STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455862	A. Building B. Wing	09/21/2025

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. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 reviews, 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, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials for 1 (Resident #1) of 5 residents reviewed for incidents. The facility failed to report Resident #1's injury of unknown origin to the SSA. Staff observed Resident #1 had discoloration to his buttocks area on 09/10/25. Staff confirmed Resident #1's discoloration was an acute (sudden) femur (thigh) fracture on 09/11/25. This failure could place residents at risk of untreated medical problems, worsening injuries, mental anguish, and reduced quality of life. Findings included:Review of Resident #1's admission Record, dated 09/18/25, reflected he was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses that included bilateral (both sides) primary osteoarthritis (a chronic, degenerative condition characterized by the progressive breakdown of joint cartilage and underlying bone) of hip, pain in left and right hip, age-related osteoporosis (the condition of bones becoming weak and brittle), schizoaffective disorder (a mental illness that combines symptoms of schizophrenia and a mood disorder), vascular dementia (a type of dementia that happens when blood vessels in the brain are damaged or blocked), muscle weakness, lack of coordination, and cognitive communication deficit. Resident #1 was discharged to the hospital on [DATE]. Review of Resident #1's Annual MDS Assessment, dated 09/11/25, reflected a BIMS of 3/15, which indicated he had severe cognitive impairment.Review of Resident #1's Care Plan, last revised 08/07/25, reflected he had potential for complications related to schizophrenia and bipolar disorder and was at risk for falls. Review of Resident #1's Progress Notes reflected:-A note created by the ADON on 09/11/25 at 6:45 a.m., Writer was called to room d/t resident c/o pain, while repositioning resident in bed for brief change. Writer noted dark discoloration to left buttock area.NP on call notified. New order: Left lateral hip x-ray stat (immediately) confirmation. DON and Guardian notified.-A note created by RN A on 09/11/25 at 7:33 p.m., Resident was transferred out to hospital per order.MPOA was called and notified. DON aware. Review of Resident #1's Radiology Results, dated 09/11/25 at 10:36 a.m., reflected he was x-rayed and had a mild displaced comminuted right proximal femoral (thigh) fracture. Review of Resident #1's Physician Note, dated 09/11/25, reflected, He was evaluated per nursing request following complaints of right hip pain with movement. Per nursing report, [Resident #1] verbalized pain during repositioning in bed for a brief change . On exam, dark discoloration was noted over the left buttock area. A stat right hip x-ray was ordered, which revealed an acute mildly displaced comminuted fracture of the right proximal femur. [Resident #1 denied any recent fall or trauma, and no recent falls have been reported or documented. The ADON, DON, and facility Administrator were notified for further investigation.[Resident #1] was sent to the emergency department for further evaluation and management. Review of Resident #1's Medical Provider Progress Note, dated 09/16/25, reflected Resident #1 presented to the hospital from the facility after a mechanical fall. The fall occurred on 09/11/25 and resulted in a right intertrochanteric area of the femur. During an interview on 09/18/25 at 10:32 a.m., the ADON stated the day before Resident #1 was sent to the hospital (09/10/25), CNA B notified her that she observed Resident #1 had dark purple discoloration to his left buttocks and experienced pain when she turned him. The ADON stated she also made the same observation as CNA B during her assessment of Resident #1 and notified the DON, who informed her to notify the on-call NP. The ADON stated the on-call NP ordered a stat x-ray on Resident #1's left hip area on 09/10/25 and the results on 09/11/25 revealed he had a right hip fracture. The ADON stated she notified the on-call NP and DON of the results and sent Resident #1 to the hospital per on-call NP orders. The ADON stated Resident #1's right hip fracture was an injury of unknown origin because the facility did not know how he sustained the discoloration and fracture. The ADON stated the ADM was responsible for immediately reporting injury of unknown origin to the SSA. The ADON stated she knew it was important to report injury of unknown origin to the SSA and said, To investigate and make sure resident safety and determine how incident occurred. Residents could be at risk of neglect I would say. During an interview on 09/18/25 at 10:57 a.m., CNA B stated she observed Resident #1 had purple colored bruise on his left buttocks when she was changing his brief and repositioning him in bed last week (09/10/25). CNA B stated she notified the ADON of Resident #1's bruise. CNA B stated Resident #1's left buttocks bruise was an injury of unknown origin because the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have evidence that all alleged violations are thoroughly investigated for 1 (Resident #1) of 5 residents reviewed for incidents. The facility failed to initiate and complete a thorough investigation of Resident #1's injury of unknown origin. Staff observed Resident #1 had discoloration to his buttocks area on 09/10/25. Staff confirmed Resident #1's discoloration was an acute (sudden) femur (thigh) fracture on 09/11/25. An IJ was identified on 09/18/25. The IJ template was provided to the facility on [DATE] at 7:10 p.m. While the IJ was removed on 09/21/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk of untreated medical problems, worsening injuries, mental anguish, and reduced quality of life. Findings include:Review of Resident #1's admission Record, dated 09/18/25, reflected he was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses that included bilateral (both sides) primary osteoarthritis (a chronic, degenerative condition characterized by the progressive breakdown of joint cartilage and underlying bone) of hip, pain in left and right hip, age-related osteoporosis (the condition of bones becoming weak and brittle), schizoaffective disorder (a mental illness that combines symptoms of schizophrenia and a mood disorder), vascular dementia (a type of dementia that happens when blood vessels in the brain are damaged or blocked), muscle weakness, lack of coordination, and cognitive communication deficit. Resident #1 was discharged to the hospital on [DATE]. Review of Resident #1's Annual MDS Assessment, dated 09/11/25, reflected a BIMS of 3/15, which indicated he had severe cognitive impairment. Resident #1 required substantial/maximal assistance with transfers. Review of Resident #1's Care Plan, last revised 08/07/25, reflected he had potential for complications related to schizophrenia and bipolar disorder and was at risk for falls. Review of Resident #1's Progress Notes reflected:-A note created by the ADON on 09/11/25 at 6:45 a.m., Writer was called to room d/t resident c/o pain, while repositioning resident in bed for brief change. Writer noted dark discoloration to left buttock area.NP on call notified. New order: Left lateral hip x-ray stat (immediately) confirmation. DON and Guardian notified.-A note created by RN A on 09/11/25 at 7:33 p.m., Resident was transferred out to hospital per order.MPOA was called and notified. DON aware. Review of Resident #1's Radiology Results, dated 09/11/25 at 10:36 a.m., reflected he was x-rayed and had a mild displaced comminuted right proximal femoral (thigh) fracture. Review of Resident #1's Physician Note, dated 09/11/25, reflected, He was evaluated per nursing request following complaints of right hip pain with movement. Per nursing report, [Resident #1] verbalized pain during repositioning in bed for a brief change . On exam, dark discoloration was noted over the left buttock area. A stat right hip x-ray was ordered, which revealed an acute mildly displaced comminuted fracture of the right proximal femur. [Resident #1 denied any recent fall or trauma, and no recent falls have been reported or documented. The ADON, DON, and facility Administrator were notified for further investigation.[Resident #1] was sent to the emergency department for further evaluation and management. Review of Resident #1's Medical Provider Progress Note, dated 09/16/25, reflected Resident #1 presented to the hospital from the facility after a mechanical fall. The fall occurred on 09/11/25 and resulted in a right intertrochanteric area of the femur. During an interview on 09/18/25 at 10:32 a.m., the ADON stated the day before Resident #1 was sent to the hospital (09/10/25), CNA B notified her that she observed Resident #1 had dark purple discoloration to his left buttocks and experienced pain when she turned him. The ADON stated she also made the same observation as CNA B during her assessment of Resident #1 and notified the DON, who informed her to notify the on-call NP. The ADON stated Resident #1 told her that he fell and could not elaborate on the incident. The ADON stated the on-call NP ordered a stat x-ray on Resident #1's left hip area on 09/10/25 and the results on 09/11/25 revealed he had a right hip fracture. The ADON stated she notified the on-call NP and DON of the results and sent Resident #1 to the hospital per on-call NP orders. The ADON stated Resident #1's right hip fracture was an injury of unknown origin because the facility did not know how he sustained the discoloration and fracture. The ADON stated the ADM was responsible for investigating injury of unknown origin. The ADON stated she knew it was important to investigate injury of unknown origin and said, To investigate and make sure resident safety and determine how incident occurred. Residents could be at risk of neglect I would say. During an interview on 09/18/25 at 10:57 a.m., CNA B stated she observed Resident #1 had a purple bruise

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure the resident environment remains free of accident hazards and each resident receives adequate supervision for 1 (Resident #1) of 5 residents reviewed for incidents. The facility failed to monitor and supervise Resident #1, who was cognitively impaired and a fall risk. Resident #1 complained of pain and had discoloration to his buttocks area on 09/10/25. Resident #1 sustained an acute (sudden) femoral (thigh) fracture and was sent to the hospital for surgery on 09/11/25. An IJ was identified on 09/18/25. The IJ template was provided to the facility on [DATE] at 7:10 p. m. While the IJ was removed on 09/21/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk of untreated medical problems, worsening injuries, mental anguish, and reduced quality of life.Findings included:1.Review of Resident #1's admission Record, dated 09/18/25, reflected he was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses that included bilateral (both sides) primary osteoarthritis (a chronic, degenerative condition characterized by the progressive breakdown of joint cartilage and underlying bone) of hip, pain in left and right hip, age-related osteoporosis (the condition of bones becoming weak and brittle), schizoaffective disorder (a mental illness that combines symptoms of schizophrenia and a mood disorder), vascular dementia (a type of dementia that happens when blood vessels in the brain are damaged or blocked), muscle weakness, lack of coordination, right eye blindness, and cognitive communication deficit. Resident #1 was discharged to the hospital on [DATE]. Review of Resident #1's Annual MDS Assessment, dated 07/07/25, reflected a BIMS of 3/15, which indicated he had severe cognitive impairment. Resident #1 had no falls since his admission. Resident #1 also required substantial/maximal assistance with chair/bed-to-chair transfers. Review of Resident #1's Care Plan, last revised 08/07/25, reflected he had potential for complications related to schizophrenia and bipolar disorder and was at risk for falls related to vision. Staff were required to follow the facility's fall protocol. Resident #1 also required 2-person assistance. There was no notes related to mechanical lift assistance with Resident #1's transfers. Review of Resident #1's Progress Notes reflected:-A note created by the ADON on 09/11/25 at 6:45 a.m., Writer was called to room d/t resident c/o pain, while repositioning resident in bed for brief change. Writer noted dark discoloration to left buttock area.NP on call notified. New order: Left lateral hip x-ray stat (immediately) confirmation. DON and Guardian notified. -A note created by RN A on 09/11/25 at 7:33 p.m., Resident was transferred out to hospital per order.MPOA was called and notified. DON aware. There were no documented notes related to an accident/incident before Resident #1 complained of pain and staff observed the discoloration to his buttocks before 09/11/25. Review of Resident #1's skin observation, pain level, and change in condition assessments, dated 09/11/25, reflected they were a system error and the documents were incomplete. Review of Resident #1's Radiology Results, dated 09/11/25 at 10:36 a.m., reflected he was x-rayed and had a mild displaced comminuted right proximal femoral (thigh) fracture. Review of Resident #1's Physician Note, dated 09/11/25, reflected, He was evaluated per nursing request following complaints of right hip pain with movement. Per nursing report, [Resident #1] verbalized pain during repositioning in bed for a brief change .On exam, dark discoloration was noted over the left buttock area. A stat right hip x-ray was ordered, which revealed an acute mildly displaced comminuted fracture of the right proximal femur. [Resident #1 denied any recent fall or trauma, and no recent falls have been reported or documented. The ADON, DON, and facility Administrator were notified for further investigation.[Resident #1] was sent to the emergency department for further evaluation and management. Review of Resident #1's Medical Provider Progress Note, dated 09/16/25, reflected Resident #1 presented to the hospital from the facility after a mechanical fall. The fall occurred on 09/11/25 and resulted in a right intertrochanteric area of the femur.2. Review of Resident #2's admission Record, dated 09/18/25, reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses including muscle weakness, repeated falls, lack of coordination, cognitive communication deficit, and unsteadiness on feet. Review of Resident #2's Quarterly MDS, dated [DATE], reflected a BIMS score of 15/15, which indicated he was cognitively intact. During an interview on 09/18/25 at 10:32 a.m., the ADON stated the day before Resident #1 was sent to the hospital (09/10/25), CNA B notified her that she observed Resident #1 had dark purple discoloration to his left buttocks and experienced pain when she turned him during perineal care. The ADON