

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Coral Rehabilitation and Nursing of Austin		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for 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.</p> <p>The facility failed to assess complete a skin assess when Resident #1 acquired a skin tear on 11/19/24. Four treatments were missed and he developed an infection requiring antibiotics.</p> <p>These failures placed residents at risk of improper wound management, the development of new skin integrity issues, deterioration in existing skin integrity, infection, and pain.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a 47-year-ole male who was admitted to the facility on [DATE] with diagnoses including cerebral infraction (stroke), type II diabetes, unsteadiness on feet, and muscle wasting and atrophy (wasting away).</p> <p>Review of Resident #1's quarterly MDS assessment, dated 10/28/24, reflected a BIMS score of 10, indicating a moderate cognitive impairment. Section M (Skin Conditions) reflected he was not at risk of developing pressure ulcers/injuries.</p> <p>Review of Resident #1's quarterly care plan, revised 10/28/24, reflected he had diabetes with an intervention of checking all of body for breaks in skin and treat promptly as ordered by doctor.</p> <p>Review of Resident #1's most recent Skin Observation Assessment, dated 11/24/24, reflected redness to his groin.</p> <p>Review of Resident #1's progress note, dated 11/19/24 and documented by LVN A, reflected the following:</p> <p>[Resident #1] noted with an open area/skin tear to LLE shin measuring 3.0 cm x 2.4 cm x 0.1 cm. ST bedding is red, no drainage noted, no skin flap . LLE noted with nonpitting edema +2. Denies pain/disc. Wound care of cleansing area with NS, then xeroform with island drsg cover, done at this time.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's physician order, dated 11/20/24, reflected skin tear to LLE. Cleans with NS, pat dry. Apply xeroform and cover with island dressing. Change 3x/week, M, W, F and PRN until healed.</p> <p>Review of Resident #1's November 2024 TAR, on 12/05/24, reflected two out of five treatments were missed, on 11/22/24 and 11/29/24.</p> <p>Review of Resident #1's physician order, dated 12/03/24, reflected left lower extremity: cleanse with wound cleaner or normal saline, pat dry, apply collogen, then apply xeroform, then nonadherent pad or (wound dressing), then wrap with kerlex daily and PRN.</p> <p>Review of Resident #1's December 2024 TAR, on 12/05/24, reflected two out of for treatments were missed, on 12/02/24 (previous order) and 12/04/24.</p> <p>Review of Resident #1's progress note, dated 12/05/24 and documented by the TN, reflected the following:</p> <p>[Resident #1] wound culture collected from left lower extremity [Resident #1] tolerated well [Resident #1] continue abt oral antibiotic and daily dressing change as ordered, no adverse reaction noted.</p> <p>Review of Resident #1's physician order, dated 12/05/24, reflected Keflex oral capsule - 250 MG - give 3 capsules by mouth two times a day for wound infection to make it 750 mg two times a day for 7 days.</p> <p>Review of Resident #1's physician order, dated 12/05/24, reflected wound culture to be picked up from labs for left lower leg infection.</p> <p>During an interview on 12/05/24 at 11:54 AM, NP B stated he was not Resident #1's NP, but if a resident had a skin tear, then definitely, of course there should be a skin assessment completed. He stated skin assessments were important to show if wounds were improving or not improving. He stated missed treatments could very likely cause infections.</p> <p>During an interview on 12/05/24 at 1:51 PM, LVN A stated she did not normally work on Resident 1's hall but did on 11/18/24 when she assessed his skin tear in his progress notes. She stated it appeared it had been there for awhile because it was dryish and not moist. She stated she put in standard wound care orders. She stated skin assessments should be done weekly. She stated a negative outcome of missed treatments could be infection or a delay in healing.</p> <p>During an observation and interview on 12/05/24 at 1:59 PM, Resident #1 was in his room. The bandage on his left leg appeared clean and intact. He stated they had cleaned and rebandaged his wound that morning. He stated when he first got the skin tear, they missed a lot of treatments but seemed to be doing better not. He stated he was not sure how he acquired the skin tear, but it did not really hurt but it did itch a lot.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/05/24 at 2:06 PM, LVN D stated she completed wound care on Resident #1 that morning. She stated when she arrived that morning (12/05/24), the night nurse asked her to get a wound culture because of the way his wound looked and because his leg was swollen. She stated when the TN was not working, the nurses were to provide wound care. She stated she believed the NP should have been notified of the wound sooner so antibiotics could have been started sooner. She stated she treated the wound that day per the NP's orders but did not document a weekly skin assessment.</p> <p>During an interview on 12/05/24 at 2:58 PM, the CNO stated skin assessments should be completed every seven days to ensure any skin integrity issues were being identified. She stated it was the nurse's responsibility to ensure these were being completed. She stated nurses were responsible for wound care when the TN was out.</p> <p>During a telephone interview on 12/06/24 at 9:52 AM, NP C stated she was Resident #1's NP. She stated the day before, 12/05/24, was her first day back after vacation and it was her first-time hearing about Resident #1's wound. She stated when she saw it, she noticed it was blistered and so she started him on antibiotics because it looked infected. She stated she asked the nurse to ensure the WCD saw him the next day on his rounds, 12/06/24. She stated the WCD had not assessed his wound yet. She stated her expectations were that wound care treatments were not missed because wounds needed to be cleaned or it could cause them to worsen.</p> <p>Review of the facility's Skin Assessments Policy, dated July 2021, reflected the following:</p> <p>Skin assessment is important in pressure injury (PI) prevention, classification, diagnosis and treatment.</p> <p>When to conduct skin assessment: As soon as possibly on admission (within 2 hours) and every 7 days thereafter.</p> <p>Review of the facility's Wound Care Policy, Revised October 2010, reflected the following:</p> <p>The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</b></p> <p>Based on interview and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (Resident #2) of five residents reviewed for nutrition.</p> <p>The facility failed to ensure Resident #2 maintained acceptable parameters of nutritional status as demonstrated by Resident #2 experiencing a 25.38% weight loss in six months. He had an active decline in his weight from 05/01/24 - 11/01/24.</p> <p>This failure could place residents at risk for decreased nutritional status, decline in health, malnutrition, or hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #2's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including diabetes, reduced mobility, muscle weakness, and feeding difficulties.</p> <p>Review of Resident #2's quarterly MDS assessment, dated 10/18/24, reflected a BIMS score of 12, indicating a moderate cognitive impairment. Section GG (Functional Abilities) reflected he required substantial/maximal assistance with eating. Section K (Swallowing/Nutritional Status) reflected he did not have a swallowing disorder and had not had any weight loss.</p> <p>Review of Resident #2's quarterly care plan, revised 12/01/24, reflected he had an ADL self-care performance deficit with an intervention of being independent with eating meals. It further reflected he had diabetes mellitus with an intervention of consulting dietary for nutritional regimen and ongoing monitoring. There was nothing in his care plan about the potential or preference to lose weight.</p> <p>Review of Resident #2's weights in his EMR, on 12/05/24, reflected an active decline in his weight from 05/01/24 - 11/01/24. His weight on 05/01/24 reflected 226.5 pounds and a weight of 169.0 pounds on 11/01/24.</p> <p>Review of Resident #2's Nutrition Assessment, dated 07/24/24 and documented by the RD, reflected the following:</p> <p>[Resident #2] with overall good appetite and PO intake. No complaints or concerns today - continue regular diet. The assessment also reflected that his current weight was 227.0 pounds, when his weight in his EMR on that day reflected 199.0 pounds.</p> <p>Review of Resident #2's Nutrition Assessment, dated 10/28/24 and documented by the RD, reflected the following:</p> <p>[Resident #2] with good appetite and PO intake at 50-100% average. [Resident #2] with weight loss; From 10/01/24 to 10/18/24, [Resident #2] showed a weight loss of 5 pounds . Continue regular diet/current plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's physician orders, dated 10/27/24, reflected a sugar-free diabetic supplement - two times a day for weight loss. There were no supplemental interventions before the date of this order.</p> <p>During an interview on 12/05/24 at 11:54 AM, NP B reviewed Resident #2's weights and stated he had a significant weight loss and it was completely unacceptable that interventions were not put in place sooner. He stated when there was significant weight loss, they needed to find out what was going on, and what was happening with the residents' health. He stated having such a drastic change in weight could cause a major decline in their health.</p> <p>During a telephone interview on 12/05/24 at 1:28 PM, the RD stated she used to go to the facility on ce a week until she moved at the beginning of September (2024). She stated now she just worked remotely for the facility. She stated she was notified of resident's she needed to review by the DM who would send her information on new admissions or for residents who had lost weight. She stated she did not run her own report, would just go off what she was told by the DM. She stated in October (2024), she did not see Resident #2's weight loss from the previous months, just the weight loss in October. She stated if the supplements were not working, she should have been notified. She stated there were a lot of potential outcomes for unplanned weight loss such as not getting nutritional needs, muscle weakness, cause wounds not to heal, and general sickness.</p> <p>During an interview on 12/05/24 at 2:43 PM, the DM stated there was a staff member that took residents' weights and gave her the report and she would send it to the RD monthly. She stated Resident #2 had deteriorated in the past year, he started eating in his room more, and maybe he was not getting help being fed. She stated in October (2024), the RD gave orders for a supplement which she remembered supplying for Resident #2.</p> <p>During an interview on 12/05/24 at 2:58 PM, the CNO stated it was the responsibility for dietary, nursing staff, and the NP to collaborate regarding interventions for weight loss. She stated there could be a lot of negative outcomes when it came to unplanned weight loss such as nutritional deficit and skin issues.</p> <p>During a telephone interview on 12/06/24 at 9:52 AM, Resident #2's NP C reviewed and acknowledged his weight loss and stated she was not aware nor was she informed he was losing that much weight. She stated her expectations were that interventions would have been started sooner and she should have been notified so she could have assisted in orders for supplements or additional testing.</p> <p>Review of the facility's Nutrition (Impaired)/Unplanned Weight Loss Policy, Revised September 2017, reflected the following:</p> <p>Assessment and Recognition:</p> <ol style="list-style-type: none"> <li>The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time.</li> <li>.</li> <li>.</li> <li>The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Treatment/Management:</p> <p>2. The physician will authorize appropriate interventions, as indicated.</p> <p>Monitoring:</p> <p>1. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions.</p>