The surveyor team and the Dietary Manager all tasted the food. The food was rated as lukewarm The Dietary Manager stated the food was not warm enough.</p> <p>In an observation and interview with the Dietary Manager on 12/05/24 at 12:50 PM, in the Main Kitchen on the 1st floor:</p> <p>A. The holding temperatures were as follows: Turkey Entree 167.2 Fahrenheit and Carrots 158.6 Fahrenheit.</p> <p>B. At 12:52 PM, the sample tray was placed on the food cart.</p> <p>C. At 12:56 PM, the food cart left the kitchen.</p> <p>D. At 1:00 PM, the last tray was delivered to the resident.</p> <p>E. At 1:01 PM, the sampled tray was tested with the Dietary Manager. The temperature of the food was as followed: Turkey entree 132 Fahrenheit and the carrots 131 Fahrenheit. The surveyor team and the Dietary Manager all tasted the food. The food was rated as warm The Dietary Manager stated the food was warmer than the 2nd floor.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/04/24 at 11:35 AM, Resident #105's family member stated Resident #105 ate in his room and the food was cold most of the time.</p> <p>During an interview on 12/04/24 at 11:57 AM, Resident #25 stated she ate mostly in her room and the food was cold.</p> <p>During an interview on 12/04/24 at 11:48 AM, Resident #27 stated she ate in her room most of the time and stated I get cold food quite a bit.</p> <p>Record review of the Resident Council meeting minutes revealed on 10/02/2024, 09/04/24, 08/07/24, 07/03/24, 05/01/24, 04/02/24, and 03/06/24, the residents complained of cold food.</p> <p>In an interview and record review on 12/06/24 at 10:57 AM, the Dietary Manager and Dietician, stated they received reports from Resident Council that the food being served to the residents' rooms was cold. The Dietary Manager stated, as a result, they had been checking food temperatures monthly and that the food temperatures were ok. They said there was no documentation of testing the temperatures of the food. The Dietician said a potential negative outcome of hot foods not being served hot were the residents might not eat their food causing hunger and weight loss. A facility policy was requested regarding food temperatures and was provided the policy Food Safety and Sanitation Plan,. However, the policy failed to address residents receiving cold foods. The Dietary Manager said there was no other policy.</p> <p>In an interview on 12/06/24 at 12:00 PM, the Administrator said cold food had been the number one complaint he received from the residents, and the facility has been working on addressing the cold food temperatures but nothing has worked so far. He said QAPI has identified it, and is currently being worked on.</p> <p>Record review of the facility policy Food Safety and Sanitation Plan, dated as last reviewed on 11/28/17 revealed the policy did not provide any relevant references to the failure.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50133</p> <p>Based on observation, interview, and record review, the facility failed to establish and 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 1 of 33 residents (Residents #39) reviewed for infection control.</p> <p>The facility failed to ensure LVN A donned (put on) Personal Protective Equipment (PPE), as required for residents who were on transmission-based precautions (TBP), when she entered Resident #39's room.</p> <p>This failure could place residents at risk for infections.</p> <p>The findings include:</p> <p>1. Record review of Resident #39's face sheet, dated 12/05/2024, revealed a [AGE] year-old female, who was admitted to the facility on [DATE] with the following diagnoses osteomyelitis (bone infection), essential hypertension (high blood pressure), type 2 diabetes mellitus (diabetes), and chronic obstructive pulmonary disease (lung disease).</p> <p>Record review of Resident #39's MDS assessment dated [DATE] revealed the following: Section O: Special Treatments, Procedures and Programs performed: M1. Isolation or quarantine for active infectious disease while a resident.</p> <p>Record review of Resident #39's Care Plan, initiated on 11/14/24, revealed a care plan for MRSA and resident on contact isolation due to infection.</p> <p>Record review of Resident #39's physician orders, active date of 12/04/2024, revealed Resident #39 had an order for Contact Precautions for diagnosis of MRSA in effect every shift with order start date of 11/14/2024 and no end date.</p> <p>An observation on 12/04/2024 at 2:01 PM revealed, Resident #39's door was closed, there were PPE supplies hanging on the outside of door, and Contact Precaution signage which informed the viewer that the resident was on Contact Precautions. The contact precautions sign revealed: Perform hand hygiene before entering and before leaving room, Wear gloves when entering room or cubicle and when touching patient intact skin, surface, or articles in close proximity, Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient's items or potential contaminated environment, Use patient-dedicated or single use disposable shared equipment or clean and disinfect shared equipment. LVN A was observed entering Resident #39's room without donning PPE, then closed Resident #39's door. LVN A was then observed leaving Resident #39's room without PPE on 12/4/24 at 2:03 PM.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/4/24 at 2:03 PM, LVN A stated that Resident #39 was on contact precautions due to MRSA in her wound. She further stated that PPE was to be used only when we do care or mess with the wound . She stated that the staff didn't need to put PPE on for entering Resident#39's room for other resident care. Further stating, staff only need to wear PPE such as gown when in contact with the resident's wound .</p> <p>In an interview on 12/4/24 at 2:09 PM, ADON B stated that Resident #39 was on contact precautions. She also stated that her expectation is staff should only put on PPE if in direct contact with resident's wound.</p> <p>In an interview on 12/5/24 at 2:42 PM, the DON stated that Resident #39 is currently on contact precautions. The DON also verified the physician's order, care plan, MDS, and that the sign posted on Resident #39's door is for contact precautions. The DON stated that her expectation, for any resident on contact precautions, is for staff to don (put on) PPE, gown, and gloves, upon entry into resident's room. She also stated that lack of following ordered contact precautions could lead to spread of infection.</p> <p>Record review of facility policy Transmission-Based (Isolation) Precautions dated 10/24/22 revealed the following [in-part]:</p> <p>Contact Precautions - refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment.</p> <p>8. Contact Precautions -</p> <p>a. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment.</p> <p>c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment.</p> <p>d. Donning PPE upon room entry and discarding before exiting the room is done to contain pathogens.</p>		