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	02/25/2025

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 - Some	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** 42949 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality and failed to protect and promote the rights of the residents for two (Resident #1 and Resident #2) of five residents reviewed for resident rights. The facility failed to: 1.) Ensure CNA C was not on his phone during peri care with Resident #1 on 02/12/25. 2.) Ensure Resident #2 was not ambulating through the facility without a dignity (privacy) bag covering his foley catheter bag on 02/25/25. These deficient practices could place residents at risk of a decline of their sense of dignity, level of satisfaction with life, and feelings of self-worth. Findings included: 1.) Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), disease of digestive system, cerebral infarction (stroke), vascular dementia (dementia caused by brain damage from impaired blood flow), and muscle weakness. Review of Resident #1's quarterly MDS assessment, dated 11/14/24, reflected a BIMS could not be conducted due to rarely/never being understood. Section GG (Functional Abilities) reflected she was independent for her ADLs. Review of Resident #1's quarterly care plan, revised 02/25/25, reflected she had an ADL self-care performance deficit r/t muscle weakness with an intervention of requiring 2 staff participation for ADLs. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of video footage provided by Resident #1's FM A, dated 02/13/25 at 8:36 PM, revealed CNA C either texting or searching the internet while Resident #1's bottom half was completely exposed. Two minutes went by before he put his phone in his pocket and completed peri care. During a telephone interview on 02/25/25 at 9:37 AM, Resident #1's FM A stated she was appalled to have seen CNA C on his phone during peri care on 02/13/25. She stated, He could have been taking pictures of Resident #1's unclothed body! She stated Resident #1 would have been humiliated. She stated she showed the video to the DON who said she spoke to CNA C, and he had been texting during the incident. She stated she had not seen the aide care for Resident #1 since then. During an interview on 02/25/25 at 12:48 PM, the DON stated she was shown the video of CNA C performing peri care to Resident #1 while on his phone. She stated he was written up and she conducted an in-service for all staff regarding never being on the phone unless they were on break. She stated it was important to not be on your phone while providing care because it could be a HIPAA issue. Attempts to interview CNA C were made on 02/25/25 at 1:02 PM and 3:44 PM. A returned call was not received prior to exit. 2.) Review of Resident #2's undated care plan reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis to the lower half of the body), acquired absence of the right and left leg above the knee, muscle wasting and atrophy (wasting away), and muscle weakness. Review of Resident #2's quarterly MDS assessment, dated 01/16/25, reflected a BIMS score of 15, indicating he was cognitively intact. Section H (Bladder and Bowel) reflected he utilized an indwelling and external catheter. Review of Resident #2's quarterly care plan, revised 02/03/25, reflected he had a suprapubic catheter (a tube that drains urine from your bladder through an incision in your abdomen) with an intervention of checking for kinks and maintaining the drainage bag was off the floor. During an observation and interview on 02/25/25 at 9:32 AM revealed Resident #2 ambulating utilizing his wheelchair from the outside smoking area and down to the end of the hall where his room was located. His catheter bag was under his wheelchair without a privacy bag. LVN C verified Resident #2's name and did not notice the lack of privacy bag until pointed out to her. She stated she was not sure why he did not have one on but would try and find one. During an interview on 02/25/25 at 9:40 AM, Resident #2 stated it did not bother him that he did not have a dignity bag covering his catheter bag. He stated, however, he would not reject one if an aide offered him one. During an interview on 02/25/25 at 12:48 PM, the DON stated the importance of privacy bags was to prevent embarrassment. She stated all staff were responsible for ensuring catheter bags were covered by a privacy bag. She stated Resident #2 probably did not have one on today because he did not care about it. She stated, however, it could offend other people to have to see it. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/25/25 at 2:16 PM revealed Resident #2 ambulating utilizing his wheelchair from the outside smoking area and down to the end of the hall where is room was located. His catheter bag was under his wheelchair without a privacy bag. Review of the facility's Resident Rights Policy, revised August 2009, reflected the following: Employees shall treat all residents with kindness, respect, and dignity.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #1) of three residents reviewed for enteral nutrition. The facility failed to keep Resident #1's head of her bed elevated at least 30 degrees while receiving enteral nutrition through a g-tube for approximately an hour on 02/17/25. She was found to have difficulty breathing and foam/secretions in and around her mouth. This failure could place residents at risk of tube malfunction, aspiration, and death. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), disease of digestive system, cerebral infarction (stroke), vascular dementia (dementia caused by brain damage from impaired blood flow), and muscle weakness. Review of Resident #1's quarterly MDS assessment, dated 11/14/24, reflected a BIMS could not be conducted due to rarely/never being understood. Section K (Swallowing/Nutritional Status) reflected she was on a feeding tube. Review of Resident #1's quarterly care plan, revised 02/25/25, reflected she required a feeding tube with an intervention of needing the HOB elevated 30 degrees during and thirty minutes after tube feed. Review of Resident #1's physician order, dated 10/22/24, reflected a nothing by mouth diet. Review of Resident #1's physician order, dated 01/13/25, reflected Nepro continuous feeding at 50 ml/hr for 22 hrs a day with 50cc flush every six hours. Observation of video footage provided by Resident #1's FM A, dated 02/17/25, revealed LVN B connecting her feeding tube at 6:33 PM. LVN B left the room at 6:38 PM without elevating Resident #1's head of the bed. Observation of video footage provided by Resident #1's FM A, dated 02/17/25, revealed FM A at Resident #1's bedside at 7:25 PM. Resident #1 was lying flat in bed. Resident #1's lips were trembling, she was struggling to breathe from the mouth, and a thick white foam was covering her lips. FM A utilized the bed remote to elevate the head of the bed and Resident #1 immediately stopped mouth-breathing. FM A then used a towel to clean and remove the foamy substance from in and around her mouth. At 7:28 PM, Resident #1 took a deep breath. Observation on 02/25/25 at 9:32 AM revealed Resident #1 asleep. The head of her bed was elevated, and she appeared comfortable. Her mouth/lips were free of any secretions/drainage. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 9:37 AM, Resident #1's FM A stated on 02/17/25 around 6:30 PM, Resident #1 returned from the hospital from receiving a blood transfusion. She stated she looked at the camera footage in Resident #1's room around 6:56 PM and noticed the head of her bed was not elevated. She stated she called the facility multiple times, and no one would answer the phone, so she went up to the facility. She stated when she walked into Resident #1's room she was alarmed because it looked like she was struggling to breathe as her lips were moving and there was a thick foam coming out of her mouth. She stated she raised the head of her bed and cleaned out her mouth. She stated she (Resident #1) was lucky she had not drowned to death. She stated without her seeing the video footage and intervening, she did not know what would have happened. She stated she did notify the DON of the incident but did not feel like she took it seriously. During an interview on 02/25/25 at 12:48 PM, the DON stated she had never seen any kind of foamy secretions come out of Resident #1's mouth nor had she ever been told anything about that by staff. She stated she could not remember if Resident #1's FM A mentioned it to her but knew she never showed her the video or picture. She stated she knew Resident #1 had recently been to the hospital, but it was not for aspiration. She stated a resident's bed should never be flat when on tube feeding because they could be more likely to aspirate. She stated aspiration could lead to aspiration pneumonia or death. She stated all staff were responsible for ensuring someone on a tube feeding had their head of the bed elevated at least 30 degrees. During a telephone interview on 02/25/25 at 2:42 PM, LVN B stated she did remember working the evening of 02/17/15 and remembered connecting Resident #1's peg tube after she returned to the hospital. She stated she would never not move the head of the bed up when someone was on a peg tube. She stated if a resident was on a peg tube and their bed was flat and they had foam coming out of their mouth, it could lead to aspiration. During an interview an interview on 02/25/25 at 3:12 PM, the ADM stated her expectations for residents on tube feedings were that their head of the bed was elevated to ensure they did not aspirate and were receiving proper nutrition. She stated it was the nursing staff's responsibility to ensure this was done. During a telephone interview on 02/28/25 at 5:19 PM, Resident #1's NP stated that a resident on continuous tube feedings should have their head of the bed at 30 degrees or higher to negate the risk of aspiration or regurgitation. He stated aspiration could be a possibility if the resident was lying flat for a long period of time, but not necessarily an hour. If Resident #1 had foamy secretions it could have just been natural secretions, not specifically due to her bed being flat, but that could be a possibility. He stated he did not believe there needed to be an order for elevating the head of the bed as it was common sense, kind of like making sure the tube for the feeding was not clogged. Review of the facility's Enteral Feedings Policy, revised November of 2018, reflected the following: Preventing aspiration: . 3. Elevate the head of the bed (HOB) at least 30 degrees during tube feeding and at least 1 hour after feeding . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an article from the American Association of Critical-Care Nurses website entitled Aspiration Prevention, dated 09/15/16, reflected the following: Based on the latest available evidence, the expected practice to prevent aspiration is to: Maintain head-of-bed elevation at an angle of 30 to 45 degrees .