STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675112	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 of 2 residents (Resident #1) reviewed for intravenous medications. 1. The facility failed to ensure the dressing on Resident #1's Midline catheter (used to deliver intravenous medications directly to the large central veins near heart) was changed timely. Resident #1 went without a dressing change for 15 days. 2. The facility failed to have orders for Midline catheter dressing changes. The failures could affect residents by placing them at risk for infections and cross-contamination. Findings included: Record review of Resident #1's Admission Record dated 12/21/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS dated [DATE] reflected she was in a persistent vegetative state, she was dependent on staff for all ADLs and her diagnoses included hypertension (high blood pressure); Diabetes; aphasia (disorder that affects the ability to verbally communicate); and stroke. Record review of Resident #1's Order Recap Report dated 1/2/25 reflected the following orders: 12/16/24: Insert Midline. 12/17/24: Imipenem-Cilastatin Intravenous Solution 500 mg intravenously every 6 hours for UTI until 12/24/24. There were no orders for dressing changes to be performed to her midline catheter site. Record review of Resident #1's MAR and TAR dated December 2024 reflected no entries for dressing changes to her midline catheter site. (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 12/31/24 at 9:46 AM revealed Resident #1 was in bed. Her eyes were open but she made no response to verbal greeting. A midline IV insertion site on her left upper arm had a dressing intact and dated 12/16/24. In an interview on 12/31/24 at 2:23 PM, RN A stated she had an order to discontinue the midline catheter and she was checking the facility policies related to removal. She stated she had come from another facility to help out due to staff calling in sick. She stated she could not say why Resident #1's dressing had not been changed. During an interview on 12/31/24 at 3:35 PM, the DON stated Resident #1's midline IV was getting discontinued that day. She stated it would have been removed sooner but her family wanted it left in a little longer in case she needed additional medications. The DON stated they usually ordered dressing changes every 7 days and she could not say why hers had not been ordered or why her dressing had not been changed. She stated she usually had an ADON to assist with reviewing orders and MARS but had been without one for the past month. She stated she had a new ADON scheduled to start soon. The DON stated the risk of not changing the dressings was infection. During an interview on 1/2/25 at 3:05 PM, LVN B stated he typically cared for Resident #1 and did not know how often the dressing to her IV site needed to be changed. He stated they checked the IV site every shift to ensure it was intact and hers had been removed on 12/31/24 . LVN B stated the risk of not changing dressings included infection. Record review of the facility's policy titled, Peripheral IV Dressing Changes dated Revised April 2016 reflected: Purpose-This purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines .2. Change the dressing if it becomes damp, loosened or visibly soiled and at least every 5-7 days. Change dressing and perform site care if signs and symptoms of site infection are present .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on, observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 6 residents reviewed for pharmacy services in that: The facility failed to ensure Resident #1's Ketoconazole External Shampoo (used to treat hair loss and dandruff) was available and applied as ordered between 11/27/24 and 12/2/24. This failure placed the residents at risk of not receiving medications as ordered by the physician and a delay in treatment and worsening of their condition. Findings included: Record review of Resident #1's Admission Record dated 12/21/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #1's Quarterly MDS dated [DATE] reflected she was in a persistent vegetative state, she was dependent on staff for all ADLs and her diagnoses included hypertension (high blood pressure); Diabetes; aphasia (disorder that affects the ability to verbally communicate); and stroke. Record review of Resident #1's care plan reflected an entry dated initiated 11/26/24: [Resident #1] is on Ketoconazole External Shampoo 1%. Apply to scalp one time a day every Wed and Fri for rash until 12/02/2024. Intervention: Provide wound care per treatment order give as ordered. Record review of Resident #1's Order Recap Report dated 1/2/25 reflected the following order: 11/25/24: Ketoconazole External Shampoo 1%. Apply to scalp topically one time a day every Wednesday and Friday for rash until 12/2/24. Start date 11/27/24. End date 12/2/24. Record review of Resident #1's Administration Record dated November 2024 reflected and entry for Ketoconazole External Shampoo 1%. Apply to scalp topically one time a day every Wednesday and Friday for rash until 12/2/24. An entry dated 11/27/24 (Wednesday) was coded 13 which indicated, pending arrival from pharmacy. An entry dated 11/29/24 (Friday) was coded 9 which indicated, other/see Nurses Notes. Record review of Resident #1's nursing progress notes reflected: 11/25/24 8:22 PM: [Family member] is concerned about the res hair falling off. She requests the nurse to get an order from the MD . Phone call placed, and a N/O received for Ketoconazole External Shampoo 1 % (Ketoconazole (Topical)) Apply to scalp topically one time a day every Wed, Fri for Rash until 12/02/2024 . Order placed on PCC. [Family member] and res aware. The entry was signed by LVN B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/29/24 12:37 PM: Ketoconazole External Shampoo 1 % Apply to scalp topically one time a day every Wed, Fri for Rash until 12/02/2024 .shampoo not found in patient room or nurse cart. The entry was signed by RN C. An observation on 12/31/24 at 9:46 AM revealed Resident #1 was in bed. Her eyes were open but she made no response to verbal greeting. She appeared clean and well groomed. Her hair appeared clean and groomed . During and observation and interview on 12/31/24 at 12:10 PM, CNA D stated she had assisted with Resident #1's showers and was unaware of any orders for special shampoo to be used during her care. She stated Resident #1's family had wanted them to use the products they provided for her and pointed out a shelf in the resident's closet which had various bottles of shampoo and body wash. CNA D stated she always retrieved items from that shelf when preparing the resident for her showers. During an interview on 12/31/24 at 3:35 PM, the DON stated she was unsure whether the shampoo ordered for Resident #1 had been used. She stated she had been made aware the day before by Resident #1's family that they did not believe it had been used. She stated she checked the medication cart and located a partially used bottle of her Ketoconazole. She stated she had not had an opportunity to follow-up with the CNAs yet because the staff that cared for her that week were not working. The DON stated the nurses were responsible for letting the CNAs know if there was an order for special shampoo. She stated the risk of not using the shampoo would be ongoing condition. She stated she did not observe a rash or other condition when she checked Resident #1. During an interview on 12/31/24 at 4:24 PM, LVN B stated he had called the physician and entered the order for the shampoo when her family member expressed concerns about her scalp. He stated the family member had approached him at a later date and complained the shampoo had not been used. He stated he had checked with the staff the same day and learned the shampoo had been used on at least one occasion during the morning shift. He was unable to recall the date or identify the staff with whom he spoke. LVN B stated the charge nurse should have alerted the CNA of the need for the shampoo and should have signed the administration record or documented in the nurses' notes. He stated the risk for failing to use the shampoo was worsening of the condition. LVN B retrieved the bottle from his medication cart and it appeared to have been opened and used. During an interview on 1/2/25 at 3:46 PM, RN C stated she recalled a CNA asking her about Resident #1's Ketoconazole and that she had been unable to locate it in her medication cart. She stated she thought she asked someone about it and was told it had been ordered but she could not recall anything after that day. She stated the risk of not administering treatments as ordered depended on the condition for which it was ordered. She stated she never noted any rash or other condition on Resident #1's scalp. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Policy titled, Pharmacy Services Overview dated revised April 2007 reflected: The facility shall accurately and safely provide or obtain pharmacy services, including the provision of routine and emergency medications and biologicals, and the services of a licensed Pharmacist. Policy Interpretation and Implementation, .3. The facility shall contract with a licensed Pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to, collaborating with the facility and Medical Director to: a. Develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services (including ordering, delivery and acceptance, storage, distribution, preparation, dispensing, administration, disposal, documentation, and reconciliation of all medications and biologicals in the facility .