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	05/10/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observations, interviews , and record reviews, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately to the State Survey Agency (HHSC), but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, for 2 of 5 residents (Resident #3 and Resident #4) reviewed for abuse. The facility failed to report to the State Survey Agency (HHSC) an incident of alleged abuse/neglect when Resident #4 grabbed Resident #3's walker and pushed it causing Resident #3 to fall and sustain a large skin tear on his forearm on 04/05/25. This failure could place residents at risk for harm to include physical abuse, a diminished quality of life, and psychosocial harm. Th e findings included: A review of Resident #3's face sheet, printed on 05/09/25, reflected a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE]. His diagnoses included thrombocytopenia (a blood disorder that can lead to bleeding and bruising), muscle weakness, recurrent falls, chronic kidney disease, and alcoholic cirrhosis (scarring of the liver that impairs liver function, caused by alcohol). A review of Resident #3's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 13 which indicated intact cognition. Section E (Behavior) reflected no behavior problems. Section GG (Functional Abilities) reflected he used a walker as a mobility device, and he required partial/moderate assistance to walk 150 feet. A review of Resident #3's comprehensive care plan, revised 01/17/25 reflected in part: Focus: (Resident #3) has had an actual fall r/t hypotension, poor balance, unsteady gait. Goal: (Resident #3) will resume usual activities without further incident through the review date. Interventions: Urinal at bedside, encourage resident to sit on side of bed for few moments before getting OOB for BP adjustment, encourage good lighting and make sure path to bathroom is uncluttered . (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #3's Order Summary Report for active orders as of 05/09/25 reflected in part: Left forearm: Change Daily, Cleanse with wound cleanser apply collagen, Apply Hydrogel, dress with Superabsorbent, wrap with Kerlix. every day shift every Mon, Tue, Wed, Thu, Fri for skin tear. Order date 05/06/25, Start date 05/07/25. Left forearm: Change Daily, Cleanse with wound cleanser apply collagen, Apply Hydrogel, dress with Superabsorbent, wrap with Kerlix every day shift every Sat, Sun for Skin Tear Supplies located in Nurse's station for wound care. Order date 05/06/25, Start date 05/10/25. A review of Resident #3's Treatment Administration Record for May 2025 reflected in part: Left forearm: Change Daily, Cleanse with wound cleanser apply Hydrogel, apply Xeroform, dress with Superabsorbent, wrap with Kerlix. every day shift every Mon, Tue, Wed, Thu, Fri for skin tear. Start Date 04/16/25, D/C date 05/06/25. The treatment was marked as completed on 05/01/25, 05/02/25, 05/05/25, and 05/06/25. Left forearm: Change Daily, Cleanse with wound cleanser apply collagen, Apply Hydrogel, dress with Superabsorbent, wrap with Kerlix. every day shift every Mon, Tue, Wed, Thu, Fri for skin tear. The treatment was marked as completed on 05/07/25 and 05/08/25. Review of Resident #3's progress note dated 04/05/25 at 6:41 PM and written by RN A, reflected, This resident was walking on the hallway by room (#), another resident in room (#), was blocking the way and nurse was re directing him. This resident asked him to make way and quit blocking the hallway, he grabbed at this resident's walker, pushed the walker, before this nurse could get to the other resident, he was already pushed down, lying on his left side. Resident sustained large skin tear to his left FA, area of skin peeled off. Resident helped off the floor, area cleaned and treated. DON/NP notified. A review of Resident #4's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included encephalopathy (damage or disease that affects the brain), cognitive communication deficit (problem with communication caused by cognition rather than a language or speech deficit), Alzheimer's disease with early onset, unspecified mood disorder, and unspecified dementia. A review of Resident #4's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 9 which indicated moderately impaired cognition. Section E (Behavior) reflected physical and verbal behaviors directed towards others occurred 1 to 3 days. Section GG (Functional Abilities) reflected he did not use any mobility devices (cane, walker, wheelchair) and he required substantial/maximal assistance for mobility and transfers. A review of Resident #4's comprehensive care plan, initiated 11/05/24, reflected in part: Focus: The resident has potential to demonstrate verbally abusive behaviors r/t Dementia, Mental / Emotional illness Behavior: Verbal/Physical Aggression. Date Initiated 04/15/25. Goal: The resident will demonstrate effective coping skills through the review date. Date Initiated 04/15/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Date Initiated 04/15/25. Review of Resident #4's progress note dated 04/05/25 at 7:28 PM and written by RN A reflected, Resident was blocking hallway, another resident was walking on the same hallway, asked him to move and quit blocking the hallway, he grabbed on the other resident's walker, pushed it and the other resident fell on his left side before nurse could get to him. The other resident sustained a large skin tear to his left FA. DON/NP on call notified. Unable to reach this resident's [family member]. An observation and interview on 05/08/25 at 11:30 AM, Resident #4 was observed sitting in a wheelchair in his room. He was well groomed and wearing clean clothes. He stated the staff at the facility treat him okay and he denied any concerns with the staff. He stated he gets along with the other residents. He stated he did not remember any incident or altercation with another resident. An observation and interview on 05/08/25 at 11:34 AM, Resident #3 was observed in his bed with the head of the bed elevated. His left arm was wrapped with a gauze wrap and two areas of blood were visible through the dressing. He stated on 04/04/25 or 04/05/25, another resident was beating a nurse when he approached the area, the resident attacked him. He stated he fell and received a skin tear on his left forearm. He stated the staff changed his dressing daily and he still had some pain in that area. During an interview on 05/08/25 at 2:32 PM, RN A stated she reported the incident between Resident #3 and Resident #4 to the pervious DON and put the progress note on the 24-hour report. During an interview on 05/09/25 at 12:54 PM, the ADM stated, based on the incident that occurred on 04/05/25 with Resident #3 and Resident #4, she said it was not reported because when she spoke to the nurse about the events leading up to the incident she was told Resident #3 was intervening with Resident #4 being upset with the nurse and upon doing so Resident #4 turned his attention to Resident #3 and they were both tugging on the walker which resulted in Resident #3 losing balance and falling backwards. The ADM stated since there was no malicious intent towards the resident to begin with, she did not feel like it needed to be reported. Review of the Reporting Abuse to State Agencies and Other Entities/Individuals Policy, revised December 2009, reflected in part: All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law. 1. Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident: a. The State Licensing/certification agency responsible for surveying/licensing the facility; 2. Verbal/written notices to agencies will be made within twenty-four (24) hours of the occurrence of such incident and such notice may be submitted via special carrier, fax, e-mail, or by telephone . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility Abuse Prevention Program Policy, revised December 2016, reflected in part, As part of the resident abuse prevention, the administration will: 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.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interview and record review, the facility failed to ensure each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 5 residents (Resident #1) reviewed for prevention and treatment of mental and substance use disorders. -The facility failed to ensure behavioral health interventions were implemented for Resident#1, who was admitted with a diagnosis of bi-polar disorder and had a history of being aggressive to residents and staff, after physician orders for psychiatry evaluation and management were received on 02/24/25 and again on 03/08/25. -The facility failed to protect Resident #2 from Resident #1 when Resident #1 scratched Resident #2 with her fingernails during an outburst on 05/03/25 which caused injuries to his thigh. An IJ was identified on 05/08/25. The IJ template was provided to the facility on [DATE] at 5:26 PM. While the IJ was removed on 05/10/25, the facility remained out of compliance at a level of 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. These failures could place residents at risk of not receiving behavioral health services, not having their mental and psychosocial needs met, and a decline in quality of life. Findings included: A review of Resident #1's face sheet, printed on 05/08/25 reflected a [AGE] year-old female admitted to the facility on [DATE] Her diagnoses included partial traumatic amputation of right foot (loss of a body part as the result of an accident or injury), bipolar disorder (a mental illness that causes extreme mood swings), unspecified intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently), major depressive disorder, and type 2 diabetes (a condition that affects the way the body processes blood sugar). A review of Resident #1's quarterly MDS assessment, dated 04/07/25, Section C (Cognitive Patterns) reflected a BIMS score of 15 which indicated intact cognition. Section D (Mood) reflected she felt down, depressed, or hopeless two to six days in the previous two weeks. Section E (behavior) reflected no behaviors occurred during the reporting period. Section GG (Functional Abilities) reflected resident was independent with wheelchair mobility. Section O (Special Treatments, Procedures, and Programs) reflected the resident did not receive any psychological therapy. A review of Resident #1's comprehensive care plan revealed in part: Focus: (Resident #1) has a diagnosis of bipolar disorder. Date initiated 05/08/25. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Goals: The resident will identify coping mechanisms (new and old) by the review date. Date initiated 05/08/25. Mood stabilization: Managing and stabilizing mood fluctuations to minimize the severity and duration of manic and depressive episodes. Date initiated 05/08/25. Interventions: Allow the resident time to answer questions and verbalize feelings, perceptions, and fears. Date initiated 05/08/25. Provide opportunities for the resident and family to participate in care. Date initiated 05/08/25. The resident needs assistance/encouragement/support to identify problems that cannot be controlled. Date initiated 05/08/25. Focus: (Resident #1) has demonstrated demanding behaviors towards others, yelling, pushing, hitting, scratching. Date initiated 05/05/25. Goals: Demonstrate less demanding behavior towards others over the next 90 days. Date initiated 05/05/25. Review possible options for adjusting to the current situation over the next 90 days. Date initiated 05/05/25. Interventions: Encourage participation in activities with other residents who have interests that are similar. Date initiated 05/05/25. Enlist assistance of family in controlling demanding behaviors as needed. Date initiated 05/05/25. Listen openly to resident's requests and offer assistance, explanations or clarifications as needed. Date initiated 05/05/25. Offer an outlet for resident to express feelings, wishes, and frustrations. Date initiated 05/05/25 . A review of Resident #1's current physician orders reflected the following: BEHAVIORS - MONITOR Other FOR THE FOLLOWING: (specify in nurses note) ITCHING, PICKING AT SKIN, RESTLESSNESS (AGITATION), HITTING, INCREASE IN COMPLAINTS, BITING, KICKING, SPITTING, CUSSING, RACIAL SLURS, ELOPEMENT, STEALING, DELUSIONS, HALLUCINATIONS, PSYCHOSIS, AGGRESSION, REFUSING CARE. Document: 'N' if monitored and none of the above observed. 'Y' if monitored and any of the above was observed, DOCUMENT IN PROGRESS NOTES every shift for Bipolar Disorder, written 10/17/2024 . Sertraline HCl oral tablet 100mg give one tablet by mouth in the morning for depression, written 10/17/24. Refer to (name) psychiatry for evaluation and management, written 02/24/25. Refer to (name) psychiatry for evaluation and management, written 03/08/25. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Depakote Sprinkles oral capsule delayed release sprinkle 125 mg, give two capsules by mouth two time a day for mood stability related to bipolar disorder, written 05/05/25. A review of Resident #1's MAR for May 2025 reflected the Sertraline was administered as ordered and the Depakote Sprinkles were administered after arrival from the pharmacy on 05/06/24. The MAR reflected the behavior monitoring was documented each shift as ordered. There were no 'Y' responses recorded. A review of Resident #1's progress note, dated 04/25/25 and written by the APRN, reflected in part, Follow up increased agitation mood changes .She was seen per nursing after she was noted with mood swings, anxious, crying earlier today .Denies urinary complaints. UA C&S if indicated, CBC, CMP ordered . Assessment and Plan: 1. Mood swings: -She was seen per nursing after she was noted with mood swings, anxious, crying earlier today . 8. Bipolar Disorder: - Mood stable - On Sertraline 100mg daily. A review of Resident #1's progress note, dated 05/03/25 and written by LVN C, reflected, AROUND 8 AM. RESIDENT STARTED YELLING, WHEN SHE GET TO THE DINNERING room, RESIDENT STATED BREAKING PLATES AND CUPS. SHE WAS REMOVED AND TAKE TO HER ROOM. [sic] A review of Resident #1's progress note, dated 05/03/25 at 8:15 PM and written by RN A, reflected, (Name) NP on call, called and notified of incident involving this resident and another in the DR just before supper. A review of Resident #1's progress note, dated 05/05/25 at 6:19 PM and written by LVN B, reflected, Resident is sitting at the door of the kitchen getting verbally aggressive with the kitchen staff. When nurse asked what was wrong she stated that these damn demons did it again and put ham on my salad instead of turkey and I'm going teach these people a lesson today since they dont understand no English!. At this time peer passed by with his leftovers to warm up in breakroom and she turned with the fork in her hand screaming Im going to kill you nigga! She rolled towards the breakroom aide attempted to intervene and she was kicking the aide in the knees and calves. Nurse was attempting to get the fork away when resident pulled back and was screaming that we weren't going to stop her from killing him when she stabbed the nurse in the right palm with the fork. SW came up to assist with redirection. Nurse was able to get fork away from resident and aide removed resident from area back to her room across building after SW spoke to her. [sic] A review of Resident #1's progress note dated 05/05/25 at 6:52 PM by LVN B, reflected, Resident came propelling herself down 100 hall yelling she was going to get him and kill him. This nurse went to see what had upset patient and saw her with a butter knife in her hand. She stated that she was going to kill him this time and nothing we said would stop her. Male aide came to assist and she was jabbing knife at him and pushing at my cart to head down hallway toward peers room. Admin was called and resident notified to give up the knife or we would have to call outside assistance. Resident refused and Admin gave approval for us to proceed with contacting outside agency. Male CNA was able to retrieve the knife when she began to wave it at the nurse and nurse went to get residents charge nurse. [sic] (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #1's progress note, dated 05/06/25 and written by the APRN, reflected in part, Chief Complaint/Reason for this Visit - Multiple behavioral outbursts, homicidal ideation, mood changes. Seen per nursing request after recurrent episodes of homicidal ideation. She threatened to stab kitchen staff, another male resident with fork. She was found propelling WC to kitchen and another resident with fork in her hand. Mental health officers were called due to safety concerns. Pending admission to an acute Psych hospital. She is currently in a fair mood, w/o anxiety, impulsive behaviors. She denies CP/SOB, fever, chills, headache or dizziness, nausea, vomiting, diarrhea, or constipation, or insomnia. Denies urinary complaints. UA 4/29 negative for UTI. She was seen by in-house Psych yesterday and was started on Depakote 125 mg BID, PRN hydroxyzine. Likely experiencing acute psych decompensation and will benefit from inpatient psych rehabilitation . A review of Resident #1's progress note, dated 05/06/25 at 2:22 PM and written by the SW, reflected, Law enforcement saw the resident regarding an incident that happened between the resident and another resident on 4/5/25 around 6 pm. Law enforcement informed the resident about the consequences of her behavior. The resident was advised to avoid any future incidents. SW will monitor resident behavior. A review of Resident #2's face sheet, printed on 05/08/25 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral infarction (stroke), major depressive disorder, type 2 diabetes (a condition that affects the way the body processes blood sugar), chronic pain syndrome, and age-related physical debility. A review of Resident #2's admission MDS assessment, dated 03/31/25, Section C (Cognitive Patterns) reflected a BIMS score of 11 which indicated moderate cognitive impairment. Section D (Mood) reflected no mood symptoms were present. Section E (Behavior) reflected verbal behaviors directed at others were present one to three days. Section GG (Functional Abilities) reflected he required substantial/maximal assistance with his ADLs and supervision with wheelchair mobility. Section N (Medications) reflected he was taking antianxiety and antidepressant medications. A review of Resident #2's comprehensive care plan reflected in part: Focus: (Resident #2) has an alteration in neurological status r/t bipolar disorder. Date initiated 04/14/25. Goals: The resident will be able to communicate needs daily through the review date. Date initiated 04/14/25. The resident will be able to function at the fullest potential possible as outlined by the interdisciplinary team through the review date. Date initiated 04/14/25. Interventions: Cueing, reorientation as needed. Date initiated 04/14/25. Give medications as ordered, monitor/document for side effects and effectiveness. Date initiated 04/14/25. Focus: (Resident #2) has major depressive disorder, recurrent r/t alcohol dependence with alcohol-induced persisting dementia. Date initiated 04/14/25. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Goal: The resident will exhibit indicators of depression, anxiety, or sad mood less than daily by review date. Date initiated 04/14/25. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date initiated 04/14/25. Monitor/document/report to Nurse/MD s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. Date initiated 04/14/25. A review of Resident #2's current physician orders reflected the following: Wound care for right anterior thigh abrasion: cleanse with wound cleanser, apply TAO, leave open to air, daily, written 05/06/25. A review of Resident #2's nurse progress note, dated 05/03/25 at 8:56 PM and written by RN A reflected in part, Just before supper, this resident was wheeled from the DR to the nurse's station by a staff. Staff, showing nurse resident's right thigh informing nurse that resident was fighting another resident in the DR, he got the scratch like marks from the other resident. Nurse assessed area, looks like scratch marks to his right anterior thigh with scant bleeding . Review of Resident #2's progress note, dated 05/07/25 at 2:10 PM and written by the wound care NP, reflected in part, 04/29/25: Patient was seen today for wound care. A new wound was observed on the right elbow .Treatment was initiated .The patient has a skin tear related to thin, fragile, atrophic skin. Recommend preventing further skin injury by avoiding friction/shear, careful handling during ambulation, assistance, and transfer . Review of Resident #2's progress noted, dated 05/07/25 at 3:55 PM, reflected in part, Nurse was called to the dining room that resident fell . Nurse noted resident lying on the floor . Review of Resident #1's Psychiatric Initial Assessment, dated 05/02/25 and written by the mental health NP, reflected in part, Reason for Referral: Agitation, Verbal Aggression, Physical Aggression, Sexually Inappropriate Behavior, Cognitive Testing For Medical Necessity. Chief Complaint: I'm real aggressive History of Presenting: Illness .bipolar disorder, cocaine abuse, nicotine dependence, and alcohol abuse . On exam . bright affect, very distractible and disorganized at times. Patient states I'm real aggressive and I get real angry. Patient reports poor frustration tolerance . Symptoms have been occurring for 2 weeks. Patient with a history of Bipolar d/o, labile mood, impulsive, irritable, hostile at times. Will start Depakote for mood stability . Patient with irritability, anxious, will continue Sertraline . Review of Resident #1's Psychiatric Subsequent assessment dated [DATE] and written by the mental health NP, reflected in part, Reason for Referral: Agitation, Verbal Aggression, Physical Aggression, Sexually Inappropriate Behavior, Cognitive Testing For Medical Necessity Chief Complaint: I was upset on Monday Medical Necessity for visit: Patient seen today for multiple chronic conditions requiring prescription management. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Bipolar d/o, current episode mixed, labile mood, impulsive, irritable, and hostile at times. recent violent behaviors, Continue Depakote for mood stability. Will check VPA level . Mild to moderate anxiety, denies current symptoms, reports intermittent irritability and recent violent behavior. will continue Sertraline . Future Visits Revisit in I weeks. During an interview on 05/08/25 at 12:15 PM, the ADM stated Resident #1 had been having more behaviors of yelling, threatening, and throwing things, so they made a psych referral and had the resident seen . She stated it did not meet her expectations that referrals were made in February and March and the resident was not seen until May . She stated she started working at the facility in February and was not aware of the referrals at that time. During an observation and interview on 05/08/25 at 12:25 PM, Resident #2 was observed sitting up in a wheelchair in the dining room. Resident #2 had multiple small, fading bruises and healing skin tears on his arms and hands. A dressing was observed on his right elbow. Resident #2 stated he had an altercation with Resident #1 recently. He stated he may have called the other resident a name, but that was no reason for them to attack me. He stated he wanted to go back to his previous facility because he was treated better there. During an interview on 05/08/25 at 1:35 PM, the SW stated Resident #1 had been aggressive to staff and other residents. He stated Resident #1 had mood swings, she was sad, happy, or angry, and it changed day to day. He stated he had put a referral in the computer for psych services and the resident was added to the referral list. He stated he put in a referral in February for Resident #1, because of her bipolar disorder diagnosis, but there were some insurance problems, so she was not seen. He stated the company they used for psychiatric services had staff turnover and it had been difficult to get someone out to the facility. He stated everyone with a psychiatric diagnosis was referred for psych services upon admit. He stated he believed Resident #1 was admitted in February 2025 and that is when she was referred. He stated anyone with a psychiatric diagnosis was referred to psych on admission. He stated he did not know why she was not referred when she was admitted in October 2024. He stated it did not meet his expectations that it took so long for the resident to be seen. He stated Resident #1 was seen by psych services last week and medications were ordered. The SW stated Resident #1 had an incident directed towards another resident on 05/05/25. He stated they called for a mental health officer to come to the facility. He stated 3 police officers came to the facility on [DATE] and spoke briefly with Resident #1 and informed her of possible consequences of her behavior. On 05/08/25 at 2:09 PM a voice message requesting a return call was left for the psychiatric provider. A return call was not received prior to exit from the facility. On 05/08/25 at 2:11 PM a voice message requesting a return call was left for the APRN. A return call was not received prior to exit from the facility. During an interview on 05/08/25 at 2:32 PM RN A stated Resident #1 had been in her current room for about 3 weeks. She stated Resident #1 used to be on the other unit, but she was having problems with another resident, so they moved her room. She stated she had worked with Resident #1, and she had behaviors since her admission. She stated resident often cussed, yelled, slammed her door, or threw items from her room into the hallway. (continued on next page)

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	455862	A. Building B. Wing	05/10/2025

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

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/08/25 at 2:44 PM, CNA F stated she had worked with Resident #1 on both halls. She stated the resident had behaviors off and on since being at the facility. She stated she frequently threw things from her room into the hall. During an interview on 05/08/25 at 4:12 PM, the ADON stated residents who had a psychiatric diagnosis on admit, were usually referred for psych services. She stated she did not remember if Resident #1 had been referred upon admit, but stated the resident may have refused psych services. She stated she was not able to find any documentation that the resident had been referred or refused services on admit. She stated Resident #1 had increased behaviors, so she contacted the SW to make a psych referral. She stated the resident always had complaints about staff but did not have problems with other residents until recently. She stated the psychiatrist was in the facility on 05/02/25 and when she returned to work on 05/05/25, she saw that there were new medication orders for Resident #1. During an interview on 05/09/25 at 12:10 PM, the MHNP stated he was usually in the facility once a week but if there was an emergency, he was able to respond more frequently. He stated Resident #1 was new to him as he began seeing her last week on 05/02/25, and saw her just prior to this interview. He stated usually the provider put in a referral for psychiatric services. The facility, usually the SW, entered the referral into the (company name) portal for verification and approval. Once approved, he was sent out to see the resident. He stated to his knowledge, Resident #1 had not been seen by psych before him. He stated Resident #1 was on Sertraline before and he added a regularly scheduled mood stabilizer and a PRN medication for anxiety. He stated he would continue to follow and monitor the resident. A review of the facility Social Services Policy, revised December 2010, reflected in part, Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. 1. The Director of Social Services is a qualified social worker and is responsible for: b. Consultation to an allied professional health personnel regarding provisions for the social and emotional needs of the resident and family; 2. Medically-related social services is provided to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating, ambulation, etc.); and mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose). 3. Factors that have a potentially negative effect on psychosocial functioning include: e. Presence of a progressive, chronic disabling condition (i.e., Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Alzheimer's disease, mental illness); g. Behavioral problems (i.e., confusion, anxiety, loneliness, depressed mood, anger, fear, wandering, psychotic episodes); 4. The social services department is responsible for: f. Making referrals to social service agencies as necessary or appropriate . A review of the facility Unmanageable Residents Policy, revised August 2010, reflected in part, Each resident will be provided with a safe place of residence. A review of the facility Abuse Prevention Program Policy, revised December 2016, reflected in part, As part of the resident abuse prevention, the administration will: 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. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM, DON, and RDHR were notified on 05/08/25 at 5:26 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 05/09/25 at 3:15 PM: (Facility Name) Immediate action: 05/08/2025 Resident #1 was affected by this deficiency (F740), was assessed and noted to be stable as of 05/08/2025. An audit of this resident's current list of medications was performed by the Administrator on 05/08/2025 and revealed that all current medications for this resident were delivered and are available in the facility. The resident was last seen by Psych services on 05/02/2025 and will be seen again on 05/09/2025 for follow up and intervention (personal safety). The resident's care plan was updated 05/06/2025 with current psych diagnosis and interventions as well as specific behaviors and interventions. One on one monitoring has been placed for the resident effective today when near other residents until stable per psych NP recommendation or transfer out of the facility. Resident #2 was assessed on 05/03/2025 after the event involving Resident #1, and again today 05/08/2025 revealing no signs of distress or emotional agitation. Training of staff and audits of all residents identified as in need of behavioral health services as well as abuse and neglect were initiated by the Administrator on 05/08/2025. A spreadsheet was created with the identification of the services and if services were needed. The facility is verifying comprehension on staff training by following up after education based on a random selection. Verbal contact to personnel began on 05/08/2025. Staff will not be allowed to work their shifts until this Inservice, and training has been completed. The Administrator will be responsible for the direct Inservice of her staff. Identification of others: All residents who have diagnoses or demonstrated signs of behavioral health concerns have the potential to be impacted by this deficient practice. The Administrator is directing the review of all residents with Behavioral Health diagnoses (completed 05/08/25) to identify unmet behavioral or psychiatric needs. All open psychiatric referrals were verified and re-submitted or scheduled. Action: Review of all residents with Behavioral Health Diagnosis Start Date: 5/8/25 Completion Date: 5/8/25 Responsible: DON, ADON, Administrator Action: Creation of spreadsheet identifying unmet behavioral or psychiatric needs. Any other residents identified will be referred to psych as well. Start Date: 5/8/25 (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Completion Date: 5/9/25 Responsible: DON, Admin, Social Worker. Action: A review of their medications will be completed as well. The Psychiatrist will be on site 05/09/2025 to assist with any referrals or review of concerns that were identified with this audit. Start Date: 05/09/2025 Completion Date: 05/09/2025 Responsible: DON, MDS, Psychiatrist Action: Creation of spreadsheet identifying unmet behavioral or psychiatric needs. Any other residents identified will be referred to psych as well. Start Date: 5/8/25 Completion Date: 5/9/25 Responsible: DON, Admin, Social Worker. A review is scheduled 05/09/2025 for the Psychiatrist and Attending Physician on the medications as it relates to any current behaviors or events since the last Dose Reduction Review. The Regional Director of Operations has educated the Administrator, DON and ADON on behavioral care and services for the residents for the facility and comprehension will be verified at this same time (copy attached), this was completed on 05/08/2025 . The administrator has created an audit tool to monitor compliance to the facility's communication procedure for contacting Physicians and confirming orders on behavioral health matters. Audits will be conducted by the DON daily for two weeks, weekly for 2 weeks and monthly for two months. A spreadsheet was created for the audit to be conducted and documented. Any negative findings will be reported to the administrator for immediate correction. The Medical Director was notified of the deficiency (F740) on 05/08/2025 and an Ad-Hoc QAPI meeting was held on 05/08/2025 to discuss the findings. All findings will be reported to the QAPI team for QAPI. Expected compliance date is 05/08/2025. The Surveyor monitored the POR on 05/10/25 as follows: During an observation and interview on 05/10/25 at 3:39 PM, Resident #1 was observed as she sat in her wheelchair. Resident #1 was calm and had no s/sx of distress. Resident #1 stated she was fine and rolled away. CNA H stated she was assigned to Resident #1 to monitor for behaviors , for example yelling, throwing things, or being aggressive towards others. She stated there were none of those behaviors exhibited by Resident #1. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 05/10/25 from 12:44 PM - 3:07 PM, staff from all shifts including the ADON, two LVNs (LVN D and LVN E), one CNA (CNA G), one MA (MA I), one SW, and the HSK Supervisor all stated they were in-serviced on 05/08/25 or 05/09/25 on abuse and neglect. All staff knew to report any suspected abuse immediately to the ADM who was the Abuse Coordinator. All staff stated they were to report any new behaviors or increased number of behaviors such as hitting, kicking, cussing, or increased complaints, to the charge nurse. Staff stated if two residents were involved in an altercation, they would separate the residents and report the incident to the nurse. The LVNs and SW stated all diagnoses were reviewed on admit and which diagnoses required psych referrals. They stated the NP was to be notified of any new or change in behaviors. The SW stated he was to follow up on all psych referrals within 2-3 days. During an interview on 05/10/25 at 1:31 PM, the SW stated the expectation was to send psych service referrals for residents with a psychiatric diagnosis or behavior medications evaluations for residents with behaviors when admitted and as needed. He stated the expectation was to follow up on all referrals within two to three days. During an interview on 05/10/25 at 1:40 PM, the Psych NP stated he had no recommendations for staff regarding Resident #1, who he observed was stable on 05/09/25. Staff were expected to follow the facility's policy if a resident exhibited new behaviors. Staff were expected to deescalate the resident, notify appropriate parties, and provide psych services. He stated he planned to see Resident #1 weekly for a few weeks to monitor medication effectiveness. He would reevaluate then if weekly visits were still indicated or adjust the frequency as needed. During an interview on 05/10/25 at 3:07 PM, the ADON stated it was her expectation that psych and behavioral referrals were initiated and sent when a resident was admitted and if a change in behaviors occurred. She stated the SW was responsible to follow up on the referral status. During a telephone interview on 05/10/25 at 3:53 PM, the RDO stated he in-serviced the ADM, DON, and ADON on 05/08/25 regarding behavioral care and services for the residents for the facility and following up on psych referrals after sending out psych referrals. During a telephone interview on 05/10/25 at 3:55 PM, the MD stated the DON notified him about Resident #1's incident resulting in an IJ on 05/08/25 or 05/09/25. During an interview on 05/10/25 at 4:29 PM, the ADM stated she expected psych referrals be sent timely when a resident with a psychiatric diagnosis was admitted . She expected the SW to follow up with the referral to ensure the service was provided. She stated they had implemented audit tools and now monitored for compliance. She stated the audit tools were to monitor compliance to the facility's communication procedure for contacting physicians and confirming orders on behavioral health matters. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an in-service titled Behavioral Care and Services in Texas Nursing Homes, dated 05/08/25, reflected the RDO in-serviced the ADM, DON, and ADON on the policy and procedures. The outline from the in-service reflected in part, Objective: Equip staff with the knowledge and skills to deliver person-centered behavioral care in compliance with Texas regulations and CMS guidelines. Objectives of This In-Service: By the end of this session, participants will be able to: Recognize common behavioral and psychological symptoms in residents. Respond effectively and compassionately to behavioral issues . Understanding Behavioral Health in LTC Settings . Resident-Centered Behavioral Interventions . Role of the Interdisciplinary Team . Documentation Best Practices . Key Takeaways Behavioral care is part of holistic resident care. Staff training and communication are essential. Non-pharmacological approaches should be tried first. Documentation must be timely, factual, and complete. Interdisciplinary collaboration leads to better outcomes. Review of an in-service titled Behavioral Care and Services in Texas Nursing Homes, dated 05/08/25 and 05/09/25, reflected staff, which included 1 RN, 9 LVNs, 6 MAs, and 20 CNAs, were in-serviced, in person or over the phone, by the ADM, DON, and ADON on the policy and procedures. Review of an in-service titled Abuse/Neglect, dated 05/08/25 and 05/09/25, reflected staff , which included 1 RN, 9 LVNs, 6 MAs, 20 CNAs, 10 dietary staff, 12 housekeeping staff, 1 maintenance aide, and 7 therapy staff, were in-serviced, in person or over the phone, by the ADM, DON, and ADON on the policy and procedures. Review of an in-service titled Ensure Proper Documentation, dated 05/08/25 and 05/09/25, reflected nursing staff, which include 1 RN and 9 LVNs, were in-serviced, in person or over the phone, by the ADM, DON, and ADON on the policy and procedures. Review of an in-service titled New Admits, dated 05/08/25 and 05/09/25, reflected the SW and nursing staff, which included 1 RN, 9 LVNs, were in-serviced, in person or over the phone, by the ADM, DON, and ADON on reviewing diagnoses in a timely manner and referring to psych services. Review of the ADM's Random Selection of Staff Training Comprehension Verification reflected two staff members were verbally contacted by the ADM and verified for education on 05/09/25 and one staff member was verbally contacted b [TRUNCATED]