

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675913	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2024
NAME OF PROVIDER OR SUPPLIER  Pflugerville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  521 S Heatherwilde Blvd Pflugerville, TX 78660	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of five residents reviewed for quality of care, in that:</p> <p>The facility failed to ensure Resident #1's Eliquis (blood thinner) was held two days before a tooth extraction procedure, subsequently causing him to go without the procedure, leaving him in pain, and feeling frustrated and neglected.</p> <p>This failure placed residents at risk of frustration, uncontrolled pain, and a decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility with diagnoses including spastic quadriplegic cerebral palsy (a form of cerebral palsy that affects both arms and legs), epilepsy (seizures), bipolar disorder, major depressive disorder, and muscle wasting and atrophy (wasting away).</p> <p>Review of Resident #1's quarterly MDS assessment, dated 03/01/24, reflected a BIMS of 15, indicating he was cognitively intact. Section L (Oral/Dental Status) reflected he had no issues.</p> <p>Review of Resident #1's quarterly care plan, revised 02/15/24, reflected he had a potential for uncontrolled pain with an intervention of monitoring/recording/reporting to nurse when he complained of pain or requested pain treatment.</p> <p>Review of Resident #1's physician order, dated 12/28/23, reflected Eliquis Oral Tablet - 5 MG - Give 1 tablet by mouth twice a day.</p> <p>Review of Resident #1's dental records, dated 05/17/24, reflected the following:</p> <p>Treatment Notes: Comprehensive review of medical hx completed . Discomfort noted by [Resident #1] . Recommend extracting remaining maxillary detention NV. [Resident #1] is on blood thinner, PCP stated it should be held before any extractions. It further reflected he was put on Clindamycin (antibiotic) 150 mg - 3 times daily for 5 days for chronic abscess.</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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress notes, dated 05/17/24 and documented by LVN A, reflected the following:</p> <p>[Resident #1] requested to be seen by dentist. [Resident #1] was notified that he is on anticoagulant and a tooth extraction will not be completed if needed after assessment. Another appointment can be scheduled for 5/28/24 and [Resident #1]'s anticoagulant medication (Eliquis) will be on hold 2 days or more prior to the extraction per NP recommendation .</p> <p>Review of Resident #1's dental records, dated 05/28/24, reflected the following:</p> <p>.Extraction was recommended by previous dental provider. [Resident #1]'s Eliquis was not held prior to today's visit . The PCP was contacted by the ADON to obtain approval to proceed with extraction. However, the PCP did not approve for the extraction procedure to proceed without Eliquis being held . It is recommended for Eliquis to be held 48 hours prior to extraction procedure.</p> <p>Review of Resident #1's progress notes, dated 05/28/24 and documented by the DON, reflected the following:</p> <p>[Resident #1] was scheduled for dental procedure today and extraction was unable to be performed due to [Resident #1]'s Eliquis that was not held .</p> <p>Review of Resident #1's physician order, dated 05/28/24, reflected Eliquis needed to be stopped two days prior to dental extraction and two days after dental extraction.</p> <p>During an observation and interview on 05/29/24 at 10:14 AM revealed Resident #1 in his room watching television. He stated he was supposed to have been taken off his blood thinner to receive dental work due to the pain in his tooth. He stated he told the SW a few weeks ago he wanted to be seen by the dentist because of his tooth pain. He stated he saw the dentist and he was told he had an infection in his tooth and they would return to remove the tooth and he was put on antibiotics. He stated the facility knew the dentist would be back the day prior (05/28/24). He stated when he spoke to the DON yesterday and told her he was unable to have his tooth removed due to his Eliquis not being held, she replied, Oh well. He stated he told the DON, You do not understand the amount of pain I am in! He stated he was able to eat but could only chew on one side of this mouth. He stated his regular pain medications managed his everyday pain but he felt like the pain in his tooth was now radiating. He stated he was extremely frustrated with the facility and felt it was a disservice and he was being neglected.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 05/29/24 at 10:34 AM, Resident #1's NP stated it was brought to her attention (she could not remember who brought it to her attention) that Resident #1 would be needing a tooth extraction. She stated the nurse who informed her was not sure of the exact date and she told the nurse to let her know because his Eliquis would need to be held two days prior and two days after the extraction. She stated she never heard anything after that. She stated she felt like it was a break-down in communication because it could have gone in as a general order without any specific dates. She stated, to her, she would have thought, Hey, that was important - I need to get that in immediately! She stated she 100% thought the ball was dropped and would speak to the DON to ensure something like that did not happen again. She stated no resident should have to live with tooth pain as it could be unbearable. She stated she was glad the facility staff caught the fact that his Eliquis had not been held prior to yesterday (05/28/24) because it could have been bad if Resident #1 had the procedure without it being held because he was on such a high dose.</p> <p>During a telephone interview on 05/29/24 at 11:13 AM, the DSA with the dental company utilized by the facility stated Resident #1 was seen on 05/17/24. She stated he was not initially scheduled to be seen but was added by the facility SW that same day. The dentist that saw him recommended extractions for the next visit and the facility's PCP stated his blood thinner would need to be held prior to the extractions. She stated she reached out to the facility a month prior to the visits and sends out a preliminary list. She stated she sends out a final list of residents that will be seen by the dentist about a week prior to the appointment. She stated she called the SW at the facility on 04/02/24 and confirmed via mail regarding the visit on 05/28/24. She stated the final list of residents to be seen on 05/28/24 was sent out on 05/21/28 and Resident #1 was included in the list.</p> <p>During a telephone interview on 05/29/24 at 11:21 AM, the SW stated sometime back in May (2024) Resident #1 was in her office filing a grievance (unrelated to tooth pain) when another resident came in and asked about dental services and Resident #1 requested to be seen as well at that time. She stated when any resident had an upcoming appointment, she put it in as an announcement in their EMR system. She stated that was where nurses would see that there was an upcoming appointment and would ensure the resident was ready for it. She stated that after residents are seen by the dentist, she forwarded the progress notes to the DON. She stated she could not recall when the dental company gave her the final list for the visit on 05/28/24 but knew it would have been well over 48 hours in advance. She stated she heard Resident #1 was not able to get his tooth extracted on 05/28/24. She stated she used to work in dentistry and knew that dental pain could be extremely uncomfortable. She stated she knew the DON offered for Resident #1 to go to the ER because he told her how much pain he was in, but that he had declined.</p> <p>During an interview on 05/29/24 at 11:37 AM, RN C stated she had worked the previous day (05/28/24) with Resident #1. She stated that whoever made the appointments would tell the nurses verbally or would give them paperwork and the nurse would schedule transportation if needed. She stated if it was an in-house appointment such as podiatry or dental, the SW would notify the nurse in the morning meeting. She stated if there was a medication that needed to be held prior to a visit, then the NP was notified. She stated she was not aware of a planned extraction for Resident #1 and she had not received any information about the dentist appointment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/29/24 at 12:24 PM, the DON stated any nurse could enter orders if they came from the NP. She stated nurses are notified of upcoming appointments on their EMR system. She stated Resident #1 went to the SW earlier in May (2024) about something unrelated to dental services. She stated another resident inquired about the dentist and Resident #1 requested to be on the list. She stated he did not say why and did not mention any pain. She stated on 05/17/24 they did an exam and put him on antibiotics. She stated the dentist would be returning on 05/28/24. She stated there was a recommendation from the dentist to hold his Eliquis, but that was not an order, just a recommendation. She stated the NP was notified and she wrote the order, but it somehow never got put into the system. She stated it was a standing recommendation that never became an order. She stated Resident #1 was unable to get his tooth extracted the day prior (05/28/24) because the NP did not want him to unless his blood thinner had been held since he was on such a high dose and took it twice a day. She stated he was not in pain and did offer for him to go to the ER but he declined. She stated she was not sure if the ER provided services such as teeth extractions. She reiterated that holding the Eliquis was just a recommendation and it was left for the judgement of the physician.</p> <p>Review of the facility's Appointments Policy, dated 2023, reflected the following:</p> <p>.</p> <p>3. Prior to the appointment staff will assist the resident as needed to prepare for the appointment.</p> <p>Review of the facility's Dental Services Policy, dated 2023, reflected the following:</p> <p>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.</p> <p>1. Oral health services are available to meet the resident's needs.</p>		