

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Austin		STREET ADDRESS, CITY, STATE, ZIP CODE 6909 Burnet LN Austin, TX 78757	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600</p> <p>Based on interviews and record review, the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly for 1 (Resident #1) of 4 residents reviewed for physician notification, in that:</p> <p>The facility failed to notify Resident #1's physician or nurse practice of missed medications due to the resident being out on pass from the facility on 04/01/2025, 04/02/2025, 04/03/2025, 04/05/2025, 04/06/2025 04/07/2025 and 04/08/2025.</p> <p>This failure could result in decreased continuity of care, and a delay in needed treatment and services.</p> <p>Findings included:</p> <p>Review of Resident #1 face sheet reflected a [AGE] year-old woman admitted on [DATE] with diagnoses of apraxia (disorder that disrupts the brains' ability to plan and sequence motor movements), atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the walls in the heart), cerebral aneurysm (bulge or ballooning in a weakened area of a blood vessel in the brain), paranoid schizophrenia (prominent delusions, hallucinations, lack of other disorganized symptoms), bipolar disorder (a mental illness characterized by extreme and persistent shifts in mood, energy, and activity levels), and anxiety disorder (excessive worry, fear and other physical and behavioral symptoms that interfere with daily life).</p> <p>Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 15 (no cognitive impairment).</p> <p>Review of Resident #1's care plan dated 03/06/2025 reflected Resident #1 had coronary artery disease with interventions to encourage compliance with treatment regime and follow up with physician. Resident #1 required psychotropic medications for schizophrenia and bipolar diagnosis with interventions to administer medications as ordered.</p> <p>Review of Resident #1's physician's orders reflected:</p> <p>Aspirin with a start date of 02/11/2025 for hearth health one time a day</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Divalproex tablet with a start date of 02/11/2025 for bipolar disorder twice a day</p> <p>Doxepin capsule with start date of 02/11/2025 once a day for sleep for sleep</p> <p>Folic Acid tablet with a start date of 02/11/2025 one time a day</p> <p>Multivitamin tablet with a start date of 02/16/2025 one time a day</p> <p>Haloperidol tablet with a start date of 02/12/2025 twice a day for paranoid schizophrenia</p> <p>Metoprolol tablet with a start date of 02/11/2025 twice a day for hypertension</p> <p>Review of Resident #1's April 2025 MAR reflected the follow medications were marked as missed (indicated as away from the facility):</p> <p>Aspirin - 04/01/2025, 04/02/2025, 04/03/2025 and 04/07/2025</p> <p>Doxepin- 04/02/2025, 04/03/2025, 04/05/2025, 04/06/2025, and 04/07/2025</p> <p>Divalproex- 04/01/2025 (morning dose), 04/02/2025 (morning and night dose), 04/03/2025 (morning and night dose), 04/05/2025 (night dose), 04/06/2025 (night dose), and 04/07/2025 (morning and night dose).</p> <p>Haloperidol- 04/01/2025 (morning dose), 04/02/2025 (morning and night dose), 04/03/2025 (morning and night dose), 04/05/2025 (night dose), 04/06/2025 (night dose), 04/07/2025 (morning and night dose), and 04/08/2025 (morning dose).</p> <p>Folic Acid- 04/01/2025, 04/02/2025, 04/03/2025, 04/07/2025, and 04/08/2025.</p> <p>Multivitamin- 04/01/2025, 04/02/2025, 04/03/2025, and 04/07/2025.</p> <p>Metoprolol- 04/01/2025 (morning dose), 04/02/2025 (morning dose and night dose), 04/03/2025 (morning and night dose), 04/05/2025 (night dose), 04/06/2025 (night dose), 04/07/2025 (morning and night dose) and 04/08/2025 (morning dose).</p> <p>Review of Resident #1's sign-out / sign-in record reflected Resident #1 signed out of the facility on 04/01/2025 (returning on 04/04/2025), 04/04/2025, 04/05/2025, and 04/06/2025.</p> <p>Review of Resident #1's progress notes dated 02/11/2025 to 04/09/2025 reflected the NP nor MD was contacted when resident returned for missed medications.</p> <p>During an interview on 04/10/2025 at 11:46 AM, Resident #1 stated that she liked to go out on pass and signed out almost every day. She stated she signed out of the facility with the nurse. Resident #1 stated that if she was going to be out overnight the nurse gave her medications to take while she was gone. Resident #1 stated that sometimes she went out for the day and stayed out overnight. Resident #1 stated she knew that she missed medications because of this but she liked to go out and be with family.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/10/2025 at 1:15 PM, LVN A stated that if a resident was out on pass longer than anticipated and missed medication there was an option on the MAR and it was marked that the resident was out. LVN A stated she was supposed to let the NP know of missed medication and it depended on how many doses were missed. LVN A stated progress note was put in that the nurse made the notification.</p> <p>During an interview on 04/10/2025 at 1:25 PM, RN B stated that if a resident was out on pass longer and missed medication she would have reached out to the resident and advise them to come back to take medications. RN B stated if a resident missed medication, the physician should have been notified and it should have been documented in the progress notes.</p> <p>During an interview on 04/10/2025 at 3:34 PM, the NP stated that Resident #1 was new to him but he was familiar with her. The NP stated his first visit with Resident #1 was on 04/04/2025. He stated that he was told she was out on pass for three days. The NP stated that he did not believe he was informed that Resident #1 was out and missed several days of medications. The NP stated that he expected that the nurses contacted him or the on-call provider to ensure the nurses received the proper authorization to continue to administer medication. The NP stated missed medications could have causes withdrawal symptom, specifically with missing psychotropics. The NP stated that the missed medication and length of time that they were missed would determine his recommendations for the nurses. The NP stated that it was important that staff notified him of any missed medications so he could decide how to proceed.</p> <p>During an interview on 04/11/2025 at 12:20 PM, LVN D stated that if a resident was out on pass during medication pass, there was an option for the medication to be marked as the resident was out. LVN D stated the nurse had to make a note that they were out. LVN D stated that the provider should have been notified that the resident missed the medication and it should be documented in the nurses note.</p> <p>During an interview on 04/11/2025 at 12:48 PM, CMA E stated that if a resident was out of the facility during medication pass the option was selected and marked that indicated the resident was out on pass. CMA E stated if that was marked it meant that the medication was missed. CMA E stated the selection was number 3 on the MAR. CMA E stated that the nurse was notified verbally but it was not documented anywhere.</p> <p>During an interview on 04/11/2025 at 1:29 PM, the DON stated that the protocol for missed medication was that the NP was notified. The DON stated that the notification should have been documented under the resident's progress notes. The DON stated the charge nurse was responsible to make the notification and document it. The DON stated the CMA should have told the nurse. The DON stated that she did not believe the CMA was supposed to document that the nurse was notified of missed medications and they did not have access to add a note. The DON stated the nurse should have documented the notification of missed medication from the CMA. The DON stated the potential harm depended on the medication. The DON stated that some medications that have missed doses cannot have a subsequent dose administered but it depended on the medication.</p> <p>During an interview on 04/11/2025 at 1:45, the ADM stated that she expected staff to notify the physician of missed medications. The ADM stated that it should have been documented in the progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of in-services from February 2025 to April 2025, no training was completed regarding notification to provider of missed medication.</p> <p>Review of facility policy titled Change in a Resident's Condition or Status with revision date of December 2010 reflected the facility shall promptly notify the residents, his or her attending physician of changes in the resident's medical/mental conditions and/or status. Further review reflected the nurse supervisor or charge nurse will notify the resident's attending physician or on-call physician when there has been refusal of treatment or medications (two or more consecutive times).</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>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** 42600</p> <p>Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified for one (Resident #1) of four residents reviewed for care plans.</p> <p>The facility failed to revise Resident #1's care plan to reflect her falls on 02/11/2025, 03/09/2025 and 03/23/2025.</p> <p>This failure could place residents at risk of not receiving appropriate interventions to meet their current needs.</p> <p>Findings include:</p> <p>Review of Resident #1 face sheet reflected a [AGE] year-old woman admitted on [DATE] with diagnoses of apraxia (disorder that disrupts the brains' ability to plan and sequence motor movements), atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the walls in the heart), cerebral aneurysm (bulge or ballooning in a weakened area of a blood vessel in the brain), paranoid schizophrenia (prominent delusions, hallucinations, lack of other disorganized symptoms), bipolar disorder (a mental illness characterized by extreme and persistent shifts in mood, energy, and activity levels), and anxiety disorder (excessive worry, fear and other physical and behavioral symptoms that interfere with daily life).</p> <p>Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 15 (no cognitive impairment). Review reflected Resident #1 was independent for transfers.</p> <p>Review of Resident #1's care plan reflected no falls.</p> <p>Review of incident report dated 02/11/2025 reflected Resident #1 had a witnessed fall with no injuries.</p> <p>Review of incident report dated 3/09/2025 reflected Resident #1 had an unwitnessed fall with no injuries.</p> <p>Review of incident report dated 03/23/2025 reflected Resident #1 had an unwitnessed fall with no injuries.</p> <p>During an interview on 04/11/2025 at 12:20 PM, LVN D stated that interventions for falls should have been on the care plan. LVN D stated the purpose of the care plan was to be made aware of behaviors, ongoing falls, or problems. LVN D stated the MDS nurse and maybe the ADM, and SW were responsible for updating the care plan.</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>During an interview on 04/11/2025 at 12:52 PM, LVN C stated interventions for falls were supposed to be in the resident's care plan. LVN C stated the DON or ADON was responsible for updating the care plan. LVN C that falls were supposed to be on the care plan.</p> <p>During an interview on 04/11/2025 at 1:06 PM, MDS RN stated the purpose of the care plan was to capture a resident's story. The MDS RN stated she was still learning a lot about the care plans. MDS RN stated when a fall occurred it should have been on the care plan whether it was witnessed or unwitnessed. The MDS RN stated she was told to put everything on the care plan as it was the resident's story so staff could know exactly what happened. The MDS RN stated that whoever observed what occurred was responsible to add falls on the care plan. The MDS RN stated she then went in and added interventions or goals. The MDS RN stated she did not know why Resident #1's falls were not on Resident #1's care plan. The MDS RN stated that usually the IDT were responsible for different sections of the care plan. The MDS RN stated she reviewed resident's documents and tried to add information from the documents to the care plan.</p> <p>During an interview on 04/11/2025 at 1:29 PM, the DON stated the purpose of a care plan was to show a picture of the residents. The DON stated that falls should have been added to the care plan. The DON stated that any management staff (social worker, activities, nursing management, MDS) could add to the care plan and were responsible to update their respective sections. The DON stated it was important that the care plan accurately reflected a resident's status so anyone could get a picture of that person.</p> <p>During an interview on 04/11/2025 at 1:45 PM, the ADM stated that the purpose of a care plan was to gain an understanding of the resident and to learn what their goals were and to list any concerns. The ADM stated she told her staff to write a story to understand the resident. The ADM stated that each department was responsible for each of their own sections on the care plan. The ADM stated MDS RN helped with the nursing section. The ADM stated overall the MDS RN oversaw the care plan and if something was missing she modified it. The ADM stated that the care plan should have reflected any fall that occurred and she expected falls to be on the care plan.</p> <p>Review of facility policy titled Care Plans - Comprehensive with revision date of December 2010 reflected an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Each resident's comprehensive care plan is designed to incorporate identified problem areas, risk factors associated with identified problems, aid in preventing or reducing declines in the resident's functional status and/or functional levels. Further review reflected the policy reflected to reflect currently recognized standards or practice for problem areas and conditions. Resident's care plans are revised as information about the resident and the resident's condition change.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals for 1 of 4 residents (Resident #1) reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #1's aspirin, doxepin, divalproex, haloperidol, folic acid, multivitamin and metoprolol were administered according to the physician's orders.</p> <p>These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status and decreased quality of life.</p> <p>Findings include:</p> <p>Review of Resident #1's face sheet reflected a [AGE] year-old woman admitted on [DATE] with diagnoses of apraxia (disorder that disrupts the brains' ability to plan and sequence motor movements), atherosclerotic heart disease (buildup of fats, cholesterol and other substances in and on the walls in the heart), cerebral aneurysm (bulge or ballooning in a weakened area of a blood vessel in the brain), paranoid schizophrenia (prominent delusions, hallucinations, lack of other disorganized symptoms), bipolar disorder (a mental illness characterized by extreme and persistent shifts in mood, energy, and activity levels), and anxiety disorder (excessive worry, fear and other physical and behavioral symptoms that interfere with daily life).</p> <p>Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 15 (no cognitive impairment).</p> <p>Review of Resident #1's care plan dated 03/06/2025 reflected Resident #1 had coronary artery disease with interventions to encourage compliance with treatment regime and follow up with physician. Resident #1 required psychotropic medications for schizophrenia and bipolar diagnosis with interventions to administer medications as ordered. Review reflected Resident #1 had a mood problem related to schizophrenia with goal to have improved mood and interventions to administer medications as ordered.</p> <p>Review of Resident #1's physician's orders reflected:</p> <p>Aspirin with a start date of 02/11/2025 for hearth health one time a day</p> <p>Divalproex tablet with a start date of 02/11/2025 for bipolar disorder twice a day</p> <p>Doxepin capsule with start date of 02/11/2025 once a day for sleep for sleep</p> <p>Folic Acid tablet with a start date of 02/11/2025 one time a day</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Multivitamin tablet with a start date of 02/16/2025 one time a day</p> <p>Haloperidol tablet with a start date of 02/12/2025 twice a day for paranoid schizophrenia</p> <p>Metoprolol tablet with a start date of 02/11/2025 twice a day for hypertension</p> <p>Review of Resident #1's April 2025 MAR reflected the follow medications were marked as missed (indicated as away from the facility):</p> <p>Aspirin - 04/01/2025, 04/02/2025, 04/03/2025 and 04/07/2025</p> <p>Doxepin- 04/02/2025, 04/03/2025, 04/05/2025, 04/06/2025, and 04/07/2025</p> <p>Divalproex- 04/01/2025 (morning dose), 04/02/2025 (morning and night dose), 04/03/2025 (morning and night dose), 04/05/2025 (night dose), 04/06/2025 (night dose), and 04/07/2025 (morning and night dose).</p> <p>Haloperidol- 04/01/2025 (morning dose), 04/02/2025 (morning and night dose), 04/03/2025 (morning and night dose), 04/05/2025 (night dose), 04/06/2025 (night dose), 04/07/2025 (morning and night dose), and 04/08/2025 (morning dose).</p> <p>Folic Acid- 04/01/2025, 04/02/2025, 04/03/2025, 04/07/2025, and 04/08/2025.</p> <p>Multivitamin- 04/01/2025, 04/02/2025, 04/03/2025, and 04/07/2025.</p> <p>Metoprolol- 04/01/2025 (morning dose), 04/02/2025 (morning dose and night dose), 04/03/2025 (morning and night dose), 04/05/2025 (night dose), 04/06/2025 (night dose), 04/07/2025 (morning and night dose) and 04/08/2025 (morning dose).</p> <p>Review of Resident #1's sign-out / sign-in record reflected Resident #1 signed out of the facility on 04/01/2025 (returning on 04/04/2025), 04/04/2025, 04/05/2025, and 04/06/2025.</p> <p>Review of Resident #1's progress notes dated 02/11/2025 to 04/09/2025 reflected the NP nor MD was contacted when resident return for missed medications or to hold the medication.</p> <p>During an interview on 04/10/2025 at 11:46 AM, Resident #1 stated that she liked to go out on pass and signed out almost every day. She stated she signed out of the facility with the nurse. Resident #1 stated that if she was going to be out overnight the nurse gave her medications to take while she was gone. Resident #1 stated that sometimes she went out for the day and stayed out overnight. Resident #1 stated she knew that she missed medications because of this but she liked to go out and be with family.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/10/2025 at 1:15 PM, LVN A stated that if a resident was out on pass longer than anticipated and missed medication there was an option on the MAR and it was marked that the resident was out. LVN A stated she was supposed to let the NP know of missed medication and it depended on how many doses were missed. LVN A stated progress note was put in that the nurse made the notification. LVN A stated that residents were supposed to let the nurse know if they were going out on pass and the nurse asked how long. LVN A stated if the resident went out overnight, then medication will be sent with the resident.</p> <p>During an interview on 04/10/2025 at 1:25 PM, RN B stated that if a resident was out on passed longer and missed medication she would have reached out to the resident and advise them to come back to take medications. RN B stated that if she was unable to reach anyone, she would have notified the ADM and the DON. RN B stated if a resident missed medication, the physician should have been notified and it should have been documented in the progress notes. RN B stated that when a resident went out on pass, she asked how long they are going to be gone. RN B stated if the resident was going to be gone for several days, they could provide medications and instructions on how to take them to the family or resident. RN B stated she was unsure of the risk of missed medications because the physician handled it from there and it was out of her control.</p> <p>During an interview on 04/10/2025 at 2:18 PM, LVN C stated that Resident #1 goes out on pass whenever she wanted and she said she did not know if she was going to be out overnight or night sometimes. LVN C stated that if a resident left to go out on pass, she asked before if the resident wanted to wait so they could get their medications.</p> <p>During an interview on 04/10/2025 at 3:34 PM, the NP stated that Resident #1 was new to him but he was familiar with her. The NP stated his first visit with Resident #1 was on 04/04/2025. He stated that he was told she was out on pass for three days. The NP stated that he did not believe he was informed that Resident #1 was out and missed several days of medications. The NP stated that he expected that the nurses contacted him or the on-call provider to ensure the nurses received the proper authorization to continue to administer medication. The NP stated missed medications could have causes withdrawal symptom, specifically with missing psychotropics. The NP stated that the missed medication and length of time that they were missed would determine his recommendations for the nurses. The NP stated that it was important that staff notified him of any missed medications so he could decide how to proceed.</p> <p>During an interview on 04/11/2025 at 12:20 PM, LVN D stated that if a resident was out on pass during medication pass, there was an option for the medication to be marked as the resident was out. LVN D stated the nurse had to make a note that the resident was out. LVN D stated that the provider should have been notified that the resident missed the medication, and it should be documented in the nurses note.</p> <p>During an interview on 04/11/2025 at 12:48 PM, CMA E stated that if a resident was out of the facility during medication pass the option was selected and marked that indicated the resident was out on pass. CMA E stated if that was marked it meant that the medication was missed. CMA E stated the selection was number 3 on the MAR. CMA E stated that the nurse was notified verbally but it was not documented anywhere.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Austin		STREET ADDRESS, CITY, STATE, ZIP CODE 6909 Burnet LN Austin, TX 78757	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/11/2025 at 1:29 PM, the DON stated that the protocol for missed medication was that the NP was notified. The DON stated that the notification should have been documented under the resident's progress notes. The DON stated the charge nurse was responsible to make the notification and document it. The DON stated the CMA should have told the nurse. The DON stated that she did not believe the CMA was supposed to document that the nurse was notified of missed medications, and they did not have access to add a note. The DON stated the nurse should have documented the notification of missed medication from the CMA. The DON stated the potential harm depended on the medication. The DON stated that some medications that have missed doses cannot have a subsequent dose administered but it depended on the medication.</p> <p>During an interview on 04/11/2025 at 1:45, the ADM stated that she expected staff to notify the physician of missed medications. The ADM stated that it should have been documented in the progress notes.</p> <p>Review of facility policy titled Change in a Resident's Condition or Status with revision date of December 2010 reflected the facility shall promptly notify the residents, his or her attending physician of changes in the resident's medical/mental conditions and/or status. Further review reflected the nurse supervisor or charge nurse will notify the resident's attending physician or on-call physician when there has been refusal of treatment or medications (two or more consecutive times).</p> <p>Review of undated facility policy titled Administering Medications reflected medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600</p> <p>Based on interviews and record review, the facility failed promptly to assist residents in obtaining routine dental services to meet the needs of 3 (Resident #2, Resident #3, and Resident #4) of 4 residents reviewed for dental services.</p> <ol style="list-style-type: none"> 1. The facility failed to provide or obtain dental services for Resident #2, Resident #3, and Resident #4. 2. The facility failed to promptly provide dental services for Resident #3 due for denture placement and document why the referral did not occur within three days. <p>This failure could place residents at risk of oral complications, pain, difficulty eating and diminished quality of life.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of Resident #2's face sheet reflected a [AGE] year-old woman readmitted on [DATE] with diagnoses of malignant neoplasm of brain (brain cancer), central pain syndrome (chronic pain due to damaged or dysfunction of brain or spinal cord), dysphagia (difficulty swallowing), generalized anxiety disorder (mental condition that causes persistent and excessive worry), cognitive communication deficit (communication difficulties) and major depressive disorder (mood disorder characterized by persistent sadness, loss of interest or pleasure in activities). <p>Review of Resident #2's quarterly MDS dated [DATE] reflected no mouth or facial pain, or discomfort or difficulty chewing. Review reflected a BIMS score of 15, which indicated no cognitive impairment.</p> <p>Review of Resident #2's physician orders dated 08/28/2024 reflected refer to the dentist for dental exam, complaints of tooth/ gingiva pain.</p> <p>Review of Resident #2's care plan conference dated 02/05/2025 reflected there were no consults needed (podiatry, dental).</p> <p>During an interview on 04/10/2025 at 10:29 AM, Resident #2 stated that she had not seen a dentist in over 5 years. Resident #2 stated that she asked staff but could not remember who. She stated she had issues with her teeth. Resident #2 stated they're just terrible. Resident #2 stated she did not have pain but had a couple of broken teeth and had some pain every now and then. Resident #2 stated she was able to eat okay.</p> <p>Review of Resident #2's weight from 10/01/2024 to 04/01/2025 reflected no significant weight loss.</p> <p>Review of Resident #2's progress notes from 09/01/2024 to 04/11/2025 reflected no notes regarding dental exam.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of dental visit report dated 12/20/2021 for Resident #2 reflected resident had a filling completed with note to have NP sign clearance to begin too extractions.</p> <p>2. Review of Resident #3's face sheet reflected a [AGE] year-old woman readmitted on [DATE] with diagnoses of vascular dementia (memory loss caused by impaired blood flow to brain), major depressive disorder (mood disorder characterized by persistent sadness, loss of interest or pleasure in activities), type 2 diabetes mellitus (chronic condition characterized by persistently high blood sugar levels), dysphagia (difficulty swallowing), and need for assistance with personal care (need for assistance with daily living activities such as bathing, dressing or eating).</p> <p>Review of Resident #3 quarterly MDS dated [DATE] reflected a BIMS score of 15, indicated no cognitive impairment. Review also reflected no broken or loosely fitting dentures and no mouth of facial pain, or discomfort or difficulty with chewing.</p> <p>Review of Resident #3's care plan dated 12/22/2022 reflected Resident #3 has oral/dental health problems of missing, carious lower teeth.</p> <p>Review of Resident #3's physician order reflected an order dated 08/23/2024 refer to the dentist for denture placement.</p> <p>Review of NP progress note dated 02/17/2025 reflected Resident #3 is hoping that dentist would be able to construct a new denture for her and discussed and coordinated with social worker.</p> <p>Review of Resident #3's weight from 10/01/2025 to 04/01/2025 reflected no weight loss.</p> <p>During an interview on 04/10/2025 at 10:13 AM, Resident #3 stated that she asked to see the dentist for her teeth. Resident #3 stated she had some pain with her teeth but it was not consistent. Resident #3 stated that she wore upper dentures and had a broken tooth on the bottom. Resident #3 stated it sometimes rubbed her bottom lip. Resident #3 stated she does not have pain and was able to eat fine, but wanted her denture adjusted.</p> <p>3. Review of Resident #4 face sheet reflected a [AGE] year-old man readmitted on [DATE] with diagnoses of respiratory failure (condition where the lungs can't adequately provide oxygen to the blood or remove carbon dioxide), anxiety disorder (excessive worry and fear), other recurrent depressive disorders (depressive episodes that involved recurring periods of low mood), and chronic obstructive pulmonary disease(condition caused by damage to air ways or other parts of lung that make it difficult to breathe).</p> <p>Review of Resident #4 quarterly MDS date 03/25/2025 reflected a BIMS score if 15, which indicated no cognitive impairment. Review reflected Resident #4 had no broken or loosely fitting dentures and no mouth or facial pain or discomfort or difficulty chewing.</p> <p>Review of Resident #4 care plan dated 03/27/2025 reflected Resident #4 stated his teeth are not in good condition, missing teeth, denies pain or discomfort, wound like to see about dentures.</p> <p>Review of Resident #4 progress note reflected no referrals for dental services.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #4 care plan conference dated 03/27/2025 reflected dentist as consult needed/requested.</p> <p>Review of Resident #4 dental visit report dated 11/21/2022 reflected he had an exam, cleaning and varnish completed with treatment notes that Resident #4 had a new cavity.</p> <p>During an interview on 04/10/2025 at 10:09 AM, Resident #4 stated that he needed to see a dentist for a cleaning and has not seen a dentist in over a year.</p> <p>During an interview on 04/11/2025 at 12:52 PM, LVN C stated that if she received a report of concerns with mouth or teeth should would have assessed the resident and would report to the NP or MD and let the social worker know and ask the social worker to make an appointment. LVN C stated it was important to have dental concerns addressed because a resident may not have brushed their teeth well and they may have needed to be evaluated for concerns with their teeth.</p> <p>During an interview on 04/11/2025 at 12:20 PM, LVN D stated if a resident reported concerns with their mouth of teeth he would have notified the NP and if it was something the resident needed to see dentist for, the social worker was notified. LVN D stated the social worker was responsible for making the referral or appointment. LVN D stated it was important that dental concerns were addressed because without it, the resident may have not wanted to eat or could have weight loss or nutrition issues.</p> <p>During an interview on 04/11/2025 at 12:48 PM, CMA E stated she would have reported any issues with teeth to the nurse. CMA E stated she thought the nurse was responsible for dental referrals or appointments.</p> <p>During an interview on 04/11/2025 at 12:44 PM, CNA F stated if a resident reported issues with teeth or gums she would let the nurse know. She stated she thought the social worker was responsible for dental referrals.</p> <p>During an interview on 04/11/2025 at 1:19 PM, the SW stated that he started at the facility six months ago. He stated that he was not sure what company was used for dental services previously. The SW he stated recently worked to obtain a dental contract. The SW stated the contract was received and the end of February 2025 or beginning of March 2025. The SW stated he was responsible for making dental appointments. He stated that that he made the referral and would get a schedule when the dentist was available. The SW stated previously there was not an in-house provider. The SW stated if the dentist could not come for a while and if it was an emergency then an appointment could be made at a nearby dentist. The SW stated he offered dental, podiatry and vision appointments every three months at care plan meetings. The SW stated as of 04/11/2025, the dentist had not been to the facility and the SW had not been provided a schedule of who was going to be seen. The SW stated he was not aware of anyone who was waiting to see the dentist.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/11/2025 at 1:29 PM, the DON stated that the social worker handled the dental referrals. The DON stated for quite a while the facility was not aware of which company was used for dental. The DON stated recently the SW brought in dental referrals for her to sign. The DON stated that it was important that dental referrals were handled timely because a cavity could go to the heart and the bacteria could cause more trouble. The [NAME] stated if the resident was in pain, she did not want the resident to have pain. The DON stated the SW was responsible and ensured dental referrals were made. The DON stated a referral should be made as soon as an issue came up. The DON stated she was not sure how often the dentist came to the facility.</p> <p>During an interview on 04/11/2025 at 1:45 PM, the ADM stated social services was responsible for dental appointments. The ADM stated that getting a dental contract was recently worked on. The ADM stated if a resident requested dental services a referral is sent to be reviewed. The ADM stated the resident can choose to see the provider who came to the facility or in the community. The ADM stated that if it was an emergency, the referral should be made as soon as possible to ensure the resident received the emergency dental care they needed. The ADM stated if it was routine a referral would be sent to the provider and the provider would provide the facility a date of when they would be at the facility next.</p> <p>Review of facility policy titled Dental Services with revision date of December 2009 reflected routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and emergency dental services are provided to the residents through a contract agreement with a local dentist, resident's personal dentist, referral to community dentists or other health care organization that provides dental services. Social Services personnel will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.</p>		