

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 08/13/2024
NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Austin		STREET ADDRESS, CITY, STATE, ZIP CODE 6909 Burnet LN Austin, TX 78757	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident had a right to be treated with respect and dignity for 1 (Resident #81) of 5 residents reviewed for dignity.</p> <p>The facility failed to ensure Residents #81's urinary bedside drainage bag was placed in a privacy bag on 08/06/24 and 08/07/24.</p> <p>This failure could have compromised residents' dignity for those who require tubing and a urinary bedside drainage bag.</p> <p>Findings included:</p> <p>Record review of Resident #81's medical diagnosis dated 08/06/24 reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included diabetes (a group of diseases that result in too much sugar in the blood), Fractured Right Humerus (break in the upper arm bone), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood, resulting in pallor and weariness), and end stage renal disease (gradual loss of kidney function).</p> <p>Record review of Resident #81's quarterly MDS assessment dated [DATE] reflected the resident's BIMS score was 11 indicating his cognition was moderately impaired. The MDS indicated the resident was dependent on staff for toileting and showering, required substantial/maximum assistance from staff for personal hygiene, and required set-up or clean up assistance while eating. The MDS indicated resident required an indwelling catheter (including suprapubic and nephrostomy tube). Resident #81 's continence was not rated due to having a catheter, urinary ostomy, or no urine output for the entire 7 days of lookback period for the MDS.</p> <p>Record review of Resident #81's care plan dated 04/24/24 reflected:</p> <p>[Resident #81] has Indwelling Foley Catheter: obstructive uropathy</p> <p>Goals: The resident will be/remain free from catheter-related trauma through review date.</p> <p>The resident will show no s/sx of Urinary infection through review date.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions: POSITION PRIVACY BAG & TUBING BELOW THE LEVEL OF THE BLADDER.</p> <p>Record review of Resident #81's clinical physician orders dated 06/01/24 reflected an order for Foley catheter care every shift and Foley output every shift. Resident #81 ' s physician orders dated 04/24/24 reflected foley catheter care every shift and prn. Resident #81 ' s physician order is dated 05/14/24 reflected 18Fr Foley Catheter and Drainage Bag - change q month and PRN.</p> <p>In an observation on 08/06/24 at 10:59 AM, Resident #81 was lying in bed sleeping with urinary catheter BSDB hanging to left side of resident ' s bed uncovered. BSDB have a moderate amount of yellow liquid present in tubing and BSDB. BSDB and catheter tubing were visible from hallway and Resident #81 ' s door was open. Staff and other residents were back and forth in hallway during visit with Resident #81. Resident #81 showed no sign of pain or distress, and resident did not awaken to his name being called.</p> <p>In an observation and interview on 08/06/24 at 12:25 PM, Resident #81 awakened and told surveyor his name. He stated he did not know if it had been covered or not. Observation of catheter BSDB revealed the BSDB remained uncovered.</p> <p>In an interview on 08/06/24 at 12:37 PM, the DON observed Resident #81 ' s catheter BSDB uncovered and hanging to the left side of Resident #81 ' s bed. She stated catheter bedside BSDB ' s should be covered when the resident is out of their room, and she would have to check their policy to see if it was a dignity issue if the residents catheter bag was visible to those outside of the room.</p> <p>In an observation on 08/07/24 at 1:16 PM, Resident #81 ' s uncovered urinary catheter BSDB was seen from the hallway where other staff and residents were passing frequently, through an open door into Resident #81 ' s room.</p> <p>In an interview on 08/07/24 at 1:17 PM, Resident #81 stated he was ok, and staff treated him well. He stated he had no concerns, and he was happy with the care he received in the facility. He stated he felt safe in the facility. He stated he did not know if his urinary catheter BSDB was covered or not.</p> <p>In an interview on 08/08/24 at 1:08 PM, the ADM stated catheter BSDB ' s should be covered for residents ' privacy at any time when visible to others. He stated staff had been trained on resident rights and ensuring residents ' privacy by keeping catheter BSDB ' s covered when visible to others. He stated if a resident ' s catheter drainage bag was left uncovered and visible to others, it could cause the resident to have concerns with dignity and it would be undignified.</p> <p>In an interview on 08/08/24 02:03 PM, the DON stated catheter BSDB ' s should be covered for residents ' privacy at any time when visible to others. She stated staff had been trained on resident rights and ensuring residents ' privacy by keeping catheter drainage bags covered when visible to others. She stated if a resident ' s catheter drainage bag was left uncovered and visible to others, it could cause the resident to have concerns with privacy.</p> <p>(continued on next page)</p>		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled: Resident Rights dated 2001 revised December 2016 stated: Policy statement - Employees shall treat all residents with kindness, respect, and dignity. Policy interpretation and implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity;		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 4 of 5 residents (Resident ' s #81, #15, #44, and #7) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #81 ' s call light was within reach on 08/06/24 and 08/07/24.</p> <p>The facility failed to ensure Resident #15 ' s call light was in reach on 08/07/24.</p> <p>The facility failed to ensure Resident #44 ' s call light was in reach on 08/07/24 and 08/08/24.</p> <p>The facility failed to ensure Resident #7's call light was within reach on 08/11/24.</p> <p>This failure could place residents at risk of needs not being met.</p> <p>Findings included:</p> <p>1. Record Review of Resident #81's medical diagnosis dated 08/06/24 reflected the resident was a [AGE] year old male admitted on [DATE]. His diagnoses included diabetes (a group of diseases that result in too much sugar in the blood), Fractured Right Humerus (break in the upper arm bone), anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood, resulting in pallor and weariness, and end stage renal disease (gradual loss of kidney function).</p> <p>Record review of Resident #81's quarterly MDS assessment dated [DATE] reflected the resident ' s BIMS score was 11 indicating his cognition was moderately impaired. The MDS indicated the resident was dependent on staff for toileting and showering, required substantial/maximum assistance from staff for personal hygiene, and required set-up or clean up assistance while eating.</p> <p>Record review of Resident #81's care plan dated 05/06/24 reflected:</p> <p>Focus: [Resident #81] was at risk for falls r/t amputations.</p> <p>Goals: The resident will not sustain serious injury through the review date.</p> <p>Interventions: Anticipate and meet the resident's needs, Follow facility fall protocol.</p> <p>In an observation on 08/06/24 at 10:59 AM, Resident #81 was lying in bed sleeping with the call light hanging on the top of the left side of Resident #81 ' s bed and out of Resident #81 ' s reach. Resident #81 ' s door was open. Staff and other residents were back and forth in hallway during visit with Resident #81. Resident #81 showed no sign of pain or distress, and resident did not awaken to his name being called.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 08/06/24 at 12:25 PM, Resident #81 awakened and told surveyor his name. He stated he could not reach the call light at that time. Resident #81 could not answer when asked if he knew how to call for help if needed. Resident #81 ' s call light remained out of reach and was hanging on the top of the left side of Resident #81 ' s bed, out of Resident #81 ' s reach.</p> <p>In an interview on 08/06/24 at 12:37 PM, the DON observed Resident #81 ' s call light, which was out of Resident #81 ' s reach hanging on the top of the left side of Resident #81 ' s bed. She stated all residents ' call lights should be within reach at all times. She stated if a resident ' s call light was not within reach, then when someone noticed it, they would put it back in reach. She stated if a resident ' s call light was out of reach, it would not be any good and the resident would not be able to call for help.</p> <p>In an observation on 08/07/24 at 10:35 AM, Resident #81 ' s call light was laying on the floor to the left side of Resident #81 ' s bed and out of Resident #81 ' s reach. Resident #81 was sleeping and opened his eyes when his name was called but did not answer any questions. Blankets covered Resident #81 to his chest area and Resident #81 was not showing any signs of distress.</p> <p>In an interview on 08/07/24 at 10:37 AM , the DON was informed that Resident #81 ' s call light was not within his reach and was on the floor. The DON walked in the other direction down the hallway away from Resident #81 ' s room.</p> <p>In an interview on 08/07/24 at 10:39 AM, the ADM was informed of Resident #81 ' s call light being on the floor and out of residents reach. The ADM went into Resident #81 ' s room and placed Resident #81 ' s call light back in reach of resident. The ADM stated he was not sure if Resident #81 could use the call light to call for help or not, but either way Resident #81 ' s call light should have been in reach.</p> <p>In an interview on 08/07/24 at 1:17 PM Resident #81 stated he was ok, and staff treated him well. He stated he had no concerns, and he was happy with the care he received in the facility. He stated he felt safe in the facility. He stated he used the call light to call for help when needed and sometimes it took the staff a while to respond to him, but they did help him as needed.</p> <p>2. Record review of resident #44's face sheet, dated 08/08/24, admitted [DATE] and readmitted [DATE], documented a [AGE] year-old female diagnosed with systemic inflammatory response syndrome (severe inflammation throughout your body) with acute organ dysfunction, dementia, cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), and acute respiratory failure with hypoxia (occurs when the lungs have difficulty exchanging oxygen and carbon dioxide with the blood, resulting in low oxygen levels in the body ' s tissues).</p> <p>Record review of Resident #44's quarterly MDS dated [DATE] revealed resident had a BIMS score of 0 indicating the resident was severely cognitively impaired. The MDS also revealed Resident #44 was dependent in both her upper and lower extremities and used a wheelchair. Section GG, Functional Abilities and Goals - Admission was left blank.</p> <p>Record review of Resident #44 ' s care plan revealed an intervention of being sure the resident's call light was within reach and encourage the resident to use it for assistance as needed.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident #44 on 08/07/24 at 10:41 AM revealed resident lying in bed. When surveyor entered the room, she repeatedly made an undistinguishable noise and reached out to the surveyor. Surveyor was unable to communicate with the resident. Resident #44 ' s call light was located at the foot of her bed, on the floor, out of resident ' s reach.</p> <p>Observation of Resident #44 on 08/08/24 at 2:37 pm revealed resident lying in bed. When surveyor entered the room, she repeatedly made an undistinguishable noise and reached out to the surveyor. Surveyor was unable to communicate with the resident. Resident #44 ' s call light was located three quarters down from the head of the bed on the floor by the wall, out of resident ' s reach.</p> <p>Observation of Resident #44 on 08/08/24 at 3:29 pm revealed resident lying in bed. When surveyor entered the room, she repeatedly made an undistinguishable noise and reached out to the surveyor. Surveyor was unable to communicate with the resident. Resident #44 ' s call light was located on the floor at the end of her bed out of resident ' s reach.</p> <p>3. Record review of resident #15's face sheet, dated 08/08/24, admitted [DATE], documented an [AGE] year-old male diagnosed with cerebral infarction (lack of adequate blood supply to brain cells), spinal stenosis (a condition that occurs when the spinal canal narrows putting pressure on the spinal cord or nerve roots) lumbar region (the part of the body between the thoracic spine and the sacrum) with neurogenic claudication (a condition that causes pain and difficulty walking due to compression of the spinal nerves in the lower spine), contractures both hands, and voice and resonance disorder.</p> <p>Record review of Resident #15's quarterly MDS dated [DATE] revealed resident had a BIMS score of 3 indicating the resident was severely cognitively impaired. The MDS also revealed Resident #15 was dependent for toileting hygiene, dressing, rolling right and left, sit to lying, and transferring to and from wheelchair, toilet, and bed.</p> <p>Observation on 08/07/24 at 2:15 pm of Resident #15 seated in his Geri chair to the left of his bed facing forward with his shoulder against his bedrail. Observed call light wrapped around the bedrail at Resident #15 ' s left shoulder level and out of Resident #15 ' s reach.</p> <p>Interview and observation with Resident #15 on 08/07/24 at 2:15 pm reveled, when asked if he could reach his call light, he replied, in a whispered voice (surveyor had to lean close to the resident to hear due to a voice and resonance disorder) no. As Resident #15 was asked the question, he attempted to reach the call light that was wrapped around the bed rail at his shoulder level and demonstrated he could not reach the call light.</p> <p>Observation on 08/08/24 at 3:13 pm of Resident #15 sleeping in his bed. Resident ' s call light was on the right side of his bed, wrapped around his bed rail, hanging upside down about 4 inches below the bed and out of reach of Resident #15.</p> <p>Observation on 08/09/24 at 9:17 am of Resident #15 sleeping in his bed. Resident ' s call light was on the right side of his bed, wrapped around his bed rail, hanging upside down about 4 inches below the bed and out of reach of Resident #15.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Record Review of Resident #7's medical diagnosis dated 08/11/24 reflected the resident was a [AGE] year-old female admitted on [DATE]. Her diagnoses included diabetes (a group of diseases that result in too much sugar in the blood), dementia (a group of thinking and social symptoms that interferes with daily functioning), hypertension (high blood pressure), and COPD (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Record review of Resident #7 ' s quarterly MDS dated [DATE] reflected the resident ' s BIMS score was 14 indicating her cognition was intact. The MDS indicated the resident was dependent on staff for toileting, showering, and personal hygiene, and required set-up or clean up assistance while eating.</p> <p>Record review of Resident #7's care plan dated 08/01/24 reflected:</p> <p>Focus: Resident #7 has bowel incontinence.</p> <p>Goals: The resident will have less than two episodes of incontinence per day through the review date.</p> <p>Interventions: Check resident every two hours and assist with toileting as needed. Provide bedpan/bedside commode.</p> <p>Focus: Resident #7 has an ADL Self Care.</p> <p>Goals: Resident #7 will maintain current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date.</p> <p>Interventions: TOILET USE: The resident requires (dep) staff participation to use toilet. TRANSFER: The resident has requires (2) staff participation with transfers.</p> <p>In an interview and observation on 8/11/2024 at 11:41 am, Resident #7 was heard yelling Please help me, help me. Sounds were coming from room [ROOM NUMBER]. Resident #7 stated that she was yelling and asking for help. She stated that she needed to have a bowel movement. Call light was observed on the floor and not within reach. Her roommate, Resident #5, stated that she pressed her call light for Resident #7 because she was calling out Help me. Resident #5 stated that no one had responded to help. She stated that the call light had been on for about 5 minutes (about 11:36 am).</p> <p>In an interview and observation on 08/11/24 at 11:54 am, CNA A entered room [ROOM NUMBER]. She turned off the call light. She told Resident #7 to go poop in her brief, asked Resident #5 if she needed anything, and exited the room to get Resident #5 water. Surveyor asked CNA A if she assisted Resident #7 with her request for assistance with having a bowel movement. CNA A stated that Resident #7 was incontinent and could not walk. She said Resident #7 had a bowel movement in her brief. Surveyor asked CNA A if Resident #7 used a bed pan or went to the toilet for a bowel movement and CNA stated no, Resident #7 does not use the toilet or bed pan. She stated that Resident #7 was a 2-person transfer with Hoyer lift.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/08/24 at 1:08 PM, the ADM stated residents ' call lights should be in all residents ' reach at all times. He stated all staff were responsible for ensuring call lights were in residents reach at all times and all staff had been in-serviced on call light placement. He stated if a resident ' s call light was not in reach, it could have caused the resident to experience distress.</p> <p>In an interview on 08/08/24 02:03 PM , the DON stated call lights should have been in all residents reach at all times. She stated the CNAs and nurses made rounds and everyone that was in direct care of the residents were responsible for ensuring residents had their call lights in reach at all times. She stated all staff should have been checking for call light placement and all staff had been in-serviced on ensuring call light placement was in residents reach at all times. She stated if a residents call light was not in reach, the resident would not have been able to ask for assistance.</p> <p>Interview on 08/08/24 at 5:50 pm with the DON revealed if a resident did not have a call light within their reach, the staff would not know if a resident was in need of assistance.</p> <p>Review of the facility's policy titled: Answering the Call Light dated 2001 revised October 2010 stated: Purpose: The purpose of this procedures is to respond to the resident's requests and needs; General Guidelines: 1. Explain the call light to the new resident. 2. Demonstrate the use of the call light. 3. Ask the resident to return the demonstration so that you will be sure that the resident can operate the system. (Note: Explain to the resident that a call system is also located in his/her bathroom. Demonstrate how it works.) 4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .</p> <p>Review of the facility's document titled Falls Prevention - Potential Interventions dated 2001 revised April 2012 reflected Intervention: Call Light; Description: Placed within reach at all times.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Resident #57</p> <p>Based on interviews and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment for 2 of 8 residents (Resident #57 and Resident #61) reviewed for notification of changes.</p> <p>A. The facility failed to ensure the physician was notified of Resident #57 refusing his medication Mirtazapine (a medication for depression) and Risperidone (a medication used to control his schizophrenia).</p> <p>B. The facility failed to ensure the physician was notified of Resident #61 was refusing his medications Coreg (a medication used to treat his heart failure).</p> <p>This failure could place residents at risk of not receiving appropriate medical treatments, which could result in severe illness or hospitalization .</p> <p>Findings included:</p> <p>A.</p> <p>1. Record review of Resident #57's undated face sheet reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident #57's had diagnoses which included Unspecified Dementia (forgetfulness), Schizophrenia (a serious mental illness that affects how a person thinks), Depression, Malnutrition, Vitamin D Deficiency.</p> <p>Record review of Resident #57's MDS quarterly assessment, dated 07/01/24, reflected the resident had a BIMS score of 09, which indicated he had moderately impaired cognition. Section C of the MDS also reflected Resident #57 had disorganized thinking behavior that fluctuated.</p> <p>Record review of Resident #57's comprehensive care plan dated 07/26/24 reflected that he had depression with an intervention to administer medications as ordered.</p> <p>Record review of active physicians' orders dated 08/07/24 reflected Resident #57 had an active order for Mirtazapine Oral Tablet 15 MG 3 (three) tablets at bedtime dated 06/29/24 and Risperidone Oral Tablet 2 MG orally in the morning.</p> <p>Record review of Resident #57's medication administration record for the month of July 2024 reflected that Resident #57 had refused his Mirtazapine 26 out of 31 days and his Risperidone 20 out of 31 days.</p> <p>Record review of Resident #57's medication administration record for the month of August 2024 dated 08/08/24 reflected that Resident #57 had refused his Mirtazapine 7 out of 7 days and his Risperidone 7 out of 7 days.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #57's progress notes dated 07/08/24 through 08/08/24 reflected that there was no documentation related to Resident #57 refusing his medication or notifying the physician and responsible party he had refused his medications.</p> <p>In an interview with Resident #57 on 08/08/24 at 1:55 PM, he stated he refused his medications because they give him a headache. Resident #57 said he does not think anyone at the facility had notified his doctor that he knows of. He stated he occasionally will take some Tylenol, but he just does not want anything else.</p> <p>B.</p> <p>2. Record review of Resident #61's undated face sheet reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident #61's had diagnoses which included Type 2 diabetes mellitus without complications (an impairment in the way the body regulates and uses sugar), Aortic Valve Stenosis (a thickening of the heart valves), and Congestive Heart Failure (a weakening of the hearts ability to sufficiently pump blood).</p> <p>Record review of Resident #61's MDS quarterly assessment, dated 07/08/24, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Section J of the same MDS reflected Resident #61 had occasional moderate pain.</p> <p>Record review of Resident #61's comprehensive care plan dated 05/10/24 reflected he had Congestive Heart Failure with an intervention to give cardiac medications as ordered.</p> <p>Record review of active physicians' orders dated 08/06/24 reflected Resident #61 had an active order for Coreg Oral Tablet 6.25 MG 1 (one) tablet by mouth two times a day dated 05/15/24.</p> <p>Record review of Resident #61's medication administration record dated 08/06/24 reflected that he had refused his Coreg, physician ordered medication 26 out of 31 days for the month of July.</p> <p>Record review of Resident #61's medication administration record dated 08/06/24 reflected that he had refused his Coreg, physician ordered medication 6 out of 6 days for the month of August.</p> <p>Record review of Resident #61's progress notes for dated 07/08/24 through 08/08/24 reflected that there was no documentation related to Resident #61 refusing his medication or notifying the physician and responsible party he had refused his medications.</p> <p>In an interview with Resident #61 on 08/06/24 at 10:52 AM he stated he did not believe in medication, and he wanted to take his natural supplements only.</p> <p>In an interview on 08/07/24 at 09:37 AM, LVN B stated if a pt were to refused their medications, the MA should let the nurse know so a follow up and attempt could be made to give the resident their meds. The Nurse should follow up with notifying the doctor. and make a progress note within the EMR. Negative effects for residents that refuse their medications would be a lack of therapeutic medication levels. She stated the pharmacist came monthly to review all residents' medications.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/08/24 at 02:07 PM with the DON, she stated if residents were refusing medications the doctor or Nurse Practitioner should be notified. Negative outcomes for residents refusing medications could be increased behaviors or hypertensive crisis. The DON stated she and the ADON were responsible for monitoring Medication Administration Records to look for changes.</p> <p>In an interview on 08/08/24 at 02:18 PM with ADM, he stated refusal of medications should be reported to the doctor,</p> <p>the nurse practitioner, and the physician should be involved together with the nurses and produce solution as to why the residents were refusing medications. Staff should communicate better. Nurses were responsible for reporting to department heads refusals of medication and then nursing department heads were responsible for following up on refusals.</p> <p>Record review of facility policy titled Administering Medications dated December 2012 indicated Medications are administered in a safe and timely manner and as prescribed.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment</p> <p>for 3 of 8 residents (Resident #13, Resident#17, and Resident #63) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #13, Resident#17, and Resident #63 to provide a safe bedroom free from obstacles with closets accessible to the resident .</p> <p>This failure could place residents at risk for falls and rooms being overheated from the air conditioner being turned off.</p> <p>Findings included:</p> <p>1. Record review of Resident #13 undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #13 had a diagnosis of Paralytic syndrome (a condition of muscle wasting and loss of reflexes), Multiple sclerosis (an autoimmune disease that damages the central nervous system), and headaches.</p> <p>Record review of Resident #13 Annual MDS assessment dated [DATE] reflected BIMS score of 15 indicating Resident #13 was cognitively intact. Section F of the MDS Preferences reflected that it was important to Resident #13 that she be able to choose what clothes to wear. Section GG Functional Abilities and Goals of the MDS reflected Resident #13 required substantial/maximal assistance from staff with upper and lower body dressing and used a wheelchair for mobility.</p> <p>Record review of Resident #13 care plan dated 08/12/22 reflected she had a self-care deficit related to her Paralytic syndrome and required assistance of staff with her ADLs. Interventions were to encourage the resident to fully participate possible with each interaction.</p> <p>In an interview and observation on 08/06/24 11:28 AM, Resident #13 was sitting up in her wheelchair in her room. There was a portable air conditioning unit placed in front of her closet door. There was a large hose running from the unit to the window on the right-hand side of the unit. Resident #13 stated she had right sided paralysis and was unable to use her right hand and arm. She stated she had to move the portable air conditioning unit that was placed in front of her closet door to get to her clothing. She stated moving the air conditioning unit was difficult because she was unable to use her right hand. She states it was very inconvenient and made it difficult to get clothing out.</p> <p>2. Record review of Resident #17 undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #17 had a diagnosis of End stage renal disease (a failure of the kidneys), Heart Failure, and Type 2 diabetes Mellitus (elevated blood sugars).</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #17 quarterly MDS dated [DATE] reflected BIMS score of 14 indicating Resident #17 was cognitively intact. Section GG Functional Abilities and Goals of the MDS reflected Resident #17 required moderate/maximal assistance from staff with upper and lower body dressing and used a wheelchair for mobility.</p> <p>Record review of Resident #17 care plan dated 12/28/23 reflected she had a self-care and required assistance of staff with her ADLs. Interventions were to encourage the resident to fully participate possible with each interaction.</p> <p>In an interview and observation on 08/06/24 at 10:32 AM with Resident #17, she was laying in her bed. There was an electrical cord running from her window unit air conditioner on the left-hand side of the closet door to the right-hand side of the closet door to the electrical plug in. The cord was approximately 3 feet up from the floor obstructing the access to the closet. Resident #17 stated she and staff will unplug the cord and then plug it back in when she was done getting in and out of her closet. This caused her room to become warm when disconnected for short periods of time.</p> <p>3. Record review of Resident #63 undated face sheet reflected she was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #63 had a diagnosis of chronic kidney disease (a failure of the kidneys), Type 1 diabetes (elevated blood sugars), and Hypertension (elevated blood pressure).</p> <p>Record review of Resident #63 Fall Brief Interview for Mental Status dated 07/12/24 reflected. Resident #63 had a BIMS score of 13 indicating her cognition was intact</p> <p>Record review of Resident #63 Fall Risk Evaluation dated 07/12/24 reflected a fall risk score of 11 indication Resident #63 was at high risk for falling. The evaluation also reflected resident #63 had a balance problem while standing a balance problem while walking or sitting. Resident #63 required assistance of a person furniture, wall, or device when ambulating.</p> <p>Record review of Resident #63 care plan dated 09/11/22 reflected he had an alteration in musculoskeletal status r/t lumbar/rib fractures post fall. Resident #63 had an intervention to monitor/document for risk of falls. Educate resident, family /caregivers on safety measures that need to be taken to reduce risk of falls. Encourage/supervise/assist the resident with the use of supportive device of walker as recommended.</p> <p>In an interview and observation with Resident #63 on 08/06/24 at 11:40 AM, Resident #63 was ambulating in his room with the use of his walker. There was an air conditioner cord draped approximately 3 feet from floor from the right side of the closet across the door to the left side of the closet door. The cord was obstructing resident from getting into his closet. Resident #63 stated he must unplug the cord to get into his closet. He stated he occasionally forgets to plug it back in causing room to get warm. Resident #63 stated he is off balance occasionally and has a history of falls.</p> <p>In an interview on 08/07/24 at 1:18 PM, LVN B stated the CNAs generally get the resident clothing from closets. She stated if a resident or staff needed in the closet, the staff or resident would have unplugged the cord running across the center of the door for the air conditioner unit turning off the unit. LVN B stated the cord could cause a trip hazard for residents.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an Interview with the Maintenance Director on 08/07/24 at 2:59 PM, he stated he was responsible for installing the air conditioner units. He stated he could have run an extension cord with a surge protector around the resident's door frames to avoid running the cord across the center of the door. He stated the facility just started putting the portable and window air conditioner units in the residents' rooms. The Maintenance Director stated the facility's main air conditioners were working as hard as they could to cool the building. He stated would not know about the negative effects of a cord running across the center of the bathroom door frame would have on the residents. The Maintenance Director stated it could be an unnecessary task that they, either the resident or staff, would have had to complete causing an obstacle for her/him to get in closets.</p> <p>In an interview with the ADM on 08/07/24 at 3:24 PM, he stated it was not acceptable to have the electrical cords running across the center of the closet doors in that fashion. The ADM stated it was unsafe for the residents. He stated it just stinks; it is not a safe appropriate home like environment.</p> <p>Record review of facility policy titled Bedrooms dated May 2017 reflected all residents are provided with clean comfortable and safe bedrooms that meet federal and state requirements. 4. Each resident was provided with his or her own personal closet with clothes racks and shelves accessible to the resident</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50176</p> <p>Based on observation, interviews, and record review, the facility failed to ensure residents were free from physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 20 residents (Resident #74) reviewed for freedom from physical restraints.</p> <p>The facility failed to ensure Resident #74 was free from restraint when Resident #74 was left sitting in a Geriatric (elderly) chair with the feeding tray fully attached throughout the day.</p> <p>This failure could unnecessarily inhibit the resident's freedom of movement or activity and could affect residents by placing them at risk of physical harm, pain, mental anguish, emotional distress, and serious harm.</p> <p>Findings included:</p> <p>Review of Resident #74's face sheet dated 08/06/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including degenerative disease of the nervous system (chronic conditions that damage and destroy parts of the nervous system), unspecified dementia, severe with agitation (a group of symptoms affecting memory, thinking, and social abilities), dysphagia (a condition with difficulty in swallowing food), and repeated falls.</p> <p>Review of Resident #74's quarterly MDS assessment, dated 07/12/2024, reflected a BIMS score of 00, indicating severely impaired cognition.</p> <p>Review of Resident #74's quarterly care plan, dated 08/06/2024, reflected no order for the Geri chair and tray. Resident #74 was at risk for falls due to deconditioning. Interventions included: anticipate and meet resident's needs; call light within reach; fall mats on both sides; follow facility fall protocol; physical therapy to evaluate and treat as ordered; record possible root causes of fall and remove any potential causes; bed in lowest position at night; 1/4 side rails to assist with bed mobility as ordered; handrails on walls; personal items within reach; and activities that minimize the potential for falls while providing diversion and distraction.</p> <p>Review of Resident #74's progress notes, orders, and assessments dated 06/18/2024 - 08/06/2024, reflected no order for the Geri chair and tray. There was not a Pre-Restraining Assessment, nor any entrapment assessment done. Multiple skin tears noted on both arms were noted as resident constantly moves his arms against the arm rests of the Geri chair.</p> <p>During the first observation on 08/06/2024 at 12:33 PM, Resident #74 was observed in the dining room sitting in a Geri chair with feeding tray attached to the chair and across his lap. Staff were observed assisting Resident #74 with feeding.</p> <p>During an observation on 08/06/2024 at 2:09 PM, Resident #74 was in the media/television room, sitting in Geri chair with the tray attached across his lap. He was observed to drift on and off asleep during observation. He did not respond to questions.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 08/06/2024 at 3:51 PM, Resident #74 was observed in the media/television room, sitting in Geri chair with the tray attached across his lap. Resident #74 was observed grabbing at the tray with both hands. He tried to move/remove it but was not successful. Resident was aware of surveyor but could not respond appropriately to questions.</p> <p>During an observation/interview on 08/07/2024 at 9:43 AM, Resident #74 was observed in the media/television room sitting in reclined Geri chair without the tray attached. He was sleeping, but then woke up and tried to get out of the chair. The surveyor (at the survey team suggestion) asked CNA B if the tray could be put back on for an observation to see if the resident could remove it and the CNA B went to get staff assistance.</p> <p>During an interview on 08/07/2024 at 10:10 AM with LVN C, the surveyor asked for the tray to be put back on Resident's #74 Geri chair to see if resident could remove the tray. LVN C stated she did not know where the tray was. It was not in the resident's room, and she asked other staff to look for it. After more than 10 minutes of staff searching for the tray, the surveyor told LVN C not to worry about it. The tray was not needed for observation. LVN C stated that she worked with Resident #74 for about 3 months. She stated that the resident was in the Geri chair with the tray attached all day when he was up and out of his room. She said the tray was removed yesterday because it was a restraint. LVN C stated that Resident #74 could not take it off. He had tried, but he was not able to remove it. Surveyor told her that other staff members said the resident could take off the tray. LVN C thought that happened when it was loose or a little broken, but she had never seen him be able to successfully take it off. LVN C stated that resident would try to take it off and he could not remove it. She stated that she was conflicted about the tray because she felt it was a restraint, but Resident #74's AR wanted it.</p> <p>During an observation of the dining room on 08/07/2024 at 1:00 PM, the ADM was observed walking by Resident #74 in dining room sitting in Geri chair with tray attached across resident's lap. The ADM observed to have no reaction, acknowledgement, or concern as he continued to walk by the resident.</p> <p>During an observation on 08/07/2024 at 1:06 PM, Resident #74 was observed in the dining room sitting in the Geri chair with the tray attached across his lap. Surveyor asked Resident #74 if he could take off the tray attached to his Geri chair and resident stated, Yes. Surveyor asked Resident #74 to demonstrate task and take off the tray. Resident #74 reached for the dining room table in front of him. Resident did not understand the request and did not know where the tray was located. Staff seated beside Resident #74 asked resident to take off the tray and put resident's hands on the tray. Resident could not remove the tray. Resident was observed grabbing and tugging at the tray with both hands and trying to move/remove it for 4 minutes but was not successful.</p> <p>During an observation on 08/07/2024 at 1:20 PM, staff in dining room attempted to move Resident #74 sitting in the Geri chair with the tray attached. Resident #74 yelled out. Repeated attempts by staff to move the chair were made with resident crying out and grimacing before staff removed the tray to reveal that the resident's legs were entrapped between the Geri chair seat and leg recliner. Staff rolled up the resident's pants and revealed a red mark near the left knee. When the staff asked Resident #74 if he was in pain and touched the red mark on the resident's leg, Resident #74 responded that it hurt. Staff asked if Resident #74 was in pain, and he replied Yes. Staff did not ask resident to rate his pain level.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 08/07/2024 at 5:45 PM, Resident #74 was observed in the media/television room. He was in the reclined Geri chair without the tray. His legs were bent at the knees with a pillow placed between the chair and his left knee, and he was sleeping.</p> <p>During an observation on 08/08/2024 at 4:09 PM, Resident #74's door was shut. Surveyor knocked, opened the door, and observed resident lying on the floor. The call light not within reach. His head was on the floor mat and his body was on the floor perpendicular to door. He was lying face up. He stated, I'm doing well, how are you? Surveyor called staff for assistance and watched as LVN D intervened. The resident denied pain. LVN D stated this was the second time he had fallen on 08/08/2024.</p> <p>During an interview on 08/06/2024 at 2:17 PM, CNA/CMA stated Resident #74 had the tray attached to his Geri chair to keep him from getting up and walking. He could not walk but would try to get up out of chair. She stated Resident #74 had a history of falling. CNA/CMA stated the tray was designed to keep resident in the chair. She stated they (the facility) was a no restraint facility. She stated that the resident could remove the tray and did so often. She stated Resident #74 would take the tray off the chair and put it on the floor.</p> <p>During an interview on 08/06/2024 at 3:51 PM, LVN A stated Resident #74 was at risk for falls because he could not walk, but he would frequently get out of his chair. When asked about the tray attached to the chair, LVN A stated she thought that it was provided by hospice because it was a restraint, and the facility did not do that. She said it was requested by Resident #74's AR because the resident tried to get up and walk. She stated the resident could remove the tray because she had seen him do that.</p> <p>During an interview on 08/06/2024 at 4:35 PM, the DON stated she was not aware of any residents having a Geri chair with a tray attached to it. When asked about the Resident #74, the DON stated that the Resident #74's AR had concerns about the resident being in a high back chair. The DON stated that the resident's chair with the tray across it must have come from hospice. The DON stated she was not aware of how hospice communicated with the facility but thought they did it via phone or in person. The DON stated that it was the facility staff that took care of Resident #74 that placed him in the chair with the tray attached. The DON stated that the tray would need a doctor's order, family consent, and would need to be listed in the care plan. The DON confirmed that the tray table was not listed in Resident #74's care plan, because the DON was not even aware of it.</p> <p>During an interview on 08/06/2024 at 4:35 PM, the ADM stated he was not aware of any residents having a Geri chair with a tray attached to it. When asked if he would consider that a restraint, he replied, Yes if the resident could not remove it or get out of the chair, it would be a restraint. He stated that the chair with the tray for the resident should be listed in the care plan and normally they would get consent from the doctor and the family for the tray and have it in the resident's chart. He stated that it was the facility's responsibility because the resident was in their care. If hospice had approved the tray, then he would need to have the facility's physician approve it and then provide specialized training to staff about caring for resident. He stated that staff have annual in-service training on restraints and he, as the administrator, would be responsible for training the staff. When asked about how he would monitor a resident in a Geri chair with a tray, he stated that staff would do walk arounds each morning to monitor for change in condition. They also had quarterly QAPI meeting. He stated that he needed timely communication between hospice and the facility about something like a Geri chair with a tray attached and there needed to be an order in the file.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/06/2024 at 4:49 PM, the ADM stated he had immediately removed the tray attached to Resident #74 Geri chair.</p> <p>During an interview on 08/07/2024 at 8:05 AM, the ADM confirmed that there was no order nor consent for the Geri chair, or the tray attached in Resident #74's file. The ADM stated that the family had hospice bring it in, but he was ultimately responsible for it and the resident's care. The ADM stated that the potential for harm to the resident was psychological harm due to feeling trapped if the resident could not remove the tray.</p> <p>During an interview on 08/07/2024 at 9:11 AM, the Hospice RN revealed he ordered the Geri chair because a nurse at the facility asked him to (could not recall name of nurse). They ordered the chair because it was a better, more comfortable chair since the Resident #74 stayed in the chair all day. It was easy to move. The chair came with the tray. It was not needed unless the resident was eating. RN A stated the tray would be a permanent restraint because the resident did not have the cognition to release it and take it off. Two weeks ago, when the RN A visited the resident, he stated the tray was not on.</p> <p>During an interview on 08/07/2024 at 12:28 PM, the SW stated he was unaware that Resident #74 had a tray on his Geri chair full time for approximately three months. Social worker stated that the tray could cause psychosocial damage to the resident because it could have made Resident #74 feel trapped, frustrated, angry, stressed, and anxious. It was not the correct device to be used to assist the resident and other avenues should have been explored because the restraint could affect the resident's mental health in a negative manner. He stated the tray, which was a hard surface that Resident #74 could not push or move away from his body, could have had a negative outcome.</p> <p>During an interview on 08/07/2024 at 5:35 PM in the facility, Resident #74's AR confirmed that hospice ordered the chair, and it came with a tray. The AR stated the chair with the tray was wonderful and it kept Resident #74 safe by not allowing him to get up when it was reclined and when the tray was attached. When Resident #74 felt the need to urinate or have a bowel movement, he tried to get up and he did not have any strength in his legs, and he would fall. The AR stated she requested the facility use the tray as a restraint to keep the resident from getting out of the chair so he would not fall. The AR confirmed the resident could not remove the tray, but stated he tried all the time. The AR stated Resident #74 would pull and shake the tray while trying to remove it. The AR stated it made Resident #74 feel frustrated because he could not remove the tray. He would get upset and frustrated because the tray prevented him from moving and bending his legs, which he enjoyed. The AR stated she wanted the tray always used when Resident was in the chair. She stated other inventions included a side rail on bed, fall mats, bed in lowest position, and mechanical mattress positioned which prevented resident from getting out of bed, and medication (Lorazepam/Ativan oral tablet 1 MG) to sedate resident. The AR stated that the resident was given Ativan today because he was agitated, and the medication was designed to control his behavior and sedated him, so he would not get up out of chair.</p> <p>During an interview on 08/08/2024 at 8:25 AM, the NP stated Resident #74 was in a Geri chair ordered by hospice. She was not aware that the tray was attached and engaged. NP stated that a Geri chair with a tray table across the lap would be very unusual. She stated a doctor would not approve an order for that because it would be a restraint. She stated Resident #74 did not have the physical strength nor the cognition to be able to remove the tray. She stated the tray should not be used with resident as it was a restraint.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/08/2024 at 10:56 AM with Hospice, RN A stated Lorazepam 1 MG was prescribed for anxiety, restlessness, and agitation related to the diagnosed of severe dementia and delirium. He stated that Resident #74 had been doing well and had not needed that medication lately. It was prescribed as needed and he believed it was appropriate to use if the resident was agitated, anxious, or restless. The side effects included drowsiness and sedation. He also confirmed that the order for the Geri chair was just for the chair, not the tray. He visited once a week and sometimes the tray was on, and sometimes it was off.</p> <p>Record review of the Facility's Use of Restraints policy last revised December 2007 and an undated policy Physical Restraints both stated the facility was to maintain a restraint free environment. Restraints shall only be used for the safety and well-being of the residents(s) and only after other alternatives have been unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience or for the prevention of falls. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restricts freedom of movement or restricts normal access to one's body. Examples of devices that are/may be considered physical restraints include . Geri-chairs with lap table and recliner chair with lap table that the resident cannot remove. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident's safety, and help the resident attain the highest level of his/her physical or psychological well-being. Prior to restraint use, a Pre-Restraining Assessment must be conducted. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.</p> <p>Record review of a facility policy, titled Abuse Prevention Program last revised December 2016, revealed: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from . physical or chemical restraint not required to treat the resident's symptoms.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</p> <p>Based on interview and record review, the facility failed to implement their written policies and procedures regarding prohibiting and preventing abuse and for one (Resident #11) of twenty residents reviewed for developing and implementing abuse and neglect policies.</p> <p>The facility failed to implement and utilize the following two facility abuse and neglect policies; abuse investigation and reporting policy and abuse prevention and reporting policy when; 1) they did not report an allegation of rape reported to two State of Texas and the facility administrator reported by Resident #11. 2) Immediately notify police of the alleged allegations and take action to protect Resident #11 from possible physical and emotional abuse. By failing to implement these policies, the facility failed to; 3) Identify and assess all possible incidents of abuse and investigate and report all allegations of abuse within timeframes required by federal requirements.</p> <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 08/12/24 at 11:33 AM. While the IJ was removed on 08/13/24 at 5:30 PM, the facility remained at a level of actual no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure placed residents at risk of undetected abuse, trauma, and/or decline in feelings of safety and well-being or psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #11's face sheet, dated 08/09/2024, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paraplegia, unspecified intracranial injury (injury to the brain caused by an external force), diffuse traumatic brain injury with loss of consciousness (a medical condition when the brain quickly moves inside the skull as a result of a traumatic injury), mild neurocognitive disorder (brain condition causing mild or sever cognitive decline), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), bipolar disorder (a mental health condition that causes extreme mood swings between depression and mania or hypomania), major depressive disorder (a mood disorder that causes persistent sadness and loss of interest), and unspecified psychosis (a collection of symptoms where there is a loss of contact with reality).</p> <p>Review of Resident #11's MDS assessment, dated 06/21/2024, reflected a BIMS of 13, indicating cognition intact.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #11's care plan, dated 08/09/2024, an entry dated 03/13/2024 that reflected, Resident #11 has a history of making false allegations/inaccurate statements as evidenced by previously accusing/stating: They raped me. Resident #11 claimed on 03/11/2024 that people come into his room all the time and rape him. All allegations investigated and reported to administrator and was unfounded. Resident #11 was unable to explain any details or names, only repeats original statement. Interventions include, If statements are determined to be inaccurate, staff will reorient and redirect as needed with reassurance and reality orientation. Involve Ombudsman as a liaison between facility staff and Resident #11 as needed. Listen openly to allegations/inaccurate statements made by Resident #11 and offer clarification as needed.</p> <p>Review of Resident #11 psychiatric subsequent assessment, dated 07/12/2024 and signed by PMHNP, reflected Resident #11 stated, I'm fine. Resident seemed anxious, guarded, and suspicious of others. Nursing staff report that resident continues to have paranoid and persecutory delusions, recently was seen posturing at staff and accusing staff of raping him at night. A multidisciplinary team meeting was held on 07/12/2024 to discuss GDR of psychotropic medications, and to provide support and to manage any concerns or follow up if resident has behavioral or mood changes that arise during care. Team members present at the meeting included DON, ADON, SW, PMHNP, and (psychiatric services) Regional Account Manager. Seroquel was increased to 50 mg to target systems.</p> <p>Review of Resident #11 psychiatric subsequent assessment dated [DATE] signed by PMHNP, reflected Resident #11 was seen at staff request. Resident was irritable and guarded. Staff reported a history of paranoia and resident complains of being raped at night.</p> <p>Review of Resident #11 psychiatric subsequent assessment dated [DATE] signed by PMHNP, reflected Resident #11 was seen by staff request regarding complaints of being raped at night. Resident #11 stated, Everyone knows what they are fucking doing to me. Review of chart showed staff report a history of paranoia, and persecutory delusions of being raped at night. Resident #11 had recently, reported to the administrator that he is being raped at night. It is not the nurses, it is the aides, they will not sit me right in the bed. Resident #11 was angrily staring at provider, more irritable and anxious with frequent use of curse words.</p> <p>During an interview on 08/09/2024 at 12:04 pm, Resident #11 came into the conference room where two HHSC investigators were working and stated he was raped; it happened all the time and everyone knew about it. He did not give any specifics regarding perpetrators, dates, or locations. He made a statement about how he was being positioned when staff changed him, and he could not see what staff were doing to his body. When we told him we were going to investigate it, he said y'all aren't going to do anything about it.</p> <p>During an interview on 08/09/2024 at 12:11 pm, HHSC investigators notified the ADM of Resident #11's rape allegation.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/10/2024 at 12:32 pm, ADM stated to the HHSC investigators that after he learned about Resident #11's allegation of rape, he immediately went to speak with Resident #11 who said that he was not raped. The ADM stated that resident (Resident #11) told him he wants to be repositioned differently. The ADM said he then spoke with the facility PMHNP, who completed an assessment with Resident #11. The ADM stated that the facility PMHNP told him that Resident #11 said he was not raped but wanted different positioning. The ADM said he asked residents on the hallway if they felt safe and they said yes. The ADM said because he spoke with Resident #11 who stated he was not raped, and the PMHNP said that Resident #11 said that he was not raped, that he would not make a report of abuse and neglect to HHSC. At that time, ADM had not entered a report in Resident #11's progress notes about speaking with Resident #11. There ADM did not, in accordance with facility policy, provide any supporting documents relative to the alleged incident, either inform or keep the resident and his/her representative (sponsor) informed of the about Resident #11's allegations or progress of the investigation or take measures to protect the safety and privacy of the resident. The ADM did not inform the police of the alleged crime or discuss with Resident #11 or his representative the procurement of a SANE exam (Sexual Assault Nurse Examiner exam, is a medical forensic exam that collects evidence and provides healthcare services after a sexual assault). The ADM did not, in accordance with facility policy, interview the resident's attending physician, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview the resident's family members, and visitors or review all events leading up to the alleged incident.</p> <p>During an interview on 08/10/2024 at 1:13 pm, when asked if Resident #11 was still being raped, Resident #11 said, yea, all the time and everyone knows about it. When asked if the ADM asked if he was raped, he said no, and said the ADM spoke to him about how to do things better or some shit. When asked a second time if the ADM asked him if he was being raped, Resident #11 said, they just want to mess with my mind and they don't do things the right way they just want to hurt my bottom. Resident #11 said the aides manhandle him and he stated everyone knows he was being raped.</p> <p>During an interview on 08/12/2024 at 8:55 am, the ADM stated that he called HHSC/CII himself on 08/10/2024 at 6:31 pm and made the self-report about the sexual assault.</p> <p>During an interview on 08/12/2024 at 12:53 pm, the PMHNP stated that when he asked Resident #11 if he was raped, Resident #11 did not make a statement to him stating he was not raped. The PMHNP stated that Resident #11 said repeatedly that they (the facility staff) are not treating his body right and they are not positioning him on the bed right and it was the night aides that are doing it.</p> <p>During an interview on 08/13/2024 at 2:27 pm, the ADM stated that, abuse and neglect should be reported immediately and not more than two hours after the alleged event. The importance of reporting abuse was so allegations can be fully investigated. If it was not reported, and allegations were not investigated, it was possible that abuse existed and may continue to exist in the facility. The facility's abuse and neglect policy were that it was every employee's responsibility to make sure that the facility was an abuse free environment for all residents they served and that reports of abuse and neglect would be reported to the administrator, supervisor, and HHSC.</p> <p>Review on 08/10/2024 at 4:00 pm reflected facility records in TULIP on 03/11/2024; 07/12/2024; 08/02/2024; and 08/09/2024, did not reveal a self-report for the allegation of sexual abuse of Resident #11. (TULIP was a database utilized by the state to maintain licensing, demographic information, complaints, and self-reported incidents on assisted living facilities for the State of Texas.)</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review on 08/13/2024 of the Facility records in TULIP reflected a self-report email was sent to CII on 08/10/2024 at 6:12 pm, for the allegation of sexual abuse of Resident #11 made on 08/09/2024.</p> <p>Review of facility policy, undated, abuse investigation and reporting revealed:</p> <p>Policy Statement</p> <p>All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management.</p> <p>Findings of abuse investigations will also be reported.</p> <p>Policy Interpretation and Implementation</p> <p>Role of the Administrator:</p> <ol style="list-style-type: none"> 1. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. 6. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. <p>Role of the Investigator:</p> <p>The individual conducting the investigation will, as a minimum:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Review the completed documentation forms; 2. Review the resident's medical record to determine events leading up to the incident; 3. Interview the person(s) reporting the incident; 4. Interview any witnesses to the incident; 5. Interview the resident (as medically appropriate); 6. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; 7. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; 8. Interview the resident's roommate, family members, and visitors; 9. Interview other residents to whom the accused employee provides care or services; and 10. Review all events leading up to the alleged incident. <p>The following guidelines will be used when conducting interviews:</p> <ol style="list-style-type: none"> 1. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. 2. The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process. 3. If the ombudsman declines the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken. 4. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms <p>Reporting</p> <p>All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. The State licensing/certification agency responsible for surveying/licensing the facility; 2. The local/State Ombudsman; 3. The Resident's Representative (Sponsor) of Record; 5. Law enforcement officials; 6. The resident's Attending Physician; and 7. The facility Medical Director. 8. Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately. 9. Alleged abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately if the alleged events have resulted in serious bodily injury; 10. If events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours. 11. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone. <p>Notices will include, as appropriate:</p> <ol style="list-style-type: none"> 1. The name of the resident; 2. The number of the room in which the resident resides; 3. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.); 4. The date and time the alleged incident occurred; 5. The name(s) of all persons involved in the alleged incident; and 6. What immediate action was taken by the facility. 7. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. <p>Facility policy on abuse prevention program, undated, reflected:</p> <p>Policy Statement:</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Policy Interpretation and Implementation</p> <p>As part of the resident abuse prevention, the administration will:</p> <p>Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.</p> <p>Develop and implement policies and procedures to aid our facility in preventing abuse, neglect or mistreatment of our resident.</p> <p>Require staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.</p> <p>Investigate and report any allegations of abuse within timeframes as required by federal requirements; and</p> <p>Protect residents during abuse investigations.</p> <p>The ADM was notified on 08/12/24 at 11:33 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.</p> <p>The following POR was accepted on 08/12/24 at 4:49 PM:</p> <p>Plan of Removal</p> <p>On 08/12/2024 the surveyor provided an Immediate Jeopardy template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety.</p> <p>Removal of Immediacy Plan.</p> <p>The notification of Immediate Jeopardy stated as follows:</p> <p>Resident made allegations of sexual abuse on 3/11/2024 and 8/9/2024 and the allegations were not thoroughly investigated and reported to local, state, and federal agencies.</p> <p>Identified here are the steps and immediate actions facility was taking to address the non-compliance.</p> <p>Medical Director notified of immediate jeopardy. Completed 8/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Resident #1</p> <p>a. On 8/10/24 Director of Nursing called police called to report an allegation of rape. (Resident #11)</p> <p>b. On 8/10/24 at 6:12pm investigation initiated, Administrator reported to HHSC the allegation of rape.</p> <p>c. On 8/10/24 Director of Nursing sent Resident to hospital to receive a rape kit inspection.</p> <p>d. On 8/10/24 Administrator notified physician that Resident #1 has reported being raped, and the immediate response, interventions by staff personnel.</p> <p>Action taken: Reviewed documents confirming Administrator conducted resident safe surveys for both interviewable and non-interviewable residents and began in-servicing staff on abuse and neglect, reporting abuse without fear of retaliation, reporting abuse immediately, and actions to take if staff report abuse to the abuse and neglect coordinator and no action is taken.</p> <p>e. On 8/10/24 Director of Nursing called family to notify them of the allegation.</p> <p>Action taken - On 8/20/24, time unknown, telephone call with the resident's RP confirmed the facility contacted her about Resident #11's report of alleged abuse.</p> <p>f. On 8/10/24 Resident (#11) offered reassurance by the Director of Nursing. Psych services referral made by Director of Nursing on 8/11/24.</p> <p>Action Taken - On 08/21/24 reviewed Resident #11's progress notes and confirmed Resident #11 was offered reassurances by the DON and a psych services referral was made.</p> <p>2. All other Residents</p> <p>a. To be completed by 8/13/24, all interviewable Residents interviewed by Director of Nursing and Therapy Director to ensure their safety in the facility, and to report any concerns relating to their safety.</p> <p>Action Taken -Confirmed interviewable residents felt safe in the facility.</p> <p>b. To be completed by 8/13/24, non-verbal Residents visually assessed by the Director of Nursing for signs of abuse, fear or change in behavior. Signs of abuse may include grimacing, clenching of teeth, distress, moaning, groaning, yelling, guarding, intermittent body movements, or any other cues that could point to a change of condition.</p> <p>Action taken - Confirmed non-verbal Residents were asked if they feel safe in the facility.</p> <p>3. Administrator Training, in-servicing</p> <p>a. On 8/12/24 the Regional Nurse Consultant educated the Administrator on the importance of fully investigating allegations of abuse in order to ensure Resident safety as a top priority.</p> <p>(continued on next page)</p>		

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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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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Action taken - Confirmed, through an email from the Regional Nurse Consultant, the Administrator was re-educated on the company's abuse and neglect prevention policy and policy on reporting allegations of abuse timely and correctly, per the facility provider letter (TULIP, HOTLINE, EMAIL).</p> <p>On 8/12/24 the Administrator received education on facility's Chain of Command Policy reporting abuse up the chain in the facility.</p> <p>Action taken - On 08/21/24 confirmed, through an email from the Regional Nurse Consultant and interview with the Administrator that he passed the return demonstration test to demonstrate competency about the facility policy and proficient in his understanding of facility abuse and neglect and reporting and investigating abuse and neglect policies to proceeded to train the facility staff and staff who will assist training staff.</p> <p>5. Staff Training, in-servicing</p> <p>a. To be completed by 8/13/24, Administrator or a trained designee is in-servicing each staff, with a return demonstration test to confirm competence. Staff are required to come to the facility to complete their training and test. Staff out of town will complete their training virtually with a trained designee. Each current staff and newly hired staff will complete training before working their next shift in the facility.</p> <p>The chain of command policy stated:</p> <ol style="list-style-type: none"> 1. HEALTHCARE STAFF ARE MANDATED (TITLE 9) TO REPORT ABUSE, WITHOUT FEAR OF RETALIATION 2. SUSPECTED ABUSE IS REPORTED IMMEDIATELY TO YOUR SUPERVISOR AND ABUSE COORDINATOR 3. ABUSE IS TO BE REPORTED TO STATE WITHIN 2 HOURS. IF LEADERSHIP DOES NOT REPORT ABUSE, THERE IS AN HHS HOTLINE POSTED IN THE FACILITY AT ENTRANCE AND NURSE STATIONS 4. THE PERSON SUBMITTING ABUSE WILL NOTIFY <ol style="list-style-type: none"> a. HHSC b. POLICE c. OMBUDSMAN d. FAMILY e. PHYSICIAN 4. Follow up for effectiveness of the plan and auditing e. IDT meeting held 8/12/24 with Physician, DON, ADON and Administrator to ensure compliance with facility policy on abuse and neglect, training all staff to identify and report abuse. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Action taken - Received confirmation that IDT meeting was 8/12/24 with signatures from the Physician, DON, ADON and Administrator to ensure compliance with facility policy on abuse and neglect, training all staff to identify and report abuse</p> <p>f. For three months, Administrator or designee to audit weekly all incidents of abuse and confirm they are reported, investigated, and completed.</p> <p>g. All findings are presented to the quality assurance committee for continued tracking/trending, assessment, and timely intervention as is necessary. QAPI committee will review these processes for 3 months, or as long as is deemed necessary to promote a continued safe environment for all Residents free from all abuse and neglect.</p> <p>The Surveyor monitored the POR on 08/13/24 as followed:</p> <p>During interviews on 08/13/24 from 10:01 AM - 1:09 PM, one RN, three LVNs, 5 CNAs, 2 medication aides, the Therapy Directory, Business Office Manager, Dietary Manager, Dietary Aide, staffing coordinator, receptionist, and two housekeeping staff (from different shifts) all stated they were in-serviced and took a post-test before working their shifts. All were able to state that their ADM was the Abuse and Neglect Coordinator and give examples of different types of abuse such as physical, verbal, emotional, and psychosocial. All stated that if they would report any abuse or suspected abuse the facility abuse and neglect coordinator immediately and if action were not taken by the facility, they would report the incident to HHSC. All were knowledgeable about the location of the position in the facility with the HHSC reporting hotline telephone number. All stated they were aware that it was the responsibility of all healthcare workers to report abuse and neglect and the facility cannot retaliate against them for reporting abuse and neglect and they felt safe that the facility would not retaliate against them for reporting abuse and neglect.</p> <p>In an interview with the Administrator on 08/21/24, time unknown, investigator confirmed he passed the return demonstration test and demonstrate competency about the facility policy and was proficient in his understanding of facility abuse and neglect and reporting and investigating abuse and neglect policies.</p> <p>Review of in-services, dated 08/12/24 - 08/13/24 reflected staff from all shifts were in-serviced on ANE policy and procedures, the Abuse and Neglect Coordinator, reporting, healthcare staff are mandated to report abuse without fear of retaliation, suspected abuse is reported immediately to the supervisor and abuse coordinator, and if the abuse is not reported by leadership, there is an HHSC hotline posted in the facility at the entrance and nurses' stations.</p> <p>Review of Abuse Post-Tests, dated 08/12/24 - 08/13/24, reflected all staff completed the test with passing scores.</p> <p>While the IJ was removed on 08/13/24 at 5:30 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>Refer to CMS Form 2567, F dated /2023, for evidence of licensure violations.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654</p> <p>Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made for 1 of 20 residents screened for abuse (Resident #11).</p> <p>The facility failed to immediately report to the State Agency (within 2 hours) an allegation of sexual abuse made by Resident #11 on 03/11/2024 and 08/09/2024, and additionally when staff had knowledge of allegations of rape as reported to the PMHNP as collateral information on 07/12/2024 and 08/02/2024.</p> <p>This deficient practice delayed the investigation for the allegation and could have placed residents at risk for abuse and could have resulted in undetected abuse and/or decline in feelings of safety and well-being or psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #11's face sheet, dated 08/09/2024, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paraplegia, unspecified intracranial injury (injury to the brain caused by an external force), diffuse traumatic brain injury with loss of consciousness (a medical condition when the brain quickly moves inside the skull as a result of a traumatic injury), mild neurocognitive disorder (brain condition causing mild or sever cognitive decline), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), bipolar disorder (a mental health condition that causes extreme mood swings between depression and mania or hypomania), major depressive disorder (a mood disorder that causes persistent sadness and loss of interest), and unspecified psychosis (a collection of symptoms where there is a loss of contact with reality).</p> <p>Review of Resident #11's MDS assessment, dated 06/21/2024, reflected a BIMS score of 13, indicating cognition intact.</p> <p>Review of Resident #11's care plan, dated 08/09/2024, revealed an entry dated 03/13/2024 that reflected, Resident #11 had a history of making false allegations/inaccurate statements as evidenced by previously accusing/stating: They raped me. Resident #11 claimed on 03/11/2024 that people come into his room all the time and rape him. All allegations investigated and reported to administrator and was unfounded. Resident #11 was unable to explain any details or names, only repeats original statement. Interventions included, If statements are determined to be inaccurate, staff will reorient and redirect as needed with reassurance and reality orientation. Involve Ombudsman as a liaison between facility staff and Resident #11 as needed. Listen openly to allegations/inaccurate statements made by Resident #11 and offer clarification as needed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #11 psychiatric subsequent assessment, dated 07/12/2024 and signed by PMHNP, revealed Resident #11 stated, I'm fine. Resident seemed anxious, guarded, and suspicious of others. Nursing staff reported that resident continued to have paranoid and persecutory delusions, recently was seen posturing at staff and accused staff of raping him at night. A multidisciplinary team meeting was held on 07/12/2024 to discuss GDR of psychotropic medications, and provided support and managed any concerns or follow up if resident had behavioral or mood changes that raised during care. Team members present at the meeting included the DON, the ADON, the SW, the PMHNP, and [psych hospital] Regional Account Manager. Seroquel was increased to 50 mg to target systems.</p> <p>Review of Resident #11 psychiatric subsequent assessment dated [DATE] signed by the PMHNP, revealed resident was seen at staff request. Resident was irritable and guarded. Staff reported a history of paranoia and resident complained of being raped at night and said others were talking about him.</p> <p>Review of Resident #11 psychiatric subsequent assessment dated [DATE] signed by the PMHNP, revealed Resident #11 was seen per staff request regarding complaints of being raped at night. Resident #11 stated Everyone knows what they are fucking doing to me. Review of chart showed staff report a history of paranoia, and persecutory delusions of being raped at night. Resident #11 had recently reported to the administrator that he was being raped at night. It was not the nurses, it was the aides, they do not sit me right in the bed. Resident #11 was angrily staring at provider, more irritable, and anxious with frequent use of curse words.</p> <p>Review of Resident #11's progress note dated 08/11/2024 reflected a late entry effective 08/09/2024 that the ADM visited the resident to investigate the allegation of rape. Progress note reflected Resident stated he is not being raped; he wants different positioning from staff. The psych physician was in the facility and visited the resident after the administrator .psych physician reported to administrator that the resident is not reporting rape but is reporting that he wants to be repositioned differently .Without an allegation of rape from this alert resident with a BIMS of 14, and with the clarification that he is seeking a different approach with repositioning, there is no investigation founded for potential rape in the facility</p> <p>During an interview on 08/09/2024 at 12:04 pm, Resident #11 came into the conference room where two HHSC investigators were working and stated he was raped; it happened all the time and everyone knew about it. He did not give any specifics regarding perpetrators, dates, or locations. He made a statement about how he was being positioned when staff changed him, and he could not see what staff were doing to his body. When we told him we were going to investigate it, he said y'all aren't going to do anything about it.</p> <p>During an interview on 08/09/2024 at 12:11 pm, HHSC investigators notified the ADM of Resident #11's rape allegation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/10/2024 at 12:32 pm, the ADM reported to the HHSC investigators that after he learned about Resident #11's allegation of rape, he immediately went to speak with Resident #11 who said that he was not raped. The ADM stated that resident told him he wanted to be repositioned differently. The ADM said he then spoke with the facility PMHNP, who completed an assessment with Resident #11. The ADM stated that the facility PMHNP told him that Resident #11 said he was not raped but wanted different positioning. The ADM said he asked residents on the hallway if they felt safe and they said yes. The ADM said because he spoke with Resident #11 who stated he was not raped, and the PMHNP said that Resident #11 said that he was not raped, that he would not make a report of abuse and neglect to HHSC. At that time, the ADM had not entered a report in Resident #11's progress notes about speaking with Resident #11.</p> <p>During an interview on 08/10/2024 at 1:13 pm, when asked if Resident #11 was still being raped, Resident #11 said, yea, all the time and everyone knows about it. When asked if the ADM asked if he was raped, he said no, and said the ADM spoke to him about how to do things better or some shit. When asked a second time if the ADM asked him if he was being raped, Resident #11 said, they just want to mess with my mind and they don't do things the right way they just want to hurt my bottom. Resident #11 said the aides manhandle him and he stated everyone knew he was being raped.</p> <p>During an interview on 08/12/2024 at 8:55 am, the ADM stated that he called HHSC/CII himself on 08/10/2024 at 6:31 pm and made the self-report about the sexual assault.</p> <p>During an interview on 08/12/2024 at 12:53 pm, the PMHNP stated that when he asked Resident #11 if he was raped, Resident #11 did not make a statement to him stating he was not raped. The PMHNP stated that Resident #11 said repeatedly that they (the facility staff) were not treating his body right and they are not positioning him on the bed right and it is the night aides that are doing it.</p> <p>During an interview on 08/13/2024 at 9:40 am, the ADM stated that additional safe surveys were conducted with residents on 200 hall on 08/12/2024. Residents felt safe and had no concerns.</p> <p>During an interview on 08/13/2024 at 2:27 pm, the ADM stated that, abuse and neglect should be reported immediately and not more than two hours after the alleged event. The importance of reporting abuse was so allegations can be fully investigated. If it was not reported, and allegations were not investigated, it was possible that abuse existed and may continue to exist in the facility. The facility's abuse and neglect policy were that it was every employee's responsibility to make the facility an abuse free environment for all residents they served and that reports of abuse and neglect would be reported to the administrator, supervisor, and HHSC.</p> <p>Review of Safe Surveys, provided on 08/10/2024, reflected all residents were interviewed regarding their safety with no concerns.</p> <p>Review on 08/10/2024 at 4:00 pm of Facility records in TULIP on 03/11/2024; 07/12/2024; 08/02/2024; and 08/09/2024, did not reveal a self-report for the allegation of sexual abuse of Resident #11. (TULIP is a database utilized by the state to maintain licensing, demographic information, complaints, and self-reported incidents on assisted living facilities for the State of Texas.)</p> <p>Review of Resident #11's progress notes dated 08/10/2024 reflected the SW called Adult Protective Services and made a report of sexual abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review on 08/13/2024 of the Facility records in TULIP revealed a self-report email was sent to CII on 08/10/2024 at 6:12 pm, for the allegation of sexual abuse of Resident #11 made on 08/09/2024.</p> <p>Review of the facility's undated policy on abuse investigation and reporting reflected all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.</p> <p>1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:</p> <ol style="list-style-type: none"> 1. The State licensing/certification agency responsible for surveying/licensing the facility; 2. The local/State Ombudsman; 3. The Resident's Representative (Sponsor) of Record; 4. Adult Protective Services (where state law provides jurisdiction in long-term care); 5. Law enforcement officials; 6. The resident's Attending Physician; and 7. The facility Medical Director . <p>2. Suspected abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately.</p> <p>3. Alleged abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately if the alleged events have resulted in serious bodily injury.</p> <p>Record review of a facility policy, titled Abuse Prevention Program last revised December 2016, revealed: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. As part of the resident abuse prevention, the administration will: .</p> <p>7. Investigate and report any allegations of abuse within timeframes as required by federal requirements.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</p> <p>Based on interview and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated for one of twenty residents (Resident #11) reviewed for abuse and neglect, in that</p> <p>The facility had failed to conduct an investigation when there was an allegation of rape from Resident #11. The resident had approximately 3 other allegations of rape that the facility could not provide supporting documentation that those allegations were indeed investigated.</p> <p>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 08/12/24 at 11:33 AM. While the IJ was removed on 08/13/24 at 5:30 PM, the facility remained at a level of actual no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure placed residents at risk of undetected abuse, trauma, and/or decline in feelings of safety and well-being or psychosocial harm.</p> <p>Findings included:</p> <p>Review of Resident #11's face sheet, dated 08/09/2024, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paraplegia, unspecified intracranial injury (injury to the brain caused by an external force), diffuse traumatic brain injury with loss of consciousness (a medical condition when the brain quickly moves inside the skull as a result of a traumatic injury), mild neurocognitive disorder (brain condition causing mild or sever cognitive decline), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), bipolar disorder (a mental health condition that causes extreme mood swings between depression and mania or hypomania), major depressive disorder (a mood disorder that causes persistent sadness and loss of interest), and unspecified psychosis (a collection of symptoms where there is a loss of contact with reality).</p> <p>Review of Resident #11's MDS assessment, dated 06/21/2024, reflected a BIMS of 13, indicating cognition intact.</p> <p>Review of Resident #11's care plan, dated 08/09/2024, an entry dated 03/13/2024 that reflected, Resident #11 has a history of making false allegations/inaccurate statements as evidenced by previously accusing/stating: They raped me. Resident #11 claimed on 03/11/2024 that people come into his room all the time and rape him. All allegations investigated and reported to administrator and was unfounded. Resident #11 was unable to explain any details or names, only repeats original statement. Interventions include, If statements are determined to be inaccurate, staff will reorient and redirect as needed with reassurance and reality orientation. Involve Ombudsman as a liaison between facility staff and Resident #11 as needed. Listen openly to allegations/inaccurate statements made by Resident #11 and offer clarification as needed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #11 psychiatric subsequent assessment, dated 07/12/2024 and signed by PMHNP, reflected Resident #11 stated, I'm fine. Resident seemed anxious, guarded, and suspicious of others. Nursing staff report that resident continues to have paranoid and persecutory delusions, recently was seen posturing at staff and accusing staff of raping him at night. A multidisciplinary team meeting was held on 07/12/2024 to discuss GDR of psychotropic medications, and to provide support and to manage any concerns or follow up if resident has behavioral or mood changes that arise during care. Team members present at the meeting included DON, ADON, SW, PMHNP, and (psychiatric services) Regional Account Manager. Seroquel was increased to 50 mg to target systems.</p> <p>Review of Resident #11 psychiatric subsequent assessment dated [DATE] signed by PMHNP, reflected Resident #11 was seen at staff request. Resident was irritable and guarded. Staff reported a history of paranoia and resident complains of being raped at night.</p> <p>Review of Resident #11 psychiatric subsequent assessment dated [DATE] signed by PMHNP, reflected Resident #11 was seen by staff request regarding complaints of being raped at night. Resident #11 stated, Everyone knows what they are fucking doing to me. Review of chart showed staff report a history of paranoia, and persecutory delusions of being raped at night. Resident #11 had recently, reported to the administrator that he is being raped at night. It is not the nurses, it is the aides, they will not sit me right in the bed. Resident #11 was angrily starring at provider, more irritable and anxious with frequent use of curse words.</p> <p>During an interview on 08/09/2024 at 12:04 pm, Resident #11 came into the conference room where two HHSC investigators were working and stated he was raped; it happened all the time and everyone knew about it. He did not give any specifics regarding perpetrators, dates, or locations. He made a statement about how he was being positioned when staff changed him, and he could not see what staff were doing to his body. When we told him we were going to investigate it, he said y'all aren't going to do anything about it.</p> <p>During an interview on 08/09/2024 at 12:11 pm, HHSC investigators notified the ADM of Resident #11's rape allegation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/10/2024 at 12:32 pm, ADM stated to the HHSC investigators that after he learned about Resident #11's allegation of rape, he immediately went to speak with Resident #11 who said that he was not raped. The ADM stated that resident (Resident #11) told him he wants to be repositioned differently. The ADM said he then spoke with the facility PMHNP, who completed an assessment with Resident #11. The ADM stated that the facility PMHNP told him that Resident #11 said he was not raped but wanted different positioning. The ADM said he asked residents on the hallway if they felt safe and they said yes. The ADM said because he spoke with Resident #11 who stated he was not raped, and the PMHNP said that Resident #11 said that he was not raped, that he would not make a report of abuse and neglect to HHSC. At that time, ADM had not entered a report in Resident #11's progress notes about speaking with Resident #11. There ADM did not, in accordance with facility policy, provide any supporting documents relative to the alleged incident, either inform or keep the resident and his/her representative (sponsor) informed of the about Resident #11's allegations or progress of the investigation or take measures to protect the safety and privacy of the resident. The ADM did not inform the police of the alleged crime or discuss with Resident #11 or his representative the procurement of a SANE exam (Sexual Assault Nurse Examiner exam, is a medical forensic exam that collects evidence and provides healthcare services after a sexual assault). The ADM did not, in accordance with facility policy, interview the resident's attending physician, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview the resident's family members, and visitors or review all events leading up to the alleged incident.</p> <p>During an interview on 08/10/2024 at 1:13 pm, when asked if Resident #11 was still being raped, Resident #11 said, yea, all the time and everyone knows about it. When asked if the ADM asked if he was raped, he said no, and said the ADM spoke to him about how to do things better or some shit. When asked a second time if the ADM asked him if he was being raped, Resident #11 said, they just want to mess with my mind and they don't do things the right way they just want to hurt my bottom. Resident #11 said the aides manhandle him and he stated everyone knows he was being raped.</p> <p>During an interview on 08/12/2024 at 8:55 am, the ADM stated that he called HHSC/CII himself on 08/10/2024 at 6:31 pm and made the self-report about the sexual assault.</p> <p>During an interview on 08/12/2024 at 12:53 pm, the PMHNP stated that when he asked Resident #11 if he was raped, Resident #11 did not make a statement to him stating he was not raped. The PMHNP stated that Resident #11 said repeatedly that they (the facility staff) are not treating his body right and they are not positioning him on the bed right and it was the night aides that are doing it.</p> <p>During an interview on 08/13/2024 at 2:27 pm, the ADM stated that, abuse and neglect should be reported immediately and not more than two hours after the alleged event. The importance of reporting abuse was so allegations can be fully investigated. If it was not reported, and allegations were not investigated, it was possible that abuse existed and may continue to exist in the facility. The facility's abuse and neglect policy were that it was every employee's responsibility to make sure that the facility was an abuse free environment for all residents they served and that reports of abuse and neglect would be reported to the administrator, supervisor, and HHSC.</p> <p>Review on 08/10/2024 at 4:00 pm reflected facility records in TULIP on 03/11/2024; 07/12/2024; 08/02/2024; and 08/09/2024, did not reveal a self-report for the allegation of sexual abuse of Resident #11. (TULIP was a database utilized by the state to maintain licensing, demographic information, complaints, and self-reported incidents on assisted living facilities for the State of Texas.)</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review on 08/13/2024 of the Facility records in TULIP reflected a self-report email was sent to CII on 08/10/2024 at 6:12 pm, for the allegation of sexual abuse of Resident #11 made on 08/09/2024.</p> <p>Review of facility policy, undated, abuse investigation and reporting revealed:</p> <p>Policy Statement</p> <p>All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management.</p> <p>Findings of abuse investigations will also be reported.</p> <p>Policy Interpretation and Implementation</p> <p>Role of the Administrator:</p> <ol style="list-style-type: none"> 1. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. 6. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. <p>Role of the Investigator:</p> <p>The individual conducting the investigation will, as a minimum:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Review the completed documentation forms; 2. Review the resident's medical record to determine events leading up to the incident; 3. Interview the person(s) reporting the incident; 4. Interview any witnesses to the incident; 5. Interview the resident (as medically appropriate); 6. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; 7. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; 8. Interview the resident's roommate, family members, and visitors; 9. Interview other residents to whom the accused employee provides care or services; and 10. Review all events leading up to the alleged incident. <p>The following guidelines will be used when conducting interviews:</p> <ol style="list-style-type: none"> 1. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. 2. The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process. 3. If the ombudsman declines the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken. 4. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms <p>Reporting</p> <p>All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. The State licensing/certification agency responsible for surveying/licensing the facility; 2. The local/State Ombudsman; 3. The Resident's Representative (Sponsor) of Record; 5. Law enforcement officials; 6. The resident's Attending Physician; and 7. The facility Medical Director. 8. Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately. 9. Alleged abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately if the alleged events have resulted in serious bodily injury; 10. If events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours. 11. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone. <p>Notices will include, as appropriate:</p> <ol style="list-style-type: none"> 1. The name of the resident; 2. The number of the room in which the resident resides; 3. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.); 4. The date and time the alleged incident occurred; 5. The name(s) of all persons involved in the alleged incident; and 6. What immediate action was taken by the facility. 7. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. <p>Facility policy on abuse prevention program, undated, reflected:</p> <p>Policy Statement:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Policy Interpretation and Implementation</p> <p>As part of the resident abuse prevention, the administration will:</p> <p>Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.</p> <p>Develop and implement policies and procedures to aid our facility in preventing abuse, neglect or mistreatment of our resident.</p> <p>Require staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.</p> <p>Investigate and report any allegations of abuse within timeframes as required by federal requirements; and</p> <p>Protect residents during abuse investigations.</p> <p>The ADM was notified on 08/12/24 at 11:33 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided.</p> <p>The following POR was accepted on 08/12/24 at 4:49 PM:</p> <p>Plan of Removal</p> <p>On 08/12/2024 the surveyor provided an Immediate Jeopardy template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to the resident health and safety.</p> <p>Removal of Immediacy Plan.</p> <p>The notification of Immediate Jeopardy stated as follows:</p> <p>Resident made allegations of sexual abuse on 3/11/2024 and 8/9/2024 and the allegations were not thoroughly investigated and reported to local, state, and federal agencies.</p> <p>Identified here are the steps and immediate actions facility was taking to address the non-compliance.</p> <p>Medical Director notified of immediate jeopardy. Completed 8/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Resident #1</p> <p>a. On 8/10/24 Director of Nursing called police called to report an allegation of rape. (Resident #11)</p> <p>b. On 8/10/24 at 6:12pm investigation initiated, Administrator reported to HHSC the allegation of rape.</p> <p>c. On 8/10/24 Director of Nursing sent Resident to hospital to receive a rape kit inspection.</p> <p>d. On 8/10/24 Administrator notified physician that Resident #1 has reported being raped, and the immediate response, interventions by staff personnel.</p> <p>Action taken: Reviewed documents confirming Administrator conducted resident safe surveys for both interviewable and non-interviewable residents and began in-servicing staff on abuse and neglect, reporting abuse without fear of retaliation, reporting abuse immediately, and actions to take if staff report abuse to the abuse and neglect coordinator and no action is taken.</p> <p>e. On 8/10/24 Director of Nursing called family to notify them of the allegation.</p> <p>Action taken - On 8/20/24, time unknown, telephone call with the resident's RP confirmed the facility contacted her about Resident #11's report of alleged abuse.</p> <p>f. On 8/10/24 Resident (#11) offered reassurance by the Director of Nursing. Psych services referral made by Director of Nursing on 8/11/24.</p> <p>Action Taken - On 08/21/24 reviewed Resident #11's progress notes and confirmed Resident #11 was offered reassurances by the DON and a psych services referral was made.</p> <p>2. All other Residents</p> <p>a. To be completed by 8/13/24, all interviewable Residents interviewed by Director of Nursing and Therapy Director to ensure their safety in the facility, and to report any concerns relating to their safety.</p> <p>Action Taken -Confirmed interviewable residents felt safe in the facility.</p> <p>b. To be completed by 8/13/24, non-verbal Residents visually assessed by the Director of Nursing for signs of abuse, fear or change in behavior. Signs of abuse may include grimacing, clenching of teeth, distress, moaning, groaning, yelling, guarding, intermittent body movements, or any other cues that could point to a change of condition.</p> <p>Action taken - Confirmed non-verbal Residents were asked if they feel safe in the facility.</p> <p>3. Administrator Training, in-servicing</p> <p>a. On 8/12/24 the Regional Nurse Consultant educated the Administrator on the importance of fully investigating allegations of abuse in order to ensure Resident safety as a top priority.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Action taken - Confirmed, through an email from the Regional Nurse Consultant, the Administrator was re-educated on the company's abuse and neglect prevention policy and policy on reporting allegations of abuse timely and correctly, per the facility provider letter (TULIP, HOTLINE, EMAIL).</p> <p>On 8/12/24 the Administrator received education on facility's Chain of Command Policy reporting abuse up the chain in the facility.</p> <p>Action taken - On 08/21/24 confirmed, through an email from the Regional Nurse Consultant and interview with the Administrator that he passed the return demonstration test to demonstrate competency about the facility policy and proficient in his understanding of facility abuse and neglect and reporting and investigating abuse and neglect policies to proceeded to train the facility staff and staff who will assist training staff.</p> <p>5. Staff Training, in-servicing</p> <p>a. To be completed by 8/13/24, Administrator or a trained designee is in-servicing each staff, with a return demonstration test to confirm competence. Staff are required to come to the facility to complete their training and test. Staff out of town will complete their training virtually with a trained designee. Each current staff and newly hired staff will complete training before working their next shift in the facility.</p> <p>The chain of command policy stated:</p> <ol style="list-style-type: none"> 1. HEALTHCARE STAFF ARE MANDATED (TITLE 9) TO REPORT ABUSE, WITHOUT FEAR OF RETALIATION 2. SUSPECTED ABUSE IS REPORTED IMMEDIATELY TO YOUR SUPERVISOR AND ABUSE COORDINATOR 3. ABUSE IS TO BE REPORTED TO STATE WITHIN 2 HOURS. IF LEADERSHIP DOES NOT REPORT ABUSE, THERE IS AN HHS HOTLINE POSTED IN THE FACILITY AT ENTRANCE AND NURSE STATIONS 4. THE PERSON SUBMITTING ABUSE WILL NOTIFY <ol style="list-style-type: none"> a. HHSC b. POLICE c. OMBUDSMAN d. FAMILY e. PHYSICIAN 4. Follow up for effectiveness of the plan and auditing e. IDT meeting held 8/12/24 with Physician, DON, ADON and Administrator to ensure compliance with facility policy on abuse and neglect, training all staff to identify and report abuse. <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Action taken - Received confirmation that IDT meeting was 8/12/24 with signatures from the Physician, DON, ADON and Administrator to ensure compliance with facility policy on abuse and neglect, training all staff to identify and report abuse</p> <p>f. For three months, Administrator or designee to audit weekly all incidents of abuse and confirm they are reported, investigated, and completed.</p> <p>g. All findings are presented to the quality assurance committee for continued tracking/trending, assessment, and timely intervention as is necessary. QAPI committee will review these processes for 3 months, or as long as is deemed necessary to promote a continued safe environment for all Residents free from all abuse and neglect.</p> <p>The Surveyor monitored the POR on 08/13/24 as followed:</p> <p>During interviews on 08/13/24 from 10:01 AM - 1:09 PM, one RN, three LVNs, 5 CNAs, 2 medication aides, the Therapy Directory, Business Office Manager, Dietary Manager, Dietary Aide, staffing coordinator, receptionist, and two housekeeping staff (from different shifts) all stated they were in-serviced and took a post-test before working their shifts. All were able to state that their ADM was the Abuse and Neglect Coordinator and give examples of different types of abuse such as physical, verbal, emotional, and psychosocial. All stated that if they would report any abuse or suspected abuse the facility abuse and neglect coordinator immediately and if action were not taken by the facility, they would report the incident to HHSC. All were knowledgeable about the location of the position in the facility with the HHSC reporting hotline telephone number. All stated they were aware that it was the responsibility of all healthcare workers to report abuse and neglect and the facility cannot retaliate against them for reporting abuse and neglect and they felt safe that the facility would not retaliate against them for reporting abuse and neglect.</p> <p>In an interview with the Administrator on 08/21/24, time unknown, investigator confirmed he passed the return demonstration test and demonstrate competency about the facility policy and was proficient in his understanding of facility abuse and neglect and reporting and investigating abuse and neglect policies.</p> <p>Review of in-services, dated 08/12/24 - 08/13/24 reflected staff from all shifts were in-serviced on ANE policy and procedures, the Abuse and Neglect Coordinator, reporting, healthcare staff are mandated to report abuse without fear of retaliation, suspected abuse is reported immediately to the supervisor and abuse coordinator, and if the abuse is not reported by leadership, there is an HHSC hotline posted in the facility at the entrance and nurses' stations.</p> <p>Review of Abuse Post-Tests, dated 08/12/24 - 08/13/24, reflected all staff completed the test with passing scores.</p> <p>While the IJ was removed on 08/13/24 at 5:30 PM, the facility remained at a level of actual no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>Refer to CMS Form 2567, F dated /2023, for evidence of licensure violations.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Based on interview, and record review, the facility failed to develop a comprehensive person-centered care plan furnishing services to attain, or maintain, the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #61) reviewed for comprehensive care plans.</p> <ol style="list-style-type: none"> The facility failed to care plan Resident #61 right to refuse medication and refusals of medications prior to survey. The facility failed to care plan Resident #61 wishes to self-administer vitamin supplements prior to survey. The facility failed to accurately care plan Resident #68's diagnoses of malnutrition (protein or calorie) by care planning for a recommended diet for weight reduction and not weight gain. <p>This failure placed residents at risk of their needs having gone unmet.</p> <p>Findings included:</p> <p>Record review of Resident #61's undated face sheet reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident #61's had diagnoses which included Type 2 diabetes mellitus without complications (an impairment in the way the body regulates and uses sugar), Aortic Valve Stenosis (a thickening of the heart valves), and Congestive Heart Failure (a weakening of the hearts ability to sufficiently pump blood).</p> <p>Record review of Resident #61's comprehensive care plan dated 05/10/24 reflected he had Congestive Heart Failure with an intervention to give cardiac medications as ordered.</p> <p>Record review of Resident #61's MDS quarterly assessment, dated 07/08/24, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Section J of the same MDS reflected Resident #61 had occasional moderate pain.</p> <p>Record review of Resident #61's medication administration record dated 08/06/24 reflected that he had refused his Coreg, physician ordered medication 26 out of 31 days for the month of July 2024.</p> <p>Record review of Resident #61's medication administration record dated 08/06/24 reflected that he had refused his Coreg, physician ordered medication 6 out of 6 days for the month of August 2024.</p> <p>In an interview with Resident #61 on 08/06/24 at 10:52 AM he stated he did not believe in medication, and he wants to take his natural supplements only.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #68's face sheet, dated 08/08/24, admitted [DATE] and 07/27/24, documented an [AGE] year-old male diagnosed with unspecified protein-calorie malnutrition, anxiety, bilateral primary osteoarthritis of knee, limitation of activities due to disability, and need for assistance with personal care.</p> <p>Record review of Resident #68's initial MDS dated [DATE] reflected resident had a BIMS score of 6 indicating the resident was severely cognitive impaired. Section GG - Functional Abilities and Goals at Admission reflected Resident #68 had the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident, had no significant weight loss or gain, and did not require a mechanically altered diet. The MDS reflected that Resident #68 was 63 inches (5.25 feet) and weighed 124 pounds. Section I - Active Diagnoses reflected he had an active diagnoses of malnutrition (protein or calorie) or at risk for malnutrition.</p> <p>Record review of Resident #68's care plan reflected a focus dated 07/08/24 of nutritional problem or potential nutritional problem with a goal that Resident #68 would comply with recommended diet for weight reduction daily through review date and interventions if unsuccessful at weight loss, or if Resident #68 chooses not to lose weight, refer the physician and assist with obtaining special equipment as needed and monitor/document/report to the medical doctor for signs and symptoms of dysphagia, pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and appears concerned during meals.</p> <p>In an interview on 08/08/24 at 02:30 PM with the MDS coordinator who stated the IDT was responsible for creating the care plan. She stated refusal of medications and self-administration would be care planned if it was communicated to the IDT. She stated the care plans were revised every 90 days with the MDS review and assessment. The MDS coordinator stated the negative effects for not having an accurate care plan on the resident could include not being able to follow through with the care of the resident.</p> <p>In an interview on 08/08/24 at 02:07 PM with the DON who stated refusal of medications should be care planed as a behavior and self-administration of medications should be evaluated and care planed. She stated something could be missed related to the care of the resident.</p> <p>In an interview on 08/08/24 at 02:18 PM with ADM who stated the MDS coordinator was responsible for updating care plans, but our entire interdisciplinary team was responsible for the completed care plan. He stated refusal of medications and self-administration of medications should be care planned. He stated the care plan should be updated with every care plan meeting. He stated the care plan should be comprehensive and up to date. He stated the negative effects on Resident #61 for not having an accurate care plan was not receiving the care that was needed.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Care Plans, Comprehensive Person-Centered dated December 2016 reflected the comprehensive, person-centered care plan would describe the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. The Care Plan should describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights including the right to refuse treatment. The Care Plan would incorporate identified problem areas, incorporate risk factors associated with identifies problems, reflect the residents expressed wishes regarding care and treatment goals. Assessments of residents are ongoing, and the care plans are revised as information about the residents and the residents' conditions change.</p>		

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 08/13/2024
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</p> <p>Based on observation, interview, and record review the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal hygiene for 3 of 15 residents (Resident #79, Resident #66, and #68) reviewed for ADLs.</p> <p>The facility failed to ensure Residents #79 was provided assistance with ADLS and eating as documented in his plan of care which made him feel frustrated and that nobody cared about him.</p> <p>The facility failed to provide regular showers to Residents #66 and #68 in accordance with their plan of care.</p> <p>This failure could place residents at risk of weight loss, malnutrition, loss of dignity, and emotional distress.</p> <p>Findings included:</p> <p>Resident #79</p> <p>Record review of resident #79's face sheet, dated 08/08/24, admitted [DATE], documented an [AGE] year-old male diagnosed with Rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood, cirrhosis of liver, alcohol abuse, cataract, bilateral (clouding of the lens of the eye), schizoaffective disorder, bipolar type, idiopathic aseptic necrosis of left femur (a condition that causes bone tissue to die due to lack of blood supply) repeated falls, chronic angle-closure glaucoma, bilateral (a rare type of glaucoma that occurs when the anterior chamber angle of the eye narrows or closes, preventing the fluid that fills the eyeball from draining properly. This blockage causes pressure to build up in the eye, which can damage the optic nerve and lead to visual field loss).</p> <p>Record review of Resident #79's quarterly MDS dated [DATE] revealed resident had a BIMS score of 9 indicating the resident was moderately cognitively impaired. The MDS also revealed the resident had a diagnoses of other orthopedic conditions (arthritis and bursitis, affect the musculoskeletal system - most commonly the bones or joints causing pain and dysfunction, making normal daily activities difficult) hypertension, and viral hepatitis (an infection that causes liver inflammation and damage). Section B - Hearing, Speech, and Vision revealed resident is severely visually impaired and has no vision or sees only light, colors or shapes; eyes do not appear to follow objects. Section GG - Functional Abilities and Goals Eating revealed the resident needs setup or clean-up assistance. The helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. When eating, resident has the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.</p> <p>Record review of Resident #79's care plan revealed ADL intervention for self-care performance deficit related to the disease process of blindness and included eating interventions dated 11/29/23 that resident required feeding by CNA at each meal, the resident required total assistance to eat, and the resident required 1 staff participation to eat.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #79's lunch ticket dated 08/06/24 revealed red napkin, feeding and cutting assistance.</p> <p>Observation on 08/06/23 at 12:45 pm of Resident #79 revealed he was sitting alone at a lunch table reflected no red colored napkin on his tray or the table.</p> <p>Interview on 08/06/24 at 12:45 with RA A revealed the red napkin program was a program they had in place to alert the staff to residents who need assistance with meals.</p> <p>Interview and observation on 08/06/24 at 1:06 pm of Resident #79 revealed a CNA put a lunch tray on a bedside table for Resident #79 in his room and left the room. Resident #79 was seated in a wheelchair in front of the tray. He revealed to the surveyor he is blind, and the staff will not help him eat. He revealed they just set the tray down and leave and he always has to ask someone to come back to help and they never do. Resident #79 asked the surveyor to tell him where meatballs were. At 1:13 pm surveyor observed Resident #79 as he carried his lunch tray from his wheelchair to his door. He attempted to put his tray on the floor, and he fell over on his side.</p> <p>Observation on 08/07/24 at 12:50 pm of Resident #79 seated at a table in the dining room for lunch. Observed no staff present by Resident #79. Resident #79's had a piece of cake in front of him and it was covered in plastic wrap.</p> <p>Observation on 08/11/24 at 12:35 pm revealed Resident #79 seated at a table in the dining room eating catfish from a bowl with his hands. Set in front of resident was a serving of coleslaw and a serving of pudding, both covered in plastic wrap.</p> <p>Interview on 08/06 24 with at 3:39 pm CNA D stated Resident #79 could eat by himself; staff would put his plate in front of him and would take his hand and lightly touch his food. He normally ate in the dining room. After he touched his food, she came back and checked on him.</p> <p>Interview on 08/12/24 at 3:33 pm with Resident #79 revealed when they did not help him eat, it made him feel like they, don't give a damn about me. I couldn't find anything on my tray, no drink, no silverware, no food. They just laid it down and left. I am losing weight. Please help me.</p> <p>Interview on 08/09/24 at 2:28 pm with the DON who stated Resident #79 required one staff member to assist him to eat. She revealed he needed set up and he could feed himself. She revealed he should have never been left alone in his room with a tray to eat, it should never have happened because he would not be able to eat. He usually ate in the dining room. She revealed it would be upsetting to be blind and for someone put food in front of them and then leave. She is concerned that he did not getting the assistance he needed when the plastic was not taken off his cake because he would have a hard time getting the food and would feel frustrated. The resident would be less frustrated if he got more assistance.</p> <p>Residents #66 and Resident #68</p> <p>Record review of resident #66's face sheet, dated 08/08/24, admitted [DATE], 01/21/24, and 06/30/24 documented a [AGE] year-old female diagnosed with congestive heart failure, syncope and collapse, type 2 diabetes mellitus with hyperglycemia (a condition that occurs when there is too much glucose in the blood plasma).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #66's quarterly MDS dated [DATE] reflected resident had a BIMS score of 9 indicating the resident was moderately cognitively impaired. Section GG - Functional Abilities and Goals shower/bathe self reflected Resident #66 needed supervision or touching assistance, the helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity. Assistance might be provided throughout the activity or intermittently.</p> <p>Record review of Resident #66's care plan reflected Resident #66 had an ADL self-care performance deficit related to activity intolerance dated 10/27/2023 with interventions of ADL assistance of staff as needed per resident's needs. No care plan related to resident refusal reflected.</p> <p>Review of Resident #66's EMR from 07/10/24 through 08/08/24, a 29-day period, reflected Resident #66 received three showers.</p> <p>Interview on 08/06/24 at 2:46 pm with Resident #66 revealed she is not getting her showers.</p> <p>Record review of resident #68's face sheet, dated 08/08/24, admitted [DATE] and 07/27/24, documented an [AGE] year-old male diagnosed with anxiety, bilateral primary osteoarthritis of knee, limitation of activities due to disability, and need for assistance with personal care.</p> <p>Record review of Resident #68's MDS dated [DATE] reflected resident had a BIMS score of 6 indicating the resident was severely cognitive impaired. Section GG - Functional Abilities and Goals shower/bathe self-reflected Resident #68 needed shower/bathe self and reflected Resident #68 had the ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) and did not include transferring in/out of tub/shower.</p> <p>Record review of Resident #68's care plan reflected Resident #68 has an ADL Self Care performance deficit related to dementia dated 07/08/24 with intervention of Resident #68 required (1) staff participation with bathing. No care plan related to resident refusal reflected.</p> <p>Review of Resident #68's EMR from 07/09/24 through 08/07/24, a 29-day period, reflected Resident #68 received no showers.</p> <p>Interview on 08/09/24 at 4:37 pm with a family member of Resident #68 revealed when then picked him up from the facility, he was dirty.</p> <p>Interview on 08/09/24 at 5:50 pm with the DON revealed if a resident did not get their showers, the skin would not be monitored for skin breakdown and staff are not observing skin injuries.</p> <p>Review of facility shower/bath policy reflected the purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.</p> <p>Review of facility policy assistance with meals, undated, reflected residents shall receive assistance with meals in a manner that meets the individual need of each resident. The facility will serve trays and help residents who require assistance with eating.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility red napkin policy, dated 2024, revealed dietary staff and nursing staff place a red napkin on meal trays for residents who require feeding assistant to promote timely service and nutrition during mealtimes</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided consistent with professional standards of practice for 1 (Resident #5) of 8 residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #5's Oxygen tubing was changed every seven days and there was water filled in the humidifier daily.</p> <p>This failure could place all residents who use respiratory equipment at risk for respiratory complications including infections.</p> <p>Record review of Resident #5 undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had a diagnosis of Chronic Obstructive Pulmonary Disease (a disorder affecting the lungs making it difficult to breath), Hypertension (elevated blood Pressure), and Heart Failure.</p> <p>Record review of Resident #5s Admission MDS dated [DATE] reflected Bims score of 14 indicating Resident #5 was cognitively intact. Section GG of the MDS reflected Resident #5 required substantial/maximal assistance from staff with upper and lower body dressing and used a wheelchair for mobility. Section O (Special Treatments) of the same MDS reflected while a resident she used oxygen therapy.</p> <p>Record review of Resident #5s care plan dated 08/01/24 reflected she required oxygen therapy with a goal to have no symptoms of poor oxygen absorption through the review date.</p> <p>In an interview and observation with Resident #5 on 08/07/24 at 12:21 PM revealed Resident #5 was laying in her bed with oxygen on through an undated nasal canula. The oxygen humidifier (a bottle that supplies moisture in the oxygen) was out of water. Resident #5 stated the tubing was not changed and her empty humidifier was causing her nose irritation and dryness. Resident #5 stated the nurses were supposed to change the oxygen tubing weekly and check her water to make sure its full. She stated she wears her oxygen all the time because if she does not, she was short of breath. Resident #5 stated she has been wearing her oxygen since she was admitted to the facility.</p> <p>In an interview on 08/08/24 at 02:40 PM LVN B stated oxygen tubing and humidifiers were checked and changed, weekly every Sunday night. She stated Resident #5 required on oxygen all the time. She stated she was not sure why the tubing was not changed. LVN B stated the negative effects for Resident #5 not having her tubing changed or humidification could be risk for disease exacerbation or nose irritation.</p> <p>In an interview on 08/08/24 at 02:07 PM the DON stated oxygen tubing and humidifiers were checked and changed on Sunday evenings. She stated she was not sure who monitors the changing of tubing.</p> <p>The DON stated not having the tubing changed or water in Resident #5's humidifier could cause a disease exacerbation.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/08/24 at 02:18 the ADM stated oxygen concentrators were to be maintained. He said everything from the tube to the water. The ADM stated the program was monitored by the nursing department. He stated negative effects to a resident for not having their oxygen tubing changed and humidified would be changes in condition and low oxygen saturation.</p> <p>Record review of facility policy titled Departmental (Respiratory Therapy)-Prevention of Infection dated November 2011 reflected to check water levels of refillable humidifier units daily and change oxygen cannula and tubing every seven days or as needed.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Based on interview and record review, the facility failed to ensure residents' drug regimen were adequately monitored and free from unnecessary drugs for 1 (Resident #54) of 8 residents reviewed for pharmacy services.</p> <p>The facility failed to monitor Resident #54 for side effects/adverse reactions (bruising bleeding, dark black bowel movements) or the use of Eliquis (an anticoagulant medication- blood thinner) prior to survey.</p> <p>These failures could place residents at risk of bruising, and bleeding.</p> <p>Findings included:</p> <p>Record review of undated face sheet reflected Resident #54 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #54 had the following diagnoses of End Stage Renal Disease (kidney failure), Diabetes Type 2 (elevated blood sugars), Heart Failure, and Hypertension (elevated blood pressure).</p> <p>Record review of Resident #54s Quarterly MDS dated [DATE] reflected she had a BIMs score of 14 indicating resident was cognitively intact. The MDS also reflected Resident #54 required assistance with dressing and grooming and used a manual wheelchair for mobility. Section N of the same MDS indicated Resident #54 was taking an anticoagulant medication.</p> <p>Record review of Physicians Order Summary Report dated 08/08/24 for Resident #54 reflected an order for Eliquis (a blood thinner) to be given two times daily dated 04/06/24. Record review of the Order Summary also reflected there was no order for side effect monitoring of the Eliquis.</p> <p>Record review of Medication Administration Record (MAR) for the month of August 2024 reflected resident had received Eliquis two times daily. The MAR also reflected there was no monitoring for side effects in place related to the use of the Eliquis.</p> <p>In an interview on 08/08/24 at 02:40 PM LVN B stated the nursing staff did monitor for bruising and bleeding when residents were on anticoagulant. She stated that there was a standing order for monitoring that would be placed for all residents that were on an anticoagulant. She stated she was not sure why Resident #54 did not have monitoring for side effects of her anticoagulant. She stated that it may have been omitted with her recent readmissions from the hospital. She stated nurses are responsible for putting orders in to monitor for anticoagulant side effects. LVN B stated the negative effects for not monitoring for bruising or bleeding when on an anticoagulant are that the resident could have severe bleeding and the staff would not know about requiring medical attention.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/08/24 at 02:07 PM The DON stated nurses were instructed to check the skin for bleeding, dark bruising, side effects related to anticoagulant therapy. She stated she was not sure why Resident#54 was not monitored for bleeding and bruises. She stated nursing staff look for things that might have been overlooked and DON/ADON would fix it right away and update the order. She stated the negative effects for a resident on anticoagulants with no monitoring could have been the Resident's bleeding could be missed.</p> <p>Review of facility policy titled Medication and Treatment Orders dated January 2017 reflected orders for anticoagulation will only be prescribed with appropriate clinical and laboratory monitoring.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Based on observation, interview, and record review, the facility failed to maintain a medication administration error rate below 5% for 3 of 25 (error rate 12%) opportunities for errors during medication pass.</p> <p>1)The facility failed to administer Resident # 34 his folic acid tablet during the medication administration observation.</p> <p>2) The facility failed to administer Resident #76 his probiotic capsule and his men's multivitamin with minerals during the medication administration observation.</p> <p>This failure could place residents at risk of not receiving the intended therapeutic effects of medications.</p> <p>Findings included:</p> <p>1. Record review of undated face sheet reflected Resident #34 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #34 had the following diagnoses of Neuropathy (nerve pain), Chronic Viral Hepatitis (a condition causing liver failure), Muscle Weakness, and Delusional Disorder.</p> <p>Record review of Resident #34s Admission MDS dated [DATE] reflected she had a BIMs score of 14 indicating resident was cognitively intact. The MDS also reflected Resident #34 required assistance with dressing and grooming and used a manual wheelchair for mobility.</p> <p>Record review of Physicians Order Summary Report for Resident #34 reflected an order Folic Acid Oral Tablet 1 MG Give 1 tablet by mouth one time a day for supplement dated 07/02/24.</p> <p>In an observation on 08/07/24 at 8:04 AM with MA who prepared 08:00 am medications for Resident #34. The MA failed to administer Resident #34 Folic Acid tablet.</p> <p>2. Record review of undated face sheet reflected Resident #76 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #76 had the following diagnoses of Multiple Sclerosis (a chronic disease of the central nervous system), Urinary Tract Infections, Anxiety, and Depression.</p> <p>Record review of Resident #76s Quarterly MDS dated [DATE] reflected she had a BIMS score of 11 indicating resident had moderate cognitive impairment. The MDS also reflected Resident #76 required assistance with dressing and grooming and used a manual wheelchair for mobility.</p> <p>Record review of Physicians Order Summary Report for Resident #76 reflected an order for Probiotic Oral Capsule 1 capsule by mouth in the morning for Supplement dated 08/16/24 and Multivitamin Men 50+ Oral Tablet (Multiple Vitamins with Minerals) 1 tablet by mouth every day shift for supplement dated 06/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 08/07/24 at 8:39 AM MA prepared 8:00 am medications for Resident #76. The MA failed to administer Multivitamin Men's 50 plus oral tablet and Probiotic Oral capsule to Resident #76.</p> <p>In an interview on 08/07/24 at 8:53 AM MA stated she did not administer the over-the-counter medications (Folic Acid, Probiotic, and Multivitamin with Mineral) because she did not have them on her medication cart. She stated if a resident's medication were not available or out, she would let the resident and charge nurse know. She stated she would also notify medical supply so we can provide the medication as soon as possible. She stated negative effects of not having medications would be resident would not have the medications needed.</p> <p>In an interview on 08/07/24 on 9:37 AM LVN B stated if a resident were out of a medication the MA should inform the charge nurse. At that time, the changer nurse would order medication from the pharmacy to be delivered as soon as possible. If the medication were stock medication the over-the-counter medication should be obtained from the stock room. She stated the pharmacist comes in and they will check us off with med pass by observing the medication pass. The negative effects for residents not having the medications needed could be subtherapeutic levels of their supplemental needs.</p> <p>In an interview on 08/07/24 on 9:55 AM the DON stated if a resident were out of a medication, then it should be ordered from the pharmacy. If the medication was an over the counter, then the MA should get it from central supply or notify central supply to order medication. She stated the ma was checked off visually on medication pass quarterly. The DON stated she and the ADON were responsible for monitoring mars and tars to look for changes and ensure residents were getting their medications.</p> <p>Review of facility policy titled Administering Medications dated December 2021 reflected Medications shall be administered in a safe and timely manner and as prescribed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to self-administer medications and safely store medications in room if the IDT determined that the practice was clinically appropriate for one of eight residents (Resident #61) reviewed for medication self-administration.</p> <p>The facility failed to assess for IDT approval for Resident #61 to self-administer his medication and did not provide a secure area in the resident's room to store the medications prior to surveyor entry.</p> <p>This failure could place residents at risk of consuming unsafe medications.</p> <p>Findings included:</p> <p>Record review of Resident #61's undated face sheet reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident #61's had diagnoses which included Type 2 diabetes mellitus without complications (an impairment in the way the body regulates and uses sugar), Aortic Valve Stenosis (a thickening of the heart valves), and Congestive Heart Failure (a weakening of the hearts ability to sufficiently pump blood).</p> <p>Record review of Resident #61's MDS quarterly assessment, dated 07/08/24, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Record review of Resident #61's baseline care plan, dated 05/10/24, reflected the resident did not self-administer medications.</p> <p>Record review of Resident #61's comprehensive care plan dated 05/10/24 reflected there was no plan of care for self-administering of medications.</p> <p>Record review of Resident #61's physician order, dated 08/06/24, reflected there were no orders for Resident #61 to self-administer medications. The Physicians orders also reflected Resident #61 had the following medication ordered:</p> <p>Aspirin one time a day,</p> <p>Atorvastatin (a medication for elevated cholesterol) one time a day,</p> <p>Melatonin (a medication to assist with sleep) at bedtime,</p> <p>MiraLAX (a medication for constipation) in the Evening,</p> <p>Pantoprazole (a medication for stomach acid) every day,</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Coral Rehabilitation and Nursing of Austin		STREET ADDRESS, CITY, STATE, ZIP CODE 6909 Burnet LN Austin, TX 78757	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coreg (a medication for blood pressure) two times a day</p> <p>Docusate Sodium (a medication for constipation) two times a Day</p> <p>Senna Oral (a medication for constipation) two times a day</p> <p>Gabapentin (a medication for pain) three times a day</p> <p>Record review of Resident #61's medication administration record dated 08/06/24 reflected that he had refused his Aspirin, Atorvastatin, Pantoprazole, Coreg, and Gabapentin, physician ordered medications 6 out of 6 days for the month of August. He Had refused his melatonin 5 out of 6 days for the month of August.</p> <p>In an observation and interview on 08/06/24 at 10:52 AM with Resident #61 he had an unmarked purple weekly pill container with four round white medications in each contained area for seven days on top of his dresser. Resident #61 stated those were his vitamins. He stated he had them on top of his dresser since he moved into the facility 2 months ago. Resident #61 stated he kept them on top of his dresser, so he did not forget to take them. He stated no one had ever asked him about the vitamins. He stated he had not told staff, but he also did not hide his vitamin supplements either. He stated he would be moving rooms today due to his roommate was paranoid and had delusions that staff and other residents were out to get him. He reported the staff had assisted him with packing his belongings including his vitamin bottles.</p> <p>In an observation and interview on 08/06/24 at 10:59 PM with RN C, she stated Resident #61 did not normally take his own medications. The facility staff gave him his medications. She stated no one at the facility had set up his medication planner for Resident #61 and she was not sure what was in it. She stated the staff monitored for medications in rooms with routine rounds and were instructed to remove medications from the room if found. She then removed the pill planner from Resident #61's room.</p> <p>In an interview with the DON on 08/08/24 at 2:07 PM, she stated that new residents were educated on self-administration of medications on admission. The nurse practitioner would have made the decision if the resident was safe to self-administer their own medications. She stated Resident #61 would need to share with nursing staff what medications he was taking. The nursing staff should report medication information to the provider and screen for self-administration of medications. The provider would then determine if the resident could self-administer their own medications. She stated she was not aware Resident #61 was administering his own medications. She said self-administration of medications should have been addressed in the care plan and this would have informed all staff. The negative effects for the Resident #61 could have been poly pharmacy or negative drug interactions.</p> <p>Record review of facility policy titled Resident Rights dated March 2017 reflected Residents have the right to self-administer medication if the interdisciplinary care planning team determines it is safe.</p> <p>Record review of facility policy titled Self-Administration of Medications dated March 2017 reflected</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of their overall evaluation the staff and practitioner will assess each resident's mental physical abilities to determine whether self-administering medications is clinically appropriate for the resident.</p> <p>1. In addition to general evaluation of decision-making capacity the staff and practitioners will perform more specific skills assessment including the residents:</p> <ul style="list-style-type: none"> ability to read and understand medications labels. comprehension of the purpose and proper dosage and administration time for his or her medications ability to remove medications from the container and to ingest and swallow. ability to recognize risks and major adverse consequences of his or her medications. <p>8. Self-administered medication must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room, nursing staff will transfer the unopened medication to the resident when the resident request them.</p> <p>12. Nursing staff will review the self-administration record (MAR) kept at the nurses' station appropriately noting that the doses were self-administered.</p> <p>13. The staff and practitioner will periodically (for example during the quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708</p> <p>Based on interviews and records review, the facility failed to ensure that medical records were accurately documented for one (Resident #68) of twenty residents reviewed for accurate clinical records, in that:</p> <p>The facility failed to ensure Resident #68's medication administration record accurately reflected the medications Resident #68 received.</p> <p>Findings included:</p> <p>Record review of Resident #68's face sheet, dated 08/08/24, admitted [DATE] and 07/27/24, documented an [AGE] year-old male diagnosed with unspecified protein-calorie malnutrition, anxiety, bilateral primary osteoarthritis of knee, limitation of activities due to disability, and need for assistance with personal care.</p> <p>Record review of Resident #68's initial MDS dated [DATE] reflected resident had a BIMS score of 6 indicating the resident was severely cognitive impaired. Section GG - Functional Abilities and Goals at Admission reflected Resident #68 had the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident, had no significant weight loss or gain, and did not require a mechanically altered diet. The MDS reflected that Resident #68 was 63 inches (5.25 feet) and weighed 124 pounds. Section I - Active Diagnoses reflected he had an active diagnoses of malnutrition (protein or calorie) or at risk for malnutrition.</p> <p>Record review of Resident #68's care plan reflected a focus revised on 07/08/24 of impaired cognitive function/dementia or impaired thought processes related to dementia with an intervention dated 06/12/24 of administer medications as ordered, a focus revised on 07/08/24 of congestive heart failure with an intervention dated 07/08/24 of give cardiac medications as ordered, a focus revised on 07/08/24 with an intervention dated 07/08/24 administrator diabetes medication as ordered by doctor and monitor/document for side effects and effectiveness.</p> <p>Review of Resident #68's order for Lidoderm External Patch (Lidocaine) apply to left knee topically in the morning for OA (osteoarthritis) start date 06/07/2024 reflected on 07/04/24 a code 3, for absent from home, was entered. On 07/05/24, 07/11/24, 07/19/24, 07/26/24, and 07/27/14 there was no entry and no code entered for an explanation of why the medication was not given for these dates.</p> <p>Review of Resident #68's order for Memantine HCl Oral Tablet 10 MG (Memantine HCl) give 1 tablet by mouth one time a day for Dementia start date 05/29/2024 reflected on 07/04/24 a code 3, for absent from home, was entered. On 07/05/24 there was no entry and no code entered for an explanation of why the medication was not given for this date.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #68's order for Metformin HCl Oral Tablet 500 MG (Metformin HCl) give 1 tablet by mouth one time a day for DM 2 (diabetes mellitus type 2) start date 05/29/2024 reflected on 07/04/24 a code 3, for absent from home, was entered. On 07/05/24, 07/11/24, 07/19/24, 07/26/24, and 07/27/14 there was no entry and no code entered for an explanation of why the medication was not given for these dates.</p> <p>Review of Resident #68's order for Olmesartan Medoxomil Oral Tablet5 MG (Olmesartan Medoxomil) give 2 tablets by mouth one time a day for HTN (blood pressure) hold for SBP (systolic blood pressure) less than 110 HR less than 60 start date 05/29/2024 reflected on 07/04/24 a code 3, for absent from home, was entered. On 07/05/24, 07/11/24, 07/19/24, 07/26/24, and 07/27/14 there was no entry and no code entered for an explanation of why the medication was not given for these dates.</p> <p>Review of Resident #68's order for Tramadol HCl Oral reflected Tablet 50 MG (Tramadol HCl) give 1 tablet by mouth two times a day for OA start date 06/03/2024 reflected on 07/04/24 a code 3, for absent from home, was entered. On 07/05/24, 07/11/24, 07/19/24 at 7:00 pm there was no entry and no code entered for an explanation of why the medication was not given for these dates. On 07/19/24 at 8:00 pm the medication administration record reflects that the medication was administered. On 07/25/24 at 8:00 pm the medication administration record reflects a code of 13, for pending arrival from pharmacy. On 07/26/24 there was no entry and no code entered for an explanation of why the medication was not given for this date.</p> <p>Interview on 08/09/24 at 5:50 pm with the DON medication administration records should be accurately documented. The DON revealed, after a review of Resident #68's medication administration, that the records were not organized, and poor documentation could cause a change in resident condition to go unnoticed and a systemic failure of care. The DON revealed that the interdisciplinary team, consisting of the DON, ADON, the MDS coordinator, and the social worker are all part of the disciplinary team and are all responsible for the proper maintenance of resident records.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926</p> <p>Based on observations, interviews, and record review, the facility failed to 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 for 2 (Resident #57, and Resident #61) of 8 residents reviewed for infection control.</p> <p>The Medications Assistant failed to preform hand hygiene before and after medication administration between Resident #57, and Resident #61 61 during the morning medication pass.</p> <p>These failures have the potential to affect all residents in the facility by exposing them to care that could lead to the spread of viral or secondary infections and communicable diseases.</p> <p>Findings included:</p> <p>Record review of Resident #57's undated face sheet reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident #57's had diagnoses which included Unspecified Dementia (forgetfulness), Schizophrenia (a serious mental illness that affects how a person thinks), Depression, Malnutrition, Vitamin D Deficiency.</p> <p>Record review of Resident #57's MDS quarterly assessment, dated 07/01/24, reflected the resident had a BIMS score of 09, which indicated he had moderately impaired cognition. Section C of the MDS also reflected Resident #57 had disorganized thinking behavior that fluctuated.</p> <p>Record review of Resident #61's undated face sheet reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident #61's had diagnoses which included Type 2 diabetes mellitus without complications (an impairment in the way the body regulates and uses sugar), Aortic Valve Stenosis (a thickening of the heart valves), and Congestive Heart Failure (a weakening of the hearts ability to sufficiently pump blood).</p> <p>Record review of Resident #61's MDS quarterly assessment, dated 07/08/24, reflected the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Section J of the MDS reflected Resident #61 had occasional moderate pain.</p> <p>In an observation of medication administration on 08/7/24 at 08:21 am with the MA who was observed preparing for the 8:00 am medication rounds. The MA revealed that she was preparing to administer medications for Resident #57. The MA logged into the facility's EMR (electronic medical record) system, verified Resident #57's orders within her clinical record, unlocked her cart, located Resident #57's medications, placed the medications into a plastic medication cup, and closed and locked her medication cart. The MA along with the medications and a plastic cup of water, walked to Resident #57's room, and provided Resident #57 with the medications and water. The MA exited the room went back to the medication cart and immediately set up the 8:00 am medications for Resident #61. The MA did not clean her hands prior to setting up medications for Resident #57 or prior to setting up the medication for Resident #61.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/08/24 at 8:53 AM the MA stated hand sanitizer was used between each resident. She stated she just forgot today because she was being watched. She stated she was in-serviced on infection control weekly. The MA stated negative effects of cleaning/washing hands may lead to spreading germs.</p> <p>In an interview on 08/07/24 at 09:37 AM LVN B stated staff were expected, when passing medication, to sanitize hands between each resident. LVN stated not washing hands or cleaning hands may lead to spreading infections between residents.</p> <p>In an interview on 08/07/24 at 09:55 AM the DON stated yes, hands should be washed or cleaned with an alcohol-based hand sanitizer between each resident. She stated staff were educated on infection control-in-services quarterly and with daily reminders. She stated she was responsible for monitoring and training on infection control. The DON stated the negative effects of not washing hands between residents when administering medications was spreading infection.</p> <p>Review of facility policy titled Administering Medications dated December 2021 reflected staff shall follow established facility infection control procedures (handwashing, antiseptic techniques, gloves, isolation precautions) for the administration of medications as applicable.</p> <p>Review of facility policy titled Infection Control Guidelines for All Nursing Procedures dated August 2021 reflected If hands are not visibly soiled use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations including before preparing or handling medications.</p>