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	06/05/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for three (Resident #1, Resident #4, and Resident #8) of ten residents reviewed for quality of care. The facility failed to: 1. Ensure Resident #1 had orders to manage or maintain his colostomy (an opening in the large intestine) since admission date 05/23/2025. 2. Ensure Residents #4 and #8 had a physician's order for the days they received their dialysis treatment. Residents #4 and #8 both went to dialysis on Mondays, Wednesdays, and Fridays. This deficient practice could place residents at risk of not receiving adequate care, harm, or injuries. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including spina bifida (condition that affects the spinal cord), epilepsy (seizures), muscle weakness, and paraplegia (paralysis of the legs and lower body). Review of Resident #1's admission MDS assessment, dated 05/26/25, reflected a BIMS score of 15, indicating he was cognitively intact. Section H (Bladder and Bowel) reflected he had an ostomy (including urostomy, ileostomy, and colostomy). Review of Resident #1's admission care plan, dated 05/23/25, reflected he had bowel incontinence with the goal of having no skin issues related to the ostomy and an intervention of providing peri care after each incontinent episode. Review of Resident #1's physician orders, on 06/05/25, reflected no orders for managing or maintaining his colostomy. Review of Resident #4's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, acute kidney failure, and type II diabetes. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's quarterly MDS assessment, dated 03/28/25, reflected a BIMS of 15, indicating he was cognitively intact. Section O (Special Treatments, Procedures, and Programs) reflected he required dialysis treatments. Review of Resident #4's quarterly care plan, revised 02/13/25, reflected he needed dialysis with an intervention of checking and changing dressing daily at access site. Review of Resident #4's physician order, dated 12/26/24, reflected he agreed to in-house hemodialysis. There was not an order for the days he was required to receive dialysis treatments. During an interview on 06/06/25 at 10:58 AM, Resident #4 stated he went to dialysis every Monday, Wednesday, and Friday. He stated he had a chair time later in the day after lunch. Review of Resident #8's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including stroke, chronic kidney disease, and type II diabetes. Review of Resident #8's quarterly MDS assessment, dated 05/18/25, reflected a BIMS score of 8, indicating a severe cognitive impairment. Section O (Special Treatments, Procedures, and Programs) reflected she required dialysis treatments. Review of Resident #8's quarterly care plan, revised 02/13/25, reflected she had renal failure and was dependent on hemodialysis with an intervention of monitoring/documenting/reporting to MD PRN the following s/sx: edema (swelling), weight gain of over 2 lbs a day, neck vein distention, etc. Review of Resident #8's physician order, dated 06/02/24, reflected to assess dialysis permcath site Q shift for s/s of infection, bleeding, pulsation, or aneurysm. There was not an order for the days she was required to receive dialysis treatments. During an interview on 06/05/25 at 2:49 PM, the DON stated if a resident had a colostomy, they should have orders to assess it, how often to change the back, and for an assessment of the site. She stated if a resident was on dialysis they should have an order for which days they go to dialysis. She stated the admitting nurses were responsible for putting in initial orders, and all nurses were responsible for putting in orders as medications or treatments changed. She stated the importance of orders were to ensure everyone was on the same page - such as the NP, the nurses, and herself. She stated the orders were to ensure care was not missed. DON stated Residents #4 and #8 both went to dialysis on Mondays, Wednesdays, and Fridays. During an interview on 06/05/25 at 3:27 PM, RN A stated if a resident had a colostomy, they should have orders for the frequency of emptying/changing it and for assessing the stoma site. She stated if a resident was on dialysis, they should of course have an order for the days they were assigned to receive treatment. She stated orders were important, so care did not get missed. During an interview on 06/05/25 at 3:43 PM, the ADON stated the admitting nurse was responsibility for putting in orders for wound care, colostomy maintenance, catheter maintenance, and dialysis. She stated a negative outcome of not having the proper orders would be the residents could go without care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Medication and Treatment Orders Policy, revised July of 2016, reflected orders for medications and treatments will be consistent with principles of safe and effective order writing.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 (Resident #3) of 4 residents review for catheter care. The facility failed when RN A did not re-insert Resident #3's foley catheter (a medical device that helps drain urine from the bladder) when it came out on 06/05/2025 sometime around 7:00 am until 3:25 pm. Resident #3 voiced multiple times how she would prefer her catheter to be in because she could not tell when she was voiding on herself which made her uncomfortable. This deficient practice could place residents at risk for infection, sepsis (is a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death.) and hospitalization. Findings included: Review of the undated face sheet for Resident #3 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included multiple sclerosis (is a disease that causes breakdown of the protective covering nerves. It can cause numbness, weakness, trouble walking), neuromuscular dysfunction of the bladder (refers to what happens when an injury or disease interrupt the electrical signals between your nervous system and bladder function), paralytic syndrome (is the inability to move certain parts of your body due to nervous system problem.), overactive bladder (a condition characterized by a sudden urge to urinate, frequent urination and sometimes involuntary loss of urine). Review of the quarterly MDS assessment for Resident #3 dated 04/02/25 reflected a BIMS score of 15, indicating no cognitive impairment. It reflected she had an indwelling catheter and pressure ulcer/injury. Review of the care plan for Resident #3 dated 8/14/2022 reflected the following: [Resident #3] has neuromuscular dysfunction of the bladder, overactive bladder with a history of chronic cystitis, indwelling catheter in place. Indwelling catheter related to diagnosis of neuromuscular dysfunction of bladder. Review of Resident #3's physician orders reflected the following: FOLEY Catheter and Drainage Bag - change q 2 weeks and PRN dated 4/07/23. Maintain Foley catheter with 20F every shift 20 cc balloon for Neurogenic Bladder and change pm for obstruction dated 4/07/23. Observation and interview on 06/05/2025 at 10:46 am when the ADON went to perform wound care on Resident #3, Resident 3#'s foley catheter was not in place. Resident #3 told the ADON that her foley catheter came out. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2025 at 11:08 am, CNA B stated while getting Resident #3 ready for the day about some minutes after 7 am, she realized Resident #3's foley catheter was out, the bulb was still intact. CNA B stated she notified RN A that Resident #3's catheter came out and RN A stated it would be replaced later. During an interview on 06/05/2025 at 12:43 pm, the NP stated not replacing foley catheter immediately would cause urinary retention and distended bladder. The NP stated the most a Resident should go without their foley catheter was 4 hours because voiding was typically every 4 hours. During an interview on 06/05/2025 at about 1:08 pm, Resident #3 stated her foley catheter came out earlier in the morning and she wanted the catheter back in her. Resident #3 stated the CNA B was the one who noticed that her foley catheter came out when she was getting her ready this morning. Resident #3 stated CNA B said she told RN A and was told that the catheter would be replaced by 2nd shift. Resident #3 stated she did not know if she voided or not because she usually doesn't feel it. During an interview on 06/05/2025 at about 2:49 pm, the DON stated from her understanding, Resident #3 did not want her foley catheter removed. The DON stated if Resident #3's foley catheter was removed, due to the inability to void/urinate, Resident #3 would get infected and possible septic. The DON stated if the staff were having problem reinsert the foley catheter, Resident #3 would be sent out for replacement. The DON stated she did not know Resident #3 foley catheter had been out all day, she excused herself from the interview to ask RN A to reinsert Resident #3's foley catheter immediately. Observation on 06/05/2025 at 3:25 pm revealed RN A had just replaced Resident #1's foley catheter. During an interview on 06/05/2025 at 3:27 pm, RN A stated she was told by CNA B in the morning that Resident #3, foley catheter was out. RN A stated she had just reinserted Resident #3's foley catheter and Resident #3 was noted voiding on herself just before the foley catheter was re-inserted. RN A stated Resident #3's foley catheter comes out all the time and it had been changed about 2-3 times this week already. RN A stated she was not sure why Resident #3 had a foley catheter because she had no trouble voiding. Requested Catheter care policy and it was not provided by the facility prior to exit on 06/05/2025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 4 of 7 residents (Resident #2, 3, 4 & 5) reviewed for infection control. The facility failed to have signage on resident doors that reflected PPE was required for high contact care for Residents #2, 3, 4 and 5 on 06/05/2025. The facility failed on 06/05/2025 when staff failed to wear PPE while providing high contact resident care (dressing, bathing, transfers, wound care, device) to Residents #3 and 4. The facility failed when ADON did not change gloves or perform hand hygiene while providing wound care for Resident #4's left heel on 06/05/2025. These failures could place residents at risk for infection, hospitalization, or death. Findings included : Review of the undated face sheet for Resident #2 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included venous insufficiency (is a condition where the flow of blood through the veins is impaired, often leading to blood pooling in the legs), chronic venous hypertension with ulcer to right lower extremities (chronic venous hypertension - is a medical condition characterized by increased pressure in the veins, often resulting from chronic venous insufficiency) Review of the quarterly MDS assessment for Resident #2 dated 05/29/25 reflected a BIMS score of 13, indicating mild cognitive impairment. It reflected he had unhealed pressure ulcer. Review of the care plan for Resident #2 initiated 05/29/25 reflected the following: [Resident #4] has venous/stasis ulcer related to peripheral vascular disease to right lower extremities. Review of Resident #2's physician orders dated 4/23/25 reflected the following: Wound Care for Right leg Venous Ulcer cleanse with Vashe, apply wound contact layers, place foam 1 /2 thickness, apply transparent film then place wound vac setting 160 mhg continuous change 2 times per week. Review of Resident #2's physician orders and care plan did not address the need for EBP. Review of the undated face sheet for Resident #3 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included multiple sclerosis (is a disease that causes breakdown of the protective covering nerves. It can cause numbness, weakness, trouble walking), neuromuscular dysfunction of the bladder (refers to what happens when an injury or disease interrupt the electrical signals between your nervous system and bladder function), paralytic syndrome (is the inability to move certain parts of your body due to nervous system problem.), overactive bladder (a condition characterized by a sudden urge to urinate, frequent urination and sometimes involuntary loss of urine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment for Resident #3 dated 04/02/25 reflected a BIMS score of 15, indicating no cognitive impairment. It reflected she had an indwelling catheter and pressure ulcer/injury. Review of the care plan for Resident #3 dated 8/14/2022 reflected the following: [Resident #3] has neuromuscular dysfunction of the bladder, overactive bladder with a history of chronic cystitis, indwelling catheter in place. Indwelling catheter related to diagnosis of neuromuscular dysfunction of bladder. Review of Resident #3's physician orders reflected the following: FOLEY Catheter and Drainage Bag - change q 2 weeks and PRN dated 4/07/23. Maintain Foley catheter with 20F every shift 20 cc balloon for Neurogenic Bladder and change pm for obstruction dated 4/07/23. Cleans area with Normal saline every shift for Wound Treatment Other /Wound cleaner apply dry apply triad to both left and right buttocks until resolved dated 1/5/2025. Resident #3's physician orders and care plan did not address EBP. Review of the undated face sheet for Resident #4 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included acute and chronic respiratory failure (when you do not have enough oxygen in your blood), acute kidney failure (sudden loss of kidney function that can occur over s few hours or days), bacteremia (a medical condition where bacteria are present in the bloodstream), type 2 diabetes Mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood). Review of the quarterly MDS assessment for Resident #4 dated 03/28/25 reflected a BIMS score of 15, indicating no cognitive impairment. The MDS also reflected Resident #4 had a pressure ulcer/injury. Review of the care plan for Resident #4 revised 04/21/25 reflected the following: [Resident #4] will continue on wound management for pressure injury to left heel. It was also reflected Resident #4 needs hemodialysis related to renal failure. Review of Resident #4's physician orders dated 4/23/25 reflected the following: Wound Care for Left Heel every day shift every Mon . Other Pressure Ulcer/Injury: Cleanse with Vashe, apply collagen, Secure with ABD, Wrap with Rolled gauze. change daily. Enhanced Barrier Precaution: PPE required for high resident contact care activities. Indication: OPEN WOUND. Review of the undated face sheet for Resident #5 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included paraplegia-complete (a medical term that refers to paralysis of the lower limbs as a result of damage to the spinal cord), spina bifida (is a birth defect that occurs when the neural tube which forms the spine and spinal cord dose not close completely during early development in pregnancy), partial trauma amputation at level between left hip and knee, neuromuscular dysfunction of the bladder(refers to what happens when an injury or disease interrupt the electrical signals between your nervous system and bladder function) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment for Resident #5 dated 05/09/25 reflected a BIMS score of 15, indicating no cognitive impairment. It reflected he had an indwelling catheter unhealed pressure ulcer/injury. Review of the care plan for Resident #5 revised 04/24/24 reflected the following: [Resident #5] has supra pubic catheter (is a medical device inserted into the bladder through as mall insertion in the abdomen, just below the navel, to drain urine when a person is unable to urinate naturally. This is often used in the cases of urinary retention due to various medical conditions) due to BPH (prostate enlargement). It was reflected Resident #5 will continue with wound management for sacrum pressure ulcer/injury stage 4. Resident #5's physician orders and care plan did not address EBP. Observation on 06/05/2025 at about 10:30 am revealed the ADON performing wound care on Resident #4's wound at his left heel. The ADON wiped Resident's #4's bed side table with Sani clothes, gathered supplies and put a clean field on the bedside table. The ADON, - put on clean gloves, removed soiled dressing from Resident #4's left heel. The ADON did not change gloves or performed hand hygiene after removing the soiled dressing, the ADON then cleaned Resident #'4's wound with soiled gloved hands, contaminating Resident #4's wound. The ADON pat dry Resident #1's wound, applied collagen sheet, covered by ABD pad (a type of dressing used in medicine.) and kerlix wrap (is a type of bandage or dressing used in medical settings to secure and protect wounds, injuries, or surgical sites). It was also observed there was no signage at Resident #4's door indicating PPE had to be worn. Staff was just putting out signage and isolation bins at the doors. It was also observed the ADON did not wear PPE such as gown when providing wound care for Resident #4. Observation on 06/05/2025 at 10:06 through 11:08 am revealed Residents #2, 3, 4 and 5 did not have signage to their doors indicating the use of PPE and there was no bin at the doors containing PPE. The ADON was observed performing wound care on Residents #2 and #4 without gown. Observation on 06/05/2025 at 10:10 am revealed the staffing coordinator putting PPE signage and isolation bins (is a bin containing PPEs for Residents on isolation or precaution) containing PPE at the doors of Residents needing EBP. During an interview on 06/05/2025 at 11:08 am, CNA B stated Resident #3 was not on isolation or any form of precaution. CNA stated Resident #3 had a foley catheter and they were never told to wear gown when providing incontinent care for her. CNA B stated she had never worn gown for incontinent care or catheter care for Resident #4. During an interview on 06/05/2025 at about 1:08 pm, Resident #3 stated the staff have never worn gowns to perform wound or incontinent care for her. CNA B stated she did not know what EBP was for. During an interview on 06/05/2025 at about 1:44 pm, CNA C stated Residents #2, 3 and 4 were not on any form of precaution or isolation. CNA C stated the maybe someone was confused and put out all the isolation bins today but Residents # 2, 3 and 4 were not on Isolation or precaution. CNA C stated she had never worn gown to provide incontinent care or personal care for Resident #2, 3, and 4. CNA C stated the nurses were expected to tell them if the Residents were on precaution or isolation. CNA C stated she did not know what EBP was. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/2025 at about 2:49 pm, the DON stated Residents with foley catheter, trach, dialysis, or any kind of opening should be placed on Enhanced Barrier Precaution. The DON stated there should be a signage and isolation bins at the doors of Resident on EBP. The DON stated the precaution was to prevent the spread of infection and to protect the residents. The DON stated she had not in-serviced staff on EBP since she started at the facility about 3 weeks ago. The DON also stated hand glove changes and hand hygiene are done after touching the soiled dressing to prevent infection. During an interview on 06/05/2025 at 3:22 pm, the Staffing Coordinator stated she was asked by the ADON to put out signage and isolation bin at some resident's doors because they did not have it. She stated the isolation bins with PPE was because the residents had some type of infection that the staff needed to be caution of. She stated it was the responsibility of the Central Supply staff to put out PPE. During interviews on 06/05/2025 at about 3:34 pm, the ADON stated EBP was a new policy for residents with wound, foley, trach, feeding tube. The ADON stated wearing the barrier precaution was to protect the residents. The ADON stated she thought she didn't have to wear gowns for wound care for Resident #s 3 and 4 because the wounds were small. The DON stated they were in-serviced on 06/05/2025 that gowns are to be worn for all wounds. The ADON stated she was part of the management team responsible for ensuring residents with catheter, wounds, on dialysis, IV medication had PPE at their door and signage to indicate the use of PPE. The ADON stated she had been working the floor, so she had not had the time to put out PPE or signage at the doors. The ADON stated she did not change her gloves or perform hand hygiene when performing wound care on Resident # 4 because she only touched the tip of the soiled dressing. The ADON stated gloves were supposed to be change upon entering the room, while providing care, when the gloves become soiled and when leaving the room to prevent the spread of infection. Review of facility's policy titled Wound Care dated October 2010 reflect the following: Purpose The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. Personal protective equipment (e.g. gowns, gloves. mask. etc. as needed). Steps in the Procedure . 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood. urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or month is likely. Review of facility's policy titled Policies and Practices - Infection Control dated October 2018 reflect: Policy Statement This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source. 2. The objectives of our infection control policies and practices are to: Prevent, detect, investigate, and control infections in the facility. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions. Requested Hand Hygiene and EBP policies and it was not provided by the facility.