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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>455862 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                            | (X3) DATE SURVEY COMPLETED<br><br>11/08/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Coral Rehabilitation and Nursing of Austin |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6909 Burnet LN<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49097</p> <p>Based on interview and record review, the facility failed to ensure a notice before discharge was provided to 1 (Resident #1) of 3 residents reviewed for transfer/discharge, in that:</p> <p>Resident #1 and/or their representative were not provided a written notice of discharge prior to being discharged out of the facility.</p> <p>The Ombudsman was not provided a copy of the notice.</p> <p>This failure had the potential to affect the resident by not having the knowledge of why the resident was discharged, emotional distress, decline in quality of life, disregarding the residents rights, how to appeal the discharge, and the right to appeal the discharge.</p> <p>Findings include:</p> <p>Record Review of Resident #1's Face sheet dated 11/07/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnosis included respiratory failure, type 2 diabetes mellitus without complications (high blood sugar), muscle weakness, lack of coordination, hypertension (high blood pressure), pulmonary hypertension (high blood pressure that affects the lungs), other stimulant abuse.</p> <p>Record Review of Resident #1's admission MDS dated [DATE] revealed Resident #1 had a BIMS of 15 indicating the resident was intact cognitively.</p> <p>Record Review of Resident #1's care plan dated 10/31/2024 revealed focus was for functional discharge goals: Resident's rehabilitation plan will incorporate the Resident's personal discharge goals. Pick up objects, set up or clean up assistance, walking 10 feet, independent walking.</p> <p>Record Review of progress notes dated 10/29/2024 at 5:56pm revealed resident left facility with no oxygen and refused to sign AMA. Resident stated he was going to bring his property he left somewhere.</p> <p>Record Review of Resident #1's progress notes dated 10/31/2024 at 1:04pm revealed resident not in building at this time. Noted that resident signed out in sign book at 0845 this am.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Record Review of Resident #1's progress notes dated 11/01/2024 at 07:31am revealed Resident remains out on pass at this time. The Administrator notified.</p> <p>Record Review of Resident #1's progress notes dated 11/03/2024 at 3:43pm revealed the resident left the facility on [DATE] AMA. Was discharged from the facility. Nurse told resident since he left since 10/31/2024 he no longer lives here. Resident asked for his belongings that he left here. Housekeeping staff brought the resident his belongings. He is still sitting in the front lobby at this time.</p> <p>Record Review of Resident #1's Transfer/Discharge Report dated 11/07/2024 revealed that the resident was discharged on [DATE] at 7:30pm. Discharge reason was AMA.</p> <p>An interview with the SW on 11/07/2024 at 11:42am revealed he was responsible for safely discharging the resident. He stated they cannot discharge a resident without a notice. He stated Resident #1 would leave without medical clearance. He stated someone must have told Resident #1 he could sign out on the sign out book. He also said the resident was not medically cleared to go on pass because he was on oxygen. He stated because the resident did not sign an AMA and Resident #1 signed out, he should have been allowed to return. He stated he has not seen in the facility policy that stated the resident had to be back at a certain time, or how long the resident could be gone. He said he tried to get the resident to sign a blank AMA on 10/29/2024 because he wanted to leave to get his belongings and did not want to be assessed. He stated he did not fill out the AMA or have a witnesses sign an AMA showing the resident refused.</p> <p>An interview with the RN on 11/07/2024 at 12:37pm revealed the receptionist came and told her Resident #1 was back and wanted his medications. She said she told him he was discharged , and he does not live at the facility anymore. She said Resident #1 became upset and started cussing and yelling saying he lived there. She said he asked for his discharge papers, and she did not have them. She said Resident #1 said he was not going to leave without his discharge papers. She said housekeeping gave Resident #1 his belongings. She stated the facility normally does not discharge a resident when they sign out. She said she was told he left AMA.</p> <p>An interview with the CNO on 11/07/2024 at 1:04pm revealed staff were to fill out the AMA and write resident refused to sign and have witnesses. She said staff should not try to have a resident sign a blank AMA. She stated normally the facility would call the resident and depending on the conversation if the resident said they were not coming back, then they would be discharged , and it would be documented. She stated Resident #1 was not given a notice for discharge.</p> <p>An interview with the ADM on 11/07/2024 at 2:16pm revealed Resident #1 was not acting like he wanted to be a patient and got the SW to get him to sign an AMA. He also said it was not normal for the facility to get a resident to sign an AMA. He stated they could not prevent someone from signing out who was noncompliant. He stated that when a resident refused to sign an AMA the facility would fill it out and put on the AMA that the resident refused to sign and have witnesses sign.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>An interview with the NP on 11/07/2024 at 2:49pm revealed the facility informed him the resident wanted to go out on pass. Said he assessed the resident since he was in the building but still needed to be assessed by the nursing staff. He said he was informed the resident left the facility, but they did not tell him that Resident #1 came back on 10/29/2024. He said they called him on 11/01/2024 and said Resident #1 was AMA. He said they did not tell him Resident #1 signed out. He said when he assessed Resident #1, he did not say anything about wanting to leave. He said after he assessed Resident #1 the nurse was messaging him stating Resident #1 wanted to go out on pass. He said he did not approve because Resident #1 had not been assessed by the nursing staff and he was on oxygen. He stated Resident #1 was not dependent on oxygen and was not in any immediate danger without the oxygen or his medications.</p> <p>Record Review of Discharge Guidelines dated 2024 revealed The facility must permit each resident to remain in the facility, and not discharge the resident from the facility unless discharge is necessary. Notify the resident of the discharge and the reason for the move in writing and in a language and manner they understand. Record the reason for the discharge in the resident's medical record.</p> |   |  |