STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455862	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Austin	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)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on record review and interview, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one (Resident #1) of three residents reviewed for transfer and discharge rights, in that: The facility failed to provide documentation that Resident #1 received sufficient preparation and orientation when she was discharged home, to ensure a safe discharge. This failure could place residents at risk of not receiving care and services to meet their needs upon discharge. Findings Included: Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a neurological disorder that occurs when a chemical imbalance in the blood affects the brain), sequelae of cerebral infarction (symptoms after a stroke), chronic pulmonary embolism (a long-term condition where one or more blood clots form in the pulmonary arteries, reducing blood flow and increasing pressure in the lungs), congestive heart failure, type 2 diabetes, overactive bladder, and age-related physical debility (the quality or state of being weak, feeble, or infirm). Review of Resident #1's admission MDS assessment, dated 07/12/24, reflected a BIMS score of 9 indicating moderate cognitive impairment, and section GG reflected toileting hygiene maximum/substantial assist . Review of Resident #1's care plan, dated 08/14/24, reflected no discharge planning . Review of the NP progress note dated 09/10/24 reflected Resident #1 was planning to discharge home on this date under the care of home health. Per the patient she will be living at her FM's place. Review of order dated 09/10/24 by the NP reflected, the resident to be discharged home today with her personal belongings and medication with instructions. Resident was inform to f/u with her PCP a week after discharge from [facility name]. [name of home health provider] to provide assistance upon discharge. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of discharge home instructions dated 09/10/24 reflected Resident #` was to discharge home, had no special skin issues, a regular diet, and would need the following assistance: 1. walking 2-person assistance 2. transfer 2-person assistance 3. stairs 2-person assist 4. wheelchair 1-person assist Interview on 09/27/24 at 1:19 pm with the Home Health Representative revealed that the facility contacted them, and they were scheduled to go to Resident #1's home and provided skilled nursing, physical therapy and occupational therapy. The Home Health Representative said they spoke with the resident family member and confirmed the initial visit would be on 09/11/24. The Home Health Representative revealed they had a signed order from a MD for physical therapy, occupational therapy, and nursing care. Interview on 09/27/24 at 11:30 am with the Administrator revealed home health was to provide Resident #1 assistance when she discharged from the facility and her FM was living with Resident #1. When the Administrator told Resident #1's FM they were driving his mother home the FM said that the door was opened and to take her into the house and he would be there later. A facility staff member drove Resident #1 to her home and the FM was not there when the resident was left at the house. No specific time for when the FM would be at the home was given, after she was dropped off. The driver wheeled Resident #1 into the house, asked her if she wanted assistance to get into a chair, Resident #1 told her to leave, and the staff member left . Interview on 09/27/24 at 3:14 pm revealed the DON informed the FM of the discharge plans for Resident #1 because he said he would not pay, set up a payment arrangement, or discuss Medicare payment. She revealed she asked him daily if he had home health set up and she wanted to make sure she had a safe discharge. Interview on 09/27/24 at 4:28 pm with the SW revealed he was responsible for discharge planning, and he was aware that the facility discharge planning policy required a safe discharge. When he was shown the facility discharge policy, he said he had not seen the discharge policy and there was no documentation that he followed the discharge policy because he had no documentation to reflect that items listed in the facility discharge policy were followed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/27/24 at 4:14 pm with the Administrator revealed that the facility needed to do a better job of documenting and they had no documentation, nothing that showed the facility communicated with either the resident or the family that she was going home, that home health was scheduled, and on 09/13/24 that she would be going to rehabilitation facility. He revealed they were in communication with the family and felt that because he spoke to the resident's FM on the phone and the FM told him the house was unlocked and to take Resident #1 into the home. The Administrator revealed the FM was difficult to reach and did not return many calls. He revealed the facility failed to document the facility policy that would show the policy was followed. He revealed if there was no documentation that followed facility policy it put residents of delayed care or maybe an unsafe discharge. He said the Social Worker, ADM , clinical leadership and the Administrator were responsible for resident facility discharges. Review of facility preparing a resident for transfer or discharge date 2016 reflected residents will be prepared in advance for discharge. When a resident is scheduled for a transfer or discharge the business office will notify nursing service of the transfer or discharge so that appropriate procedures can be implemented. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four hours before the resident's discharge or transfer from the facility. Nursing services is responsible for obtaining orders for discharge or transfer was well as recommended discharge services and equipment. Preparing the post discharge summary and post-discharge plan. Preparing the medications to be discharged with the resident as permitted by law. Providing the resident or representative with required documents (example discharge summary and plan). Forwarding charge slips to the business office, directing the resident or representative to the business office prior to the transfer or discharge and forward completed records to the business office. Informing the resident or his or her representative of the facility's readmission appeal rights, bed-holding policies, etcetera and others as appropriate or as necessary.