STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455554	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of McGregor	414 Johnson Dr MC Gregor, TX 76657

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 5 residents (Residents #1 & #2) reviewed for resident rights. The facility failed to ensure Resident #1 and #2's call lights were within reach on 08/07/2025. This failure could place residents at risk of their needs not being met. Findings include: Record review of Resident #1's admission record, dated 08/07/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: cerebrovascular disease (a condition that affect blood flow to the brain), type 2 diabetes mellitus without complications (a condition where the body either doesn't produce enough insulin or can't properly use the insulin it makes causing blood sugar levels to become too high) age related physical debility (natural decline in physical abilities that often come with aging), acute kidney failure (when your kidneys suddenly stop working properly), muscle wasting and atrophy (decrease in size and wasting of muscle tissues), and muscle weakness (decrease ability of muscles to contract and move). Record review of Resident #1's Quarterly MDS assessment, dated 06/24/2025, reflected the resident had a BIMS score of 04, which indicated severe cognitive impairment. Resident #1 required partial/moderate assistance in the areas of toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and putting on/taking off footwear. Record review of Resident #1's care plan, dated 08/07/2025, reflected Resident #1 was care planned for ADL self-care performance deficit r/t activity intolerance, decline in physical condition, stroke and had an intervention of encourage [Resident #1] to use bell to call for assistance. During an attempted interview and observation on 08/07/2025 at 9:36 AM., revealed Resident #1's call light was observed lying on the ground out of his reach near the bed of Resident #1's bed. Resident #1 sat in his wheelchair watching tv approximately 3 feet from his call light that was on the ground. Resident #1 could not be interviewed due to his cognitive impairment. Record review of Resident #2's admission record, dated 08/07/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: unspecified dementia mild without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (memory loss and thinking difficulties), cognitive communication deficit (difficulty with thinking and using language), muscle wasting and atrophy (the muscles are shrinking and losing strength), and hyperlipidemia (having high levels of fats including cholesterol and triglycerides in your blood.) Record review of Resident #2's Quarterly MDS assessment, dated 07/18/2025, reflected the resident had a BIMS score of 03, which indicated severe cognitive impairment. Resident #2 required partial/moderate assistance in the area of shower/bathe self. Resident #2 required supervision or touching assistance in the areas of oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene Record review of Resident #2's care plan, dated 08/07/2025, reflected Resident #2 was care planned for [Resident #2] needs staff participation with ADL's due to: DX Dementia/Cognitive loss and may refuse showers at times and Resident #2 has impairment cognitive function/dementia or impaired thought processes r/t dementia. During an interview and observation on 08/07/2025 at 9:37 AM., reflected Resident #2 was laying in bed while his call light was observed lying on the ground underneath his bed. CMA A was present at the time Resident #2's call light was observed underneath his bed. Resident #2 stated his call light was often out of his reach. Resident #2 stated he would have to go look for staff if he needed help. During an interview with CMA A on 08/07/2025 at 1:15 PM, CMA A stated that she observed Resident #2's call light was underneath his bed and out of his reach. CMA A stated that it was all staff responsibility to ensure resident's call light were always within reach. CMA A if a resident call light was not in reach, then the resident would not be able to call for assistance if they needed it. During an interview with CNA A on 08/07/2025 at 1:25 PM, CNA A stated the CNAs made rounds at least every two hours. CNA A stated during rounds CNAs checked to see if residents needed water, a snack, or if a resident needed to be changed. CNAs ensured the residents call lights were always within reach. CNA A stated there was no negative outcome of Residents #1 & #2 call lights not being within reach because both residents could come find staff if they needed help. During an interview with the DON on 08/07/2025 at 2:40 PM, the DON stated all residents' call lights should always be within reach. The DON stated it was everyone's responsibility to ensure residents' call lights were always within reach. The DON stated if a resident's call light was not within

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 5 residents (Resident #3) reviewed for comprehensive care plans Resident #3's comprehensive care plan did not reflect Resident #3 had fallen on 07/12/25 and 07/29/25. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans. Findings include: Record review of Resident #3's admission record, dated 08/07/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: vascular dementia (type of dementia caused by impaired blood flow to the brain, leading to brain cell damage and cognitive decline), depression (mental health condition where a person experiences persistent feelings of sadness, loss of interest in activities and difficulty with daily task), muscle weakness (reduced ability of the body to contract muscle properly, resulting in a lower strength in one or more muscle), lack of coordination (having difficulty controlling your movements and making them work together smoothly), unsteadiness on feet (feeling wobbly, off balance, or like you might fall while walking or standing) and repeated falls (falling more than once within a specific timeframe).Record review of Resident #3's Quarterly MDS assessment, dated 07/11/2025, reflected the resident had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #3 required supervision or touching assistance in the areas of shower/bather, upper body dressing, and lower body dressing. A record review of the facility's incident by incident type dated 08/07/25, reflected Resident #3 had falls on 07/12/25 and 07/29/25. A record review of Resident #3's progress notes dated 08/07/25, reflected on 07/12/25: [Resident #3] stated to this nurse 'I fell coming out the bathroom and hit something and landed on the floor'. This nurse asked resident how she got up off the floor, resident stated 'one leg at a time'. This nurse assessed skin no injuries to report.). On 07/29/25: Resident was on the floor in her bathroom by the door. Resident was unable to say what happened or what she was doing when she fell. No injuries noted.Record review of Resident #3's care plan, dated 08/07/2025, reflected Resident #3 was care planned for [Resident #3] is at risk for fall due to unsteady gait, decrease balance, medication, poor safety awareness. Resident #3 fall care plan focused was initiated on 04/26/22 and revised 04/29/22. Resident #3 care plan did not reflect her falls on 07/12/25 and 07/29/25. During an interview with Resident #3 on 08/07/2025 at 11:10am., Resident #3 stated she has fallen recently but did not remember the dates of her falls. Resident #3 stated her last fall was in the restroom. Resident #3 stated she was not injured during her falls. During an interview with the ADON on 08/07/2025 at 2:40 PM, the ADON stated that Resident #3 had fallen recently. The ADON stated that she updated the acute care plans during the morning meeting. The ADON stated that during the weekly standard of care meeting on Thursdays, the DON and MDS Coordinator should review and update the residents' care plans. The ADON stated if a resident's care plan was not updated with new fall interventions, then the staff would not know how to assist the resident appropriately. During an interview with the DON on 08/07/2025 at 3:05 PM, the DON stated it was the MDS Coordinator's responsibility for updating residents' care plans. The DON stated if a resident had fallen then new interventions should be implemented and therapy would pick the resident up for services. The DON stated she was not aware that Resident #3's care plan was not updated to reflect her most recent fall. The DON stated that the resident was being seen by therapy as an intervention, but that was not reflected on the resident's care plan. During an interview with the ADM on 08/07/2025 at 3:45 PM, the ADM stated that it was the MDS Coordinator's responsibility to update resident's care plans. The ADM stated that if a resident had fallen then the care plan was usually updated during the morning meeting the following day. The ADM stated she could not give a negative outcome without know the specific situation. The ADM refused to look at the Resident #3's progress notes or care plan during the interview. During an interview with the DCO on 08/07/2025 at 4:45 PM, the DCO stated if a resident had fallen then the resident's care plan should be updated to reflect the fall so new intervention could added to the care plan. The DCO if a resident's care plan was not updated then staff would not know what interventions to attempt to prevent the resident from falling. The DCO stated she expected for resident care plans to be updated to reflect resident fall so new intervention can be implemented appropriately. A record review of the facility's Comprehensive Care Planning policy, revised dated December 2016, reflected A comprehensive, person-centered care plan