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	09/05/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and ensured the written notice included a statement of the resident's appeal rights, which included the name, address (mailing and email), and telephone number of the entity which received such requests and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request for 2 of 3 residents (Resident #2 and Resident #3) reviewed for discharge planning. 1. The facility failed to notify Resident #2 and Resident #2's RP of Resident #2's discharge, reasons for the move, and right to appeal in writing, in a language and manner they understood, and at least 30 days before Resident #2 was discharged from the facility on 09/04/25, in a facility-initiated discharge to another skilled nursing facility (SNF B). -. The facility failed to send a copy of the notice to the facility's Ombudsman before Resident #2 was discharged from the facility on 09/04/25. 3. The facility failed to notify Resident #3 and Resident #3's RP of a reason for her discharge from the facility, an effective discharge date , a location to which she would discharge to after the hospital since not being allowed back to SNF A, her right to appeal, and the facility Ombudsman's contact information in writing, in a language and manner he understood and at least 30 days or as soon as practicable before she was required to discharge from the facility. -. The facility failed to send a copy of the Resident #3's notice of discharge to the facility's Ombudsman. These failures could place residents at risk of being discharged without alternative placement, discharge options, their rights to appeal and access to advocacy services. Findings include: 1. Record review of Resident #2's face sheet, dated 09/05/25, reflected a [AGE] year-old male who was admitted to the facility 05/06/25. Resident #2 had diagnoses which included tracheostomy status, cerebral infarction (stroke), and acute and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues). Resident #2 discharged from the facility on 09/04/25 to home: resident's home. Record review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score was not assessed due to the resident rarely/never understood. The MDS included an active diagnosis of tracheostomy status. Record review of Resident #2's care plan, dated 01/14/25, reflected a focus of [Resident #2] has tracheostomy related to impaired breathing mechanics. Record review of Resident #2's progress note reflected a social services note, dated 09/04/25, SW spoke with POA about resident transfer to another facility. POA was ok with transfer and suggests that, if possible, can we look into a facility in [specified location]. Record review of Resident 2's progress notes reflected a nursing note, dated 09/04/25, resident discharge to [SNF B] via wheelchair with the assistance of transporter and nurse. Personal belongings and medications transfer with resident upon discharge. Review of Resident #2's EMR reflected no discharge notice. In an interview on 09/05/25 at 10:30 AM with Resident #2's family, she stated she received a call from the SW on 09/04/25 advising her Resident #2 would be discharged and transferred to [SNF C]. Resident # 2's family stated it was very abrupt and asked for a second to research the facility. She stated she requested information about other facilities in the area but she was told by the SW Resident #2 would be transferred out to [SNF C] regardless and she [Resident #2's family] could decide to move him again if she did not like [SNF C] once Resident #2 was there. She stated the SW told her it had to occur immediately because they did not have the proper staff to care for Resident #2 there at [SNF A]. During the interview with the State Surveyor, Resident #2's family stated she was about to contact [SNF A] to find out when the discharge for Resident #2 would occur, and was informed by the State Surveyor Resident #2 was already gone and discharged as of 09/04/25 per the EMR to [SNF B]. Resident #2's family stated she was shocked and was not informed of when the discharge would occur, did not know Resident #2 had already been discharged the previous day, was told he would be going to [SNF C] and never spoken to about [SNF B] and was not given enough notice to select a facility of her choosing or even options. Resident #2's family stated she would be following up with the facility [SNF A] to get confirmation of where Resident #2 actually was and why she was not informed of the changes. 2. Record review of Resident #3's face sheet, dated 09/05/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included hemiplegia (paralysis that affects only one side of the body) and hemiparesis (one sided muscle weakness) following cerebral infarction (stoke) affecting left non-dominant side, cognitive communication deficit, and acute respiratory failure. Resident #3 was discharged to an acute care hospital

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**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 needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of three residents (Resident #1) reviewed for tracheal care.1. The facility failed to have orders in place to provide care to Resident #1's tracheostomy (a hole in front of the neck and into the windpipe) since he was admitted to the facility on [DATE].2. The facility failed to provide regular tracheostomy care to Resident #1, as the nurses did not feel comfortable, leaving the resident to provide his own tracheostomy care since admission on [DATE]. Resident #1 was sent to the hospital on [DATE] and diagnosed with pneumonia. 3. The facility failed to provide trach care and suctioning to Resident #4 according to professional standards of practice. An Immediate Jeopardy (IJ) situation was identified on 08/28/2025. While the IJ was removed on 09/05/2025, the facility remained at a scope of pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.These failures could place residents at risk of infection, respiratory distress, pneumonia, and hospitalization.Findings include:1.Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included acute respiratory failure with hypoxia (low levels of oxygen in the body's tissues), tracheostomy status, dysphagia (difficulty swallowing), and end-stage renal disease.Record review of Resident #1's quarterly MDS assessment, dated 07/10/25, reflected a BIMS score of 14, which indicated he was cognitively intact. Section O (Special Treatments, Procedures, and Programs) reflected he required tracheostomy care.Record review of Resident #1's quarterly care plan, dated 08/10/25, reflected he had a tracheostomy related to impaired breathing mechanics with an intervention of suctioning as necessary and ensuring the trach ties were secured at all times.Record review of Resident #1's physician's orders in his EMR, on 08/12/25, reflected no orders for trach care.During a telephone interview on 08/12/25 at 9:33 AM, Resident #1's RP stated the facility made him clean his own trach. She stated, the other day (unsure of date) when she visited him, he had two cannulas in a bag with water in it. She stated he had been reusing the disposable cannulas. She stated she told him he could not use the same cannula twice and was worried about his trach site getting infected.During an observation and interview on 08/12/25 at 10:20 AM, LVN B stated Resident #1 was currently at the hospital . He stated he (Resident #1) performed his own trach care because he preferred to do it himself. He stated they (nurses) just ensured he had the supplies. When asked to see trach supplies, he opened his cart and realized there were no cannulas in the cart. LVN B led the State Surveyor to the supply closet where there was a box of disposable cannulas.During an interview on 08/12/25 at 12:52 PM, Resident #1's NP stated if a resident had a trach, his expectations were there be orders in place for PRN suctioning, changing the trach on a scheduled bases, and monitoring of the stoma. He stated he was not aware Resident #1 did not have orders for trach care. He stated his expectations were that nurses provided trach care. He stated he was aware Resident #1 sometimes performed his own trach care and he told him to let the nurses do it. He stated the residents were not well-educated enough and would need training. He stated you could not reuse a disposable cannula because Disposable meant disposable. He stated there was a big risk of infection control issues or suctioning too much could also cause issues . He stated if Resident #1 could properly take care of his trach, he would be living at home. He stated he lived at the facility because he needed a higher level of care.During an interview on 08/12/25 at 2:44 PM, the RDON stated if a resident had a trach, there should be orders on suctioning, monitoring, and cleaning the site. She stated it did not meet her expectations for a resident to not have orders if they had a trach. She stated it was important to ensure they received the care they needed. She stated a negative outcome could be infection issues, death, or other safety concerns. She stated residents were not supposed to care for their own trach because that could lead to improper care and maintenance.During an observation and interview on 08/13/25 at 1:35 PM revealed Resident #1 received a dialysis treatment. He was able to communicate by the State Surveyor reading his lips. He stated he often had to tend to his stoma site and trach because the staff were not cleaning or suctioning it, and he was scared it would become infected.Observation and interview on 08/28/25 at 10:00 a.m. revealed multiple used trach inner cannulas in Resident #l's room on his bedside table. Resident #1 stated he was afraid of running out of supplies and would wash off the trach inner cannula in the sink in his

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of four residents reviewed for pain. The facility failed to: - Order Resident #1's Hydrocodone before it ran out, causing him to be excruciating pain for two days (08/10/25 - 08/12/25), resulting in him being sent to the ER.- Properly document the ordered PRN Hydrocodone administered to Resident #1 as his August 2025 MAR did not match the narc count sheet for his PRN Hydrocodone.- Assess Resident #1 for the effectiveness of his PRN Hydrocodone (as ordered) after it was administered during August 2025. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 08/12/25 at 4:49 PM. While the IJ was removed on 08/13/25 at 6:05 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of increased pain, hospitalization, and a decreased quality of life. 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 acute respiratory failure with hypoxia (low levels of oxygen in the body's tissues), tracheostomy status[KA1] , dysphagia (difficulty swallowing), chronic pain, and end-stage renal disease. Review of Resident #1's quarterly MDS assessment, dated 07/10/25, reflected a BIMS score of 14, indicating he was cognitively intact. Section O (Special Treatments, Procedures, and Programs) reflected he required tracheostomy care. Section J (Health Conditions) reflected he had been hurting within the past five days and his pain occasionally affected his sleep, therapy activities, and day-to-day activities. Review of Resident #1's quarterly care plan, dated 04/16/25, reflected he required pain management D/T chronic pain r/t chronic physical back pain debility with an intervention of anticipating his need for pain relief and responding immediately to any complaint of pain. Review of Resident #1's hospital records, dated 07/09/25, reflected a discharge order for Acetaminophen-Hydrocodone (10/325 oral tablet) take by mouth every six hours as needed for pain. Review of Resident #1's physician order, dated 07/13/25, reflected Hydrocodone-Acetaminophen Oral Tablet 10-325 MG - Give 1 or 2 tablets every 4 to 6 hours as needed for pain. Review of Resident #1's August 2025 MAR, 08/01/25 - 08/12/25, reflected he was administered Hydrocodone on the following days: 08/01/25 - once08/04/25 - twice08/05/25 - three times08/06/25 - once08/07/25 - once08/09/25 - twice Review of Resident #1's August 2025 narc sheet, from 08/01/25 - 08/12/25, reflected he was administered Hydrocodone on the following days: 08/01/25 - four times08/02/25 - three times08/04/25 - twice08/05/25 - four times08/06/25 - four times08/07/25 - four times08/08/25 - four times08/09/25 - four times08/10/25 - once He received his last dose (as it ran out) on 08/10/25 at 12:00 AM. Review of Resident #1's pain assessments, on 08/12/25, reflected the following numerical pain scales: 08/10/25 at 2:00 PM - 608/12/25 at 12:15 AM - 7 Review of Resident #1's physician order, undated, reflected a pain assessment before and after PRN medications: Utilize 0-10 pain scale or PAINAD. Document pain scale results, v/s, interventions, outcomes. Review of Resident #1's August 2025 MAR, 08/01/25 - 08/12/25, reflected the above order was never utilized/documented. Review of Resident #1's progress note, dated 08/10/25 at 2:49 PM and documented by LVN B, reflected the following: [Resident #1] walked over to writer in the hallway requesting to be sent to ER, saying, Can you please call the ambulance so I can go to the hospital. [Resident #1] walked over to writer several times earlier asking for main meds, Tylenol 650MG PO given, as Norco 10/325 supply got finished at midnight. Also offered to call NP on-call to obtain Tramadol or TYL#3 order, [Resident #1] stated, Tramadol doesn't work for me and TYL3 makes me vomit. Review of Resident #1's progress note, dated 08/11/25 at 3:45 AM and documented by LVN B reflected 911 was called per his request due to complaining of chest pain. Review of Resident #1's hospital records, dated 08/11/25 at 4:35 AM reflected he was presenting from a nursing facility via EMS for chest pain onset today at 2:00 AM. He was administered Hydrocode at 5:04 AM. Review of Resident #1's progress note, dated 08/11/25 at 12:01 PM and documented by the IDON, reflected the following: [Resident #1] has returned from ER visit without new orders. Wants to go back out for pain control. Review of Resident #1's progress note, dated 08/12/25 at 7:20 AM and documented by LVN A, reflected the following: [Resident #1] complained of pain to this nurse and stated that he wanted to go to the hospital. This nurse notified the on-call practitioner. The on-call practitioner stated that the highest level of medication that he could prescribe was Tramadol, but he

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for one of three Residents (Resident #4) reviewed for competent nursing staff.LVN E failed to provide trach care and suctioning to Resident #4 according to professional standards of practice. An Immediate Jeopardy (IJ) situation was identified on 08/28/2025. While the IJ was removed on 09/05/2025, the facility remained at a scope of pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risks for infection, respiratory distress, hospitalization and death.Findings include:Record review of Resident #4's, undated, face sheet reflected a [AGE] year-old male with original admission date of [DATE] and readmission date of [DATE]. Resident #4 had diagnoses which included tracheostomy status (a surgical procedure that creates an opening in the trachea-windpipe to allow breathing), acute and chronic Respiratory failure with hypoxia (Hypoxia is a condition in which there is an inadequate supply of oxygen to the body's tissues), Gastrostomy status (refers to the presence of a surgical opening in the stomach that allows for the insertion of a tube for feeding or other purposes), acute on chronic systolic Congestive heart failure (a condition where a sudden worsening of symptoms occurs in some who already has chronic systolic heart failure), cerebral infarction (occurs when blood flow in the brain is interrupted, leading to cell death and brain damage), and dysphagia (difficulty swallowing).Record review of Resident #4's quarterly MDS assessment, dated 08/20/2025, reflected a BIMS score of 00, which indicated severe cognitive impairment. Staff assessment reflected Resident #4 had both short-term and long-term memory problems. Section O reflected Resident #4 required Oxygen therapy, suctioning and tracheostomy care.Record review of Resident #4's care plan, initiated 01/14/2025, reflected Resident #4 had tracheostomy related to impaired breathing mechanics and was on oxygen at 4LPM, Resident #4 was NPO.Record review of Resident #4's physician orders, dated 05/08/2025, reflected: Suction as needed to maintain patency every 1 hours as needed for as needed to maintain patency of trach. Trach care daily and PRN: For disposable: remove and dispose of inner cannula. Replace with new inner cannula. one time a day for Reduce risk of infection 6-inch trachRecord review of Resident #4's physician orders, dated 06/23/2025, reflected: Monitor trach for placement every shift.Record review of Resident #4's physician orders, dated 08/29/2025, reflected: Monitor trach stoma site for issues including but not limited to: S/S of infection, irritation, redness, swelling, pain, mucosal tissue issues. Notify MD or NP for any findings which are abnormal and complete progress note. every shift for tracheostomy care Notify for abnormal findings and complete progress note. Trach care daily and PRN: For disposable: (Trach Canula size 7.5) remove and dispose of inner cannula. Replace with new inner cannula, gauze, and collar. one time a day for Reduce risk of infection Inner Canula Size [NAME] 7.5During an observation on 08/29/2025 at 08:46 AM, Resident #4 was observed lying in bed with the HOB elevated at about 30 degrees, Resident #4 was observed with excessive secretions from his trach, oxygen mask full of secretions, secretions dripping down Resident #4's left neck and shoulder, trach tide and split gauze under trach saturated secretions. Resident #4 was noted on continuous oxygen via mask at 4 L per hour using the oxygen concentrator. Surveyors called for help to Resident #4's room, that Resident #4 needed a nurse. LVN G stated Resident #4's nurse was somewhere down the hall. LNV G walked down the hall could not see Resident #4's nurse assigned for the day and walked to Resident #4's room. LVN G went in Resident #4's room, looked at Resident #4, turned around a little in Resident #4's room without touching him and walked out of the room. At about 8:58 a.m. Resident #4's assigned nurse, LVN E walked to Resident #4's door and stated she was going to perform trach care and suctioning on Resident #4 .Observation on 08/29/25 at 09:03 a.m. revealed LVN E collecting supplies to perform trach care on Resident #4. LVN E was observed collecting supplies from the medication cart such as trach kit and a 10cc vial of normal saline. LVN E donned an isolation gown and a clean glove without performing hand hygiene . LVN E took clean gauze wiped Resident #4's oxygen mask removing the excess secretions, then wiped Resident #4's left neck and shoulder removing excess secretions. LVN E then reached into her pants pocket with her soiled gloved hand and pulled a glove out

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 2 of 4 residents (Resident #2, and Resident #3) reviewed for pressure ulcers.The facility failed to follow the physician's orders for providing wound care for Resident #2 and Resident #3, on a regular basis.This failure could place residents at risk of worsening their wounds. Findings Include: 1. Record review of Resident #2's face sheet, dated 09/05/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included acute congestive heart failure (sudden and severe failure of the heart) , obesity, asthma, acute respiratory failure and edema (Swelling). Record review of Resident #2's initial MDS, dated [DATE], revealed a BIMS score of 15, which indicated his cognition was intact. Resident #2 had the risk of pressure ulcers/injuries and the recommended applications of ointments. Record review of Resident #2's care plan, dated 08/13/25, reflected the resident was potential for impairment to skin integrity r/t lymphedema (swelling due to fluid accumulation). The relevant intervention was identifying potential causative factors and resolve where possible. Record review of Resident #2's comprehensive skin assessment, conducted by the WNP on 08/22/25, reflected: [Resident #2] was seen today as part of a facility-wide skin sweep. dry skin noted. No open area. emollient recommended. No redness noted to bilateral heel and buttock. Record review of Resident #2's physician order, dated 08/29/25, reflected: Cleanse buttock with wound cleanser, apply triad paste and collagen mixture. leave open to air QD and PRN for wound care. -Start Date-08/29/2025. Record review on 09/05/25 of Resident #2's TAR for August and September 2025 reflected he did not receive the treatment ordered by the physician, on 08/30/25, 08/31/25, 09/01/25 and 09/02/25. An observation of Resident #3's wound on 09/05/25 at 3:30pm revealed no infection or worsening of wound from the initial assessment. 2. Record review of Resident #3's face sheet, dated 09/05/25, reflected a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. The diagnoses included chronic obstructive pulmonary disease (difficult to breath), muscle weakness, end stage renal disease (final stage of kidney disease) , hypertension, and pressure ulcer of right buttock and sacral region(area at the base of spine above the tail bone). Record review of Resident #3's quarterly MDS ,dated 08/05/25, reflected the BIMS interview could not be conducted as the resident rarely/never understood the interview questions. Resident #1 was at high risk for pressure ulcer/injuries and the interventions were, the application of nonsurgical dressings and ointments/medications Record review of Resident #3's care plan, dated 06/25/25, reflected she had a pressure ulcer to her left upper extremity. The relevant interventions were, cleansed gently with normal saline or wound cleanser daily and applying skin prep and leave open to air until resolved. Record review of Resident #3's comprehensive skin assessment, conducted by WNP, on 08/22/25, reflected: [Resident #3] was seen today as part of a facility-wide skin sweep. Dry skin noted. No open area. Emollient (cream that moisturizing the skin) recommended. No redness noted to bilateral heel and buttock. Record review of the progress note in the her, dated 08/28/25, authored by WN, reflected: Staff notified this nurse [WN] that resident was bleeding during shower. On inspection, resident observed to have stage 2 [pressure ulcer] at coccyx, measuring 2cm x 2cm x 1cm depth. NP notified. Record Review of Resident #3's physician's order reflected:1. Cleanse stage 2 to coccyx with wound cleanser, apply calcium alginate, and dry dressing/ QD and PRN every day shift for wound care. -Start Date-08/29/20252. Cover left arm blister with dry dressing every day and night shift for wound care. -Start Date-09/01/2025. Record review on 09/05/25 of Resident #3's TAR for August and September 2025 reflected she did not receive the treatment ordered by the physician, on 08/30/25, 08/31/25, 09/01/25 and 09/02/25. An observation of Resident #3's wound on 09/05/25 at 3:20pm revealed no infection or worsening of wound from the initial assessment. Attempted interview on 09/05/25 at 4:30 PM by phone to WN was unsuccessful. A voice message was left and no return call received . During an interview on 09/05/25 at 2:20 PM, the ADON. She stated she was doing the wound care at the facility on this day, as the WN was on leave. When the investigator pointed out that there were days when the wound care was not provided to Resident #1 and Resident #2, the ADON stated it was important to adhere to the treatment order and provide the treatment per the order to residents on a regular basis. She stated if the treatment was not provided as ordered by the physician, the wound could get worsened and put the residents in danger. She stated it was the responsibility of the WN to make sure the treatment was done as ordered. During an interview on 09/05/25 at 4:15 PM, LVN G stated, She

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	09/05/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews 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 infections in one of three residents (Resident #4) review for infection control. 1. LVN E failed to perform hand hygiene before and after glove changes while performing trach care and suctioning on Resident #4. 2. LVN E failed to follow sterile technique while Suctioning Resident 42. These deficient practices could place residents at risks for infection, respiratory distress, hospitalization.Findings include:Record review of Resident #4's, undated, face sheet reflected a [AGE] year-old male with an original admission date of 01/13/2025 and readmission date of 05/06/2025. Resident #4 had diagnoses which included tracheostomy status (a surgical procedure that creates an opening in the trachea-windpipe to allow breathing), acute and chronic Respiratory failure with hypoxia (Hypoxia is a condition in which there is an inadequate supply of oxygen to the body's tissues), Gastrostomy status (refers to the presence of a surgical opening in the stomach that allows for the insertion of a tube for feeding or other purposes), acute on chronic systolic Congestive heart failure (a condition where a sudden worsening of symptoms occurs in some who already has chronic systolic heart failure), cerebral infarction (occurs when blood flow in the brain is interrupted, leading to cell death and brain damage), and dysphagia (difficulty swallowing). Record review of Resident #4's quarterly MDS assessment, dated 08/20/2025, reflected BIMS score of 00, which indicated severe cognitive impairment. The staff assessment reflected Resident #4 had both short-term and long-term memory problems. Section O reflected Resident #4 required Oxygen therapy, suctioning and tracheostomy care.Record review of Resident #4's care plan, initiated 01/14/2025, reflected Resident #4 had a tracheostomy related to impaired breathing mechanics and was on oxygen at 4LPM, Resident #4 was NPO.Record review of Resident #4's physician orders, dated 05/08/2025, reflected: Suction as needed to maintain patency every 1 hours as needed for as needed to maintain patency of trach. Trach care daily and PRN: For disposable: remove and dispose of inner cannula. Replace with new inner cannula. one time a day for reduce risk of infection 6inch trach.Record review of Resident #4's physician orders, dated 06/23/2025, reflected: Monitor trach for placement every shift. Record review of Resident #4's physician orders, dated 08/29/2025, reflected: Monitor trach stoma site for issues including but not limited to: S/S of infection, irritation, redness, swelling, pain, mucosal tissue issues. Notify MD or NP for any findings which are abnormal and complete progress note. every shift for tracheostomy care Notify for abnormal findings and complete progress note. Trach care daily and PRN: For disposable: (Trach Canula size 7.5) remove and dispose of inner cannula. Replace with new inner cannula, gauze, and collar. one time a day for Reduce risk of infection Inner Canula Size [NAME] 7.5. Observation on 08/29/25 at 09:03 AM revealed LVN E collected supplies to perform trach care on Resident #4. LVN E collected supplies from the medication cart such as trach kit and a 10cc vial of normal saline. LVN E donned an isolation gown, a clean gloves without performing hand hygiene. LVN E took clean gauze wiped Resident #4's oxygen mask removing the excess secretions, then wiped Resident #4's left neck and shoulder removing excess secretions. LVN E then reached into her pants pocket with soiled gloved hand and pull a glove out . LVN E then removed gloves from 1 hand, reached in her pants pocket again but did not get anything. LVN E removed gloves from the other hand and walked out to the doorway to get more gloves from her medication cart parked in the doorway. LVN E grabbed more gloves from her medication cart and placed gloves in her pants pocket. LVN E applied clean gloves without hand hygiene, took the yankauer (A Yankauer is a medical suction device used to remove fluids, blood, secretions, and debris from a patient's oral airway or surgical site to prevent aspiration and maintain a clear field for healthcare providers.) and inserted it into Resident #4's trach, suctioning while going in and coming out of the trach. LVN E used water which she took from a normal saline vial (10 cc), put water in a plastic cup which was not sterile to clean the yankauer. LVN E again inserted the yankauer into Resident #4's trach, with the yankauer not being sterile, and again applied suction while going in and coming out. LVN E removed the soiled gloves, no hand hygiene, reached in her pants pocket for clean gloves, nurse applied clean gloves, applied split gauze under Resident #4's trach, did not clean Resident #4's trach stoma, did not change Resident #4's trach tide even though it was saturated with secretions. During an interview on 08/29/2025 at 10:12 a.m., LVN E stated she knew to wash her hands before entering residents' rooms. LVN E stated she could not recall washing her hands before entering