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	03/06/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for one of five residents (Resident #1) reviewed for accuracy of assessments. The facility failed to accurately reflect Resident #1's use of high risk medications in his most recent quarterly MDS assessment. The failure placed residents at risk for having inaccurate assessments. Findings included: Record review of Resident #1's face sheet, dated 03/05/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's DX included: Paranoid schizophrenia (Paranoia is a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly. Delusions and hallucinations are the two symptoms that can involve paranoia.), Acute bronchitis (is an inflammation of the bronchial tubes (airways) that leads to a persistent cough. It is typically caused by a viral infection, although it can also be caused by bacteria or other irritants.), Schizoaffective Disorder, Bipolar Type (a rare mental illness that combines symptoms of schizophrenia and bipolar disorder. It's also known as schizoaffective disorder, bipolar type.), Insomnia (is a common sleep disorder that can make it hard to fall asleep or stay asleep.), Generalized anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), Schizophrenia (a chronic mental health condition characterized by significant disruptions in thought processes, perceptions, emotions, and social interactions.), Major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Constipation (difficulty passing stool), Mild cognitive impairment of uncertain etiology (when a person is experiencing symptoms of mild cognitive impairment memory decline cause of decline is unknown.) (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's quarterly MDS assessment, dated 02/20/25, reflected Resident #1 had a BIMS of 10, which indicated he was moderately impaired cognitively. Section D Mood, total severity scores 00, indicating there were no mood concerns. Section E-Behaviors E0200 behaviors symptoms presence and frequency: score of 1 behavior of this type occurred 1 to 3 days (verbal behaviors symptoms directed toward others (threatening others, screaming at others, cursing at others .1 for C. other behavioral symptoms not directed toward others (pacing, verbal/vocal symptoms like screaming disruptive. I Active Diagnosis I330. Hyperlipidemia (high cholesterol) .Section J: Health Conditions did not address acute bronchitis and pain management, pain assessment . N0415. High-Risk Drug Classes: did not document the high-risk medication resident #1 was ordered by the MD. The MDS assessment had not been reviewed and signed, due to it being incomplete and signed by the SW and Dietary manager only at the time of the review and exit. Record review of Resident #1's BIMS assessment, dated 03/06/25, reflected a score of BIMS of 14, indicating he was cognitively intact. Record review of Resident #1's quarterly care plan dated 03/05/25 reflected the following: Resident has behaviors not directed towards others has a Hx of substance abuse will also verbalize he uses drugs and also verbalized he would like a sex change psych involved in care. Resident#1 was resistive to care r/t psychiatric illness, curses staff. refuses therapy. Resident #1 requires 24-hour supervision/assistance. Discharge to the community is not feasible, requires LTC. Resident #1 uses psychotropic medications Olanzapine r/t Schizophrenia (is a chronic mental health condition characterized by disruptions in thought, perception, emotion, and behavior.) common side effects Hyperprolactinemia (is a condition characterized by abnormally high levels of prolactin, a hormone produced by the pituitary gland.), Hypertriglyceridemia (s a condition characterized by elevated levels of triglycerides in the bloodstream.), Personality Disorders (a class of mental health conditions characterized by enduring maladaptive patterns of behavior,), Parkinsonism (a term used to describe a group of disorders that share similar symptoms to Parkinson's disease), Toxic Amblyopia (a condition of vision loss.), Orthostatic Hypotension (a condition where blood pressures drops significantly when a person stans up from a sitting or lying positions), Rhinitis Xerostomia (Allergic rhinitis (hay fever) can indirectly lead to xerostomia (dry mouth) through nasal congestion causing mouth breathing, or as a side effect of antihistamine medications used to treat allergies.),Constipation, Back Pain, Drowsy Dizziness. Resident #1 uses anti-anxiety medications r/t anxiety disorder. Resident #1 has episodes of agitation and can become irritated easily. He forgets to sign out, have to reorient, refusing psych meds. Record review of the physician orders tab of Resident #1's electronic health record reflected the following active medication orders: Olanzapine Oral Tablet 20 MG (Olanzapine)Give 20 mg by mouth at bedtime for schizophrenia, dated 08/8/24. Buspirone HCl Oral Tablet 15 MG (Buspirone HCl) Give 15 mg by mouth three times a day for anxiety .dated 08/08/24. Atorvastatin Calcium Oral tablet 10 mg. Give 10 mg by mouth at bedtime for Hyperlipidemia (high cholesterol a condition where there are elevated levels of cholesterol in the blood.) .dated 08/08/24. Tessalon [NAME] capsule give 1 capsule 100 mg by mouth as needed for cough or sore throat TID (Tessalon [NAME] medication is used to treat coughs caused by the common cold and other breathing problems (such as pneumonia, bronchitis, emphysema, asthma). 08/24/24. Ibuprofen Oral Tablet 600 MG (Ibuprofen) Give 1 tablet by mouth every 6 hours as needed for Pain Give with Food 02/22/25. Bromfed DM (Dextromethorphan) Oral Syrup 2-30-10 MG/5ML: Pseudoephedrine-Bromphen- DM Give 10 ml by mouth.3very 4 hours as needed for cough/ congestion. 12/26/24. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain related to pain unspecified. (R52) 08/24/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's February 2025 MARs reflected the following: Olanzapine 10 mg Resident #1 was administered Olanzapine 10 mg on the following dates: 02/01/25, 02/08/25, 02/14/25, 02/21/25, 02/22/25, 02/23/25. Resident #1 was offered Olanzapine on the following dates, and he refused: 02/02/25, 02/03/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25, 02/09/25, 02/10/25, 02/11/25, 02/12/25, 02/13/25, 02/15/25, 02/16/25, 02/17/25, 02/18/25, 02/19/25, 02/20/25, 02/2425, 02/25/25, 02/26/25, 02/27/25. 02/28/25. Buspirone 15 mg Resident #1 was administered Buspirone 15 mg on the following dates: 02/01/25, 02/08/25, 02/14/25, 02/21/25, 02/22/25, 02/23/25. Resident #1 was offered Buspirone 15 mg on the following dates and he refused: 02/02/25, 02/03/25, 02/04/25, 02/05/25, 02/06/25, 02/07/25, 02/09/25, 02/10/25, 02/11/25, 02/12/25, 02/13/25, 02/15/25, 02/16/25, 02/17/25, 02/18/25, 02/19/25, 02/20/25, 02/2425, 02/25/25, 02/26/25, 02/27/25. 02/28/25. In an interview with the MDS C on 03/06/25 at 3:00 PM, she said the look back date of 2/20/25, and she reviewed 7 days of Resident #1's medical records (hospital discharge orders, skilled nursing notes current physician orders, mood, behaviors, and medication administration) to complete Resident #1's MDS assessment. MDS C said upon completing the assessment, the DON would review for accuracy and sign once competed. MDS C stated that though the resident had a history of mood, behavior, prescribed high risk medication, if Resident #1 was not administered his medication during the 7 days look back, she would not code it in the current MDS. MDS C said the MDS assessment was utilized to develop a plan of care for a resident. She stated care planning was completed by the interdisciplinary team and any missed information could lead to a lack of needed care, monitoring or services for the resident. She stated the MDS was not due until 3/6/25. At the time of exit on 03/06/25 at 4:09 PM Resident #1's MDS had not been updated and completed. In an interview on 03/06/25 at 3:37 p.m., The DON stated MDS staff were expected collaborate with all staff departments to complete specialty areas of care. She expected the MDS coordinator to document high risk medications, current treatments, and care for all resident assessments to be accurately document resident needs for care. The DON stated not doing so could potentially lead to misinformation/understanding of a resident condition, which could affect the care residents received. The DON stated she and the MDS Coordinator were responsible for the accuracy of the MDS assessments, as the MDS Coordinator completed the assessment, and she finalized the assessment. The DON stated the MDS was not due until 03/06/25. In an interview on 03/06/25 at 3:53 p.m., The Administrator stated he expected for assessments to be accurate, as not doing so could lead to the resident receiving a lower level of care. The Administrator stated the MDS Coordinator and DON was responsible for all facility assessments, which included the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of requested facility MDS policy was provided by the ADM and MDS coordinator on 03/06/25. The document was titled RAI Version 3.0 Manual MDS dated [DATE] .the policy reflected .Section N: Medications Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. In addition, two medication sections have been added. The first is an Antipsychotic Medication Review. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication uses, and management has important associations with the quality of life and quality of care of residents receiving these medications. The second is a series of data elements addressing Drug Regimen Review. These data elements document whether a drug regimen review was conducted upon the start of a SNF PPS stay through the end of the SNF PPS stay and whether any clinically significant medication issues identified were. addressed in a timely manner. N0415: High-Risk Drug Classes: Use and Indication N0415. High-Risk Drug Classes: Use and Indication1. Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or recently admitted in less than 7 days 2. Indication noted If Column 1is checked, check if there is an indication noted for all medications in the drug class. N0415: High-Risk Drug Classes: Use and I Planning for Care The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non pharmacological interventions, are determined by assessing the resident's underlying. condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s), since a diagnosis alone may not warrant treatment with medication. Target symptoms and goals for use of these medication should be established for each resident. Progress toward meeting the goals should be evaluated routinely. Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects. Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room).