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	01/03/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observation, interview and record review, the facility failed to treat residents with respect and dignity for 1 of 7 (Resident #2) residents reviewed for dignity in that: The facility failed to ensure staff closed Resident #2's door and pull the privacy curtain closed while changing the resident. This failure could affect residents and place them at risk for psychosocial harm due to a diminished quality of life. The findings were: Record review of Resident #2's Face sheet, dated 01/03/2025, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: heart failure, diabetes, high cholesterol, epilepsy (seizure disorder), dementia (memory, thinking, difficulty), arthritis, morbid obesity, major depressive disorder, insomnia (difficulty sleeping), reflux, muscle weakness, paranoid schizophrenia (mental disorder), cognitive communication deficit (problems with communication), lack of coordination, and reduced mobility. Record review of Resident #2's admission MDS dated [DATE] revealed Resident #2 had a BIMS score of 14 indicating Resident #2 was cognitively intact. The MDS also revealed that the resident was substantial/maximal assist on staff for toileting hygiene and showers. Record review of Resident #2's care plan dated 01.03.2025 revealed that Resident #2 had an ADL self-care performance deficit. Observation on 01/03/2025 at 9:23am revealed CNA B was changing Resident #2 with the door open . The privacy curtain was not pulled closed, exposing the resident. During an interview with CNA B on 01/03/2025 at 12:18pm revealed she had been trained on resident rights. She said staff were to provide the resident privacy when providing care for the resident such as changing the resident and showering the resident. She said CNA's were responsible for providing privacy to the resident. She said that by not providing privacy to the resident when giving care the resident may feel bad or embarrassed. She said that she closed the door and pulled the curtain when changing Resident #2. (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

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 01/03/2025
NAME OF PROVIDER OR SUPPLIER: Coral Rehabilitation and Nursing of Austin		STREET ADDRESS, CITY, STATE, ZIP CODE: 6909 Burnet LN Austin, TX 78757	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 01/03/2025 at 3:51pm revealed that her and staff had been trained on resident rights. She said that when staff are doing brief changes, they should be closing the door and pulling the curtain. She said all staff who provide care are responsible for providing privacy to the resident. She said by not providing privacy during care could impact the residents dignity. She said that CNA B said she closed the door but did not ensure that it stayed closed before walking away from it. During an interview with the ADM on 01/03/2025 at 4:11pm revealed that staff and himself had been trained on resident rights. He said he would expect staff to follow the policy when providing care to residents. He said all staff were responsible for providing privacy to the resident when giving a shower, taken to the restroom and when dressing the resident. He said if staff did not provide the resident privacy during care the resident could get upset. He said that CNA B thought she closed the door, and it did not catch. Record review of Quality of Life-Dignity Policy dated August 2009 revealed staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Demeaning practices and standards of care that compromise dignity is prohibited.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #1) of 7 residents reviewed for ADL's. The facility failed to ensure Resident #1 had clean sheets on her bed. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: Record review of Resident #1's Faces sheet, dated 01/02/2025, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: respiratory failure, muscle weakness, abnormal posture, lack of coordination, dysphagia (difficulty swallowing), post-polio syndrome (muscle weakness from polio), heart block, anxiety, high cholesterol, high blood pressure, insomnia (difficulty sleeping) and infarction of spinal cord (stoke in the spinal cord). Record review of Resident #1's admission MDS dated [DATE] revealed Resident #1 had a BIMS score of 15 indicating Resident #1 was cognitively intact. The MDS also revealed that the resident was dependent on staff for bed mobility. Record review of Resident #1's care plan dated 09/30/2024 revealed resident had an ADL self-care performance deficit related to disease process, limited mobility, and limited ROM. Observation on 01/02/2025 at 1:31pm revealed Resident #1 was lying in bed. She was observed with a fitted sheet and a top sheet with a brown substance on it. During an interview with Resident #1 at 1:31pm revealed that she had spilled coffee on her sheets in the morning. She said the staff knew she had spilled her coffee. She said staff were waiting for her to get up to strip the bed. During an interview with CNA A on 01/03/2025 at 12:05pm revealed that CNA's were responsible for changing a resident's bed. she said that staff were to change the bed on shower day, and when soiled. She said that when the resident's bed was soiled staff were supposed to change it immediately. She said by not changing a soiled bed could result in the resident having skin breakdown. She said she saw the sheets with coffee on them when she went to change the resident. She said the resident was not ready to get up, so she did not change the resident's sheet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 01/03/2025 at 3:40pm revealed that residents bedding should be changed on shower day and when soiled. She said the CNA's were responsible for changing the residents beds. She said that the CNA should have changed the bed when she saw that the resident spilled coffee on the sheets. She said that the resident could have gotten skin breakdown and not felt good due to the coffee being on her bed. She said she did not know why the CNA did not change the sheets, but she was starting an in-service for it. During an interview with the ADM on 01/03/2025 at 4:03pm revealed that should be changed as needed and he thought on shower day. He said that the CNA's were responsible for changing the resident's bedding. He said a resident would not like laying on a wet bed and may get a skin irritation. He stated that he did not know why the resident's bed was not changed that he would expect the nurse to handle it. Record review of Activities of Daily Living (ADL) Supporting Policy revised in March 1018 revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 4 of 4 residents (Resident #3, Resident #4, Resident #5, and Resident #6) reviewed for baseline care plan. The facility failed to initiate a baseline care plan within 48 hours of the admitted for Resident #3, Resident #4, Resident #5, and Resident #6. This failure could affect newly admitted residents and place them at risk of not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs were met. Findings included: Record review of Resident #3's Face sheet, dated 01/02/2025, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: respiratory failure, end stage renal disease (last stage of kidney failure), diabetes, high blood pressure, protein calorie malnutrition and tracheostomy status (surgical opening in the neck to help air and oxygen reach the lungs). Record review of Resident #3's admission MDS dated [DATE] revealed Resident #3 had a BIMS score of 14 indicating Resident #3 was cognitively intact. Record review of Resident #3's chart revealed he did not have a baseline care plan completed. Record review of Resident #4's Faces sheet, dated 01/02/2025, revealed the resident was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: cognitive communication deficit (problems with communication), pressure ulcer right buttock (sore on butt), pressure ulcer left buttock (sore on butt), urinary tract infection. Record review of Resident #4's admission MDS dated [DATE] revealed Resident #4 did not have the BIMS portion filled out. Staff stated he was cognitively intact. Record review of Resident #4's chart revealed he did not have a baseline care plan completed. Record review of Resident #5's Faces sheet, dated 01/02/2025, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: pain in left knee, muscle weakness, lack of coordination, cognitive communication deficit (problems with communication) and swelling in the kidneys. Record review of Resident #5's admission MDS dated [DATE] revealed Resident #5 did not have a BIMS score. Staff stated he was cognitively intact. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's chart revealed he did not have a baseline care plan completed. Record review of Resident #6's Faces sheet, dated 01/02/2025, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: obesity, arthritis, muscle weakness, unsteadiness on feet, cognitive communication deficit (problems with communication), speech and language deficits, high blood pressure, anxiety, and high cholesterol. Record review of Resident #6's admission MDS dated [DATE] revealed Resident #6 had a BIMS score of 15 indicating Resident #6 was cognitively intact. Record review of Resident #6's chart revealed he did not have a baseline care plan completed. During an interview with the SW on 01/03/2025 at 3:32pm revealed that he had only been working at the facility for three weeks. He stated the facility was behind on fifty-three care plans. He said he had been trained on care plans. He also said that the facility had 7 days to complete a care plan and 48 hours to complete a baseline care plan. He said that if a resident does not have a care plan staff were supposed to get information from the nurse on how to care for the resident. He also said if a resident did not have a care plan staff could be confused on how to properly care for the resident. He said the facility was behind because they did not have a social worker for a while, and he had been working to get them caught up. During an interview with the DON on 01/03/2025 at 3:46pm revealed that she had only been working at the facility for a month. She said the social worker was responsible for ensuring the care plans were done. She said that the facility had 7 days to complete the care plan and 48 hours to complete the baseline care plan. She said staff would get report from the hospital discharge and that the nurse would pass the information down to the aides. She said that if a resident does not have a care plan staff may not share care information and the resident may not get the proper care. She said she did not know why the residents did not have a care plan . She said she came into a back log. During an interview with the ADM on 01/03/2025 at 4:07pm revealed that he was trained on how to do care plans. He said that the interdisciplinary team was responsible for ensuring the care plans were done. He said the facility had 48 hours to complete a baseline care plan and 7 days for the comprehensive care plan. He said if a resident did not have a care plan staff could go into the discharge from the hospital and educate staff. He said by not having a care plan it could cause miscommunication with staff on how to care for the resident. He said the facility is behind on care plans because of the change in management. Record review of Care Plan- Baseline revised in December 2016 revealed a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 3 residents (Resident #3, Resident #5, and Resident #6) reviewed for care plans. The facility failed to develop a person-centered care plan for Resident #3, Resident #5, and Resident #6. This deficient practice could affect residents and place them at risk for not having their needs and preferences met. Findings included: Record review of Resident #3's Faces sheet, dated 01/02/2025, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: respiratory failure, end stage renal disease (last stage of kidney failure), diabetes, high blood pressure, protein calorie malnutrition and tracheostomy status (surgical opening in the neck to help air and oxygen reach the lungs). Record review of Resident #3's admission MDS dated [DATE] revealed Resident #3 had a BIMS score of 14 indicating Resident #3 was cognitively intact. Record review of Resident #3's chart revealed he did not have a care plan completed. Record review of Resident #5's Faces sheet, dated 01/02/2025, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: pain in left knee, muscle weakness, lack of coordination, cognitive communication deficit (problems with communication) and swelling in the kidneys. Record review of Resident #5's admission MDS dated [DATE] revealed Resident #5 did not have a BIMS score. Staff stated he was cognitively intact. Record review of Resident #5's chart revealed he did not have a care plan completed. Record review of Resident #6's Faces sheet, dated 01/02/2025, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included: obesity, arthritis, muscle weakness, unsteadiness on feet, cognitive communication deficit (problems with communication), speech and language deficits, high blood pressure, anxiety, and high cholesterol. Record review of Resident #6's admission MDS dated [DATE] revealed Resident #6 had a BIMS score of 15 indicating Resident #6 was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's chart revealed he did not have a care plan completed. During an interview with the SW on 01/03/2025 at 3:32pm revealed that he had only been working at the facility for three weeks. He stated the facility was behind on fifty-three care plans. He said he had been trained on care plans. He also said that the facility had 7 days to complete a care plan and 48 hours to complete a baseline care plan. He said that if a resident does not have a care plan staff were supposed to get information from the nurse on how to care for the resident. He also said if a resident did not have a care plan staff could be confused on how to properly care for the resident. He said the facility was behind because they did not have a social worker for a while, and he had been working to get them caught up. During an interview with the DON on 01/03/2025 at 3:46pm revealed that she had only been working at the facility for a month. She said the social worker was responsible for ensuring the care plans were done. She said that the facility had 7 days to complete the care plan and 48 hours to complete the baseline care plan. She said staff would get report from the hospital discharge and that the nurse would pass the information down to the aides. She said that if a resident does not have a care plan staff may not share care information and the resident may not get the proper care. She said she did not know why the residents did not have a care plan. She said she came into a back log. During an interview with the ADM on 01/03/2025 at 4:07pm revealed that he was trained on how to do care plans. He said that the interdisciplinary team was responsible for ensuring the care plans were done. He said the facility had 48 hours to complete a baseline care plan and 7 days for the comprehensive care plan. He said if a resident did not have a care plan staff could go into the discharge from the hospital and educate staff. He said by not having a care plan it could cause miscommunication with staff on how to care for the resident. He said the facility is behind on care plans because of the change in management. Record review of Care Planning- Interdisciplinary Team Policy revised September 2013 revealed that a comprehensive care plan for each resident is developed within seven days of completion of the resident assessment (MDS).