STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455862	A. Building B. Wing	03/12/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39269 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 2 of 5 residents (Resident # 1 and #2) reviewed for a clean and homelike environment. The facility failed to ensure Resident #1 and #2's wheelchair was maintained. These failures could place residents at risk of living in an uncomfortable and unsafe environment, decreased feelings of self-worth, and a diminished quality of life. Findings included: 1. Review of Resident #1's face sheet, dated 03/12/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included acquired absence of left leg above the knee, heart failure, End stage renal disease, other osteomyelitis lower leg (Osteomyelitis -infection in the bone that can be cause by bacteria or fungal). It was reflected Resident #1 was in the facility from 02/19/2025 through 02/28/2025. Review of Resident #1's Admission MDS Assessment, dated 03/04/2025, reflected Resident #1 had a BIMS score of 15, which indicated he had no cognitive impairment. Review of Resident #1's Comprehensive Care Plan initiated 02/25/2025 reflected Resident #1 had osteomyelitis (Osteomyelitis -infection in the bone that can be cause by bacteria or fungal).of right lower leg and left above the knee Amputation: with interventions to Encourage weight bearing, exercise as tolerated to help maintain bone mass and Change position frequently. Alternate periods of rest with activity out of bed in order to respiratory complications, prevent dependent edema, flexion deformity and skin pressure areas. Review of the Maintenance Logs from 01/01/2025 thru 03/12/2025 reflected there was not a working order for Resident #1's wheelchair to be repaired or replaced. During a telephone interview on 03/12/2025 at 10:16 am, Resident #1 stated, They gave me a wheelchair from 1960s, it couldn't lock. I spoke with the Social Worker and told him the wheelchair could not lock and he stated it could lock. You can ask PT and OT about my wheelchair, they would tell. I never fell at the facility. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 10:43 a.m., the PTA stated one of the locks on Resident #1's wheelchair was loose, and the chair would move when Resident #1 stood up and she was not sure if Resident #1 was safe in that wheelchair. The PTA stated Resident #1 was an amputee, was able to stand and transfer and was safe while she was working with him. The PTA stated therapy staff were aware of Resident #1's wheelchair and also aware that most of them were old, had loose back/stretched, loose handles, leg rest missing. The PTA stated there was a maintenance logbook to document or they could notify the maintenance department verbally. During an interview on 03/12/2025 at 1:04 p.m., CNA A stated Resident #1's wheelchair was not a regular wheelchair; it was a wheelchair used for transportation only and Resident #1 was not able to move around in the wheelchair. During an interview on 03/12/2025 at 1:31 p.m., the OTR stated one of the brakes on Resident #1's wheelchair was loose or there was some problem of the wheelchair being hard to propel. She stated Resident #1 was not in the facility long and she really didn't work with him. The OTR stated usually they would document in the maintenance logbook or tell the maintenance staff whenever something was broken. She stated she was focused on Resident #1's activity and tolerance level and did not have to transfer Resident #1 to the wheelchair so she did not document in the maintenance logbook. During an interview on 03/12/2025 at about 1:49 p.m., the Social Worker stated Resident #1 told him his wheelchair was not working and it was wreck. The Social Worker stated Resident #1 said he spoke with the Assistant Maintenance Director who stated they didn't fix wheelchairs; they just replace wheelchairs. The Social Worker stated Resident #1 refused a new wheelchair. 2. Review of Resident #2's face sheet, dated 03/12/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Cerebral infarction, pre-glaucoma unspecified left eye, blindness right eye category 3, repeated falls, type 2 diabetes mellitus with unspecified complications (chronic condition where the body does not use insulin effectively, causing blood sugar levels to become too high because the cells cannot absorb glucose properly, leading to a buildup of sugar in the blood stream), unspecified lack of coordination (difficulty performing physical movements smoothly, accurately, and efficiently), muscle weakness- generalized (a condition that occurs when your muscles are unable to contract properly, resulting in a loss of strength), difficulty walking. Review of Resident #2's Quarterly MDS Assessment, dated 02/04/2025, reflected Resident #2 had a BIMS score of 14, which indicated he had no cognitive impairment. Review of Resident #2's Comprehensive Care Plan revised 10/28/2024 reflected Resident #2 had resident has impaired visual function pre-glaucoma and right eye blandness, resident had an ADL Self Care Performance Deficit. Review of facility's maintenance logbook on 03/12/2025 reflected a work order for Resident #2's wheelchair brake dated 02/27/2025 and it marked as being completed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 11:59 a.m., the Maintenance Director stated he was in the facility 3 days a week and the Assistant Maintenance Director was in the facility 7 days a week. The Maintenance Director stated the Maintenance department checked the maintenance logbook daily and address the problems in the book. He stated the maintenance depart never mark done until the work was completed. He stated work was completed based on priorities and emergencies. He stated fire, beds, wheelchairs, call lights was same day fixed due to the impact it might cause to the Residents. During an observation and interview on 03/12/2025 at about 12:05 p.m., Resident #2 was sitting in his wheelchair, stated there was a problem with his wheelchair brakes. Resident #1 also stated the left wheel of his wheelchair didn't lock when the brake was applied, and his wheelchair moved whenever he tried to stand up. Resident #2 demonstrated, and his wheelchair left wheels continued moving and when Resident #2 attempted to stand, the wheelchair moved, and the Maintenance Director had to hold Resident #2 to prevent him from falling. Resident #2 stated he told a facility staff and since then, his wheelchair had not yet been fixed. Resident #2 stated he had not fallen due to wheelchair malfunction. During an interview on 03/12/2025 at 12:09 a.m., the Assistant Maintenance Director stated he checked the maintenance logbook daily. He also stated the work order is marked DONE when the work is completed or when he had fixed the problem. The Assistant Maintenance Director stated he did not fix Resident #2's wheelchair, it was marked as completed by mistake. He stated when there was a problem with resident's wheelchair, it needed to be fixed the same day because it was an emergency, and a resident could fall due to broken wheelchair. During an interview on 03/12/2025 at 12:19 p.m., the Maintenance Director stated earlier, he was afraid Resident #2 was going to fall because his wheelchair wheel did not lock, and the wheelchair was moving when Resident #2 attempted to stand. The Maintenance Director stated Resident #2's wheelchair should have been a same day fix because it was considered an emergency. During an interview on 03/12/2025 at 1:04 p.m., CNA A said he was the one that documented in the maintenance logbook about a week and a half ago that Resident #2's wheelchair brake did not work. CNA A stated he checked in the maintenance logbook sometime on 03/06/2025 and realized Resident #2's wheelchair had not yet been fixed and he spoke with the Assistant Maintenance Director who stated he would address it. CNA A stated he had been afraid that Resident #2 would fall because of the wheelchair brake not working. During an interview on 03/12/2025 at 2:20 p.m., the Administrator stated if a resident shared maintenance issues with the staff, the staff were to notify the Maintenance department through documentation and verbally. The Administrator stated, depending on the situation, some repairs were on high priority level, examples were bed not working, restroom, wheelchairs, and they needed to be addressed completely. The Administrator stated, Maintenance should mark done after the job was completed. It is not safe for a resident to be in a wheelchair with faulty brakes, potential fall risk. It should be a same day or next day depending on the time it was identified. Review of the facility policy titled Work Orders, Maintenance dated April 2010, reflected, Maintenance work orders shall be completed in order to establish a priority of maintenance service. Policy Interpretation and Implementation (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director. 2. It shall be the responsibility of the department directors to fill out and forward such work orders to the Maintenance Director. 3. A supply of work orders is maintained at each nurses' station. 4. Work order requests should be placed in the appropriate file basket at the nurses' station. Work orders are picked up daily. 5. Emergency requests will be given priority in making necessary repairs. Review of facility policy titled Maintenance Service dated December 2009 reflected: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. i. Providing routinely scheduled maintenance service to all areas. j. Others that may become necessary or appropriate. 3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 8. The Maintenance Director is responsible for maintaining the following records/ reports. a. Inspection of building. b. Work order requests. c. Maintenance schedules. d. Authorized vendor listing; and e. Warranties and guarantees. (continued on next page)

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