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	09/30/2025

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 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 immediately consult with the resident's physician and notify the resident's representative when there is an accident involving the resident which results in injury and had the potential for requiring physician intervention for 1 (Resident #86) of 5 residents reviewed for falls. The facility failed to notify Resident #86's physician and FM that he had a fall on [DATE]. He was found unresponsive at the facility around 6:30 AM on [DATE] and subsequently passed away.An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 12:23 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of serious injuries, abuse, serious harm, and death.Findings Included: Review of Resident #86's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included muscle weakness, unsteadiness on feet, unspecified abnormalities of gait and mobility, cognitive communication deficit, and muscle wasting and atrophy. Review of Resident #86's death in facility MDS dated [DATE] reflected entry/discharge reporting: death in facility. Review of Resident #86's last quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Section GG for functional abilities indicated Resident #86 used a wheelchair. Functional abilities related to chair/bed transfer indicated partial moderate assistance. Walking 10 feet indicated resident required substantial assistance. MDS active diagnosis included muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. MDS assessment did not reflect Resident #86 was on hospice or end of life care. Review of Resident #86's care plan last revised [DATE] (cancelled date due to death) reflected a focus initiated on [DATE], Resident is at risk for falls related to deconditioning, gait/balance problems with interventions that included follow facility fall protocol.Review of Resident #86's progress note dated [DATE] reflected he had an unwitnessed fall at approximately 05:45 PM. After the nurse got him off the floor and into his wheelchair, an assessment was performed and there was redness on the back of his head/neck area. There is no documented evidence in the medical record that family and physician were notified. Review of Resident #86's progress note dated [DATE] reflected nurse found him unresponsive around 06:33 AM. He was awakened but not responding. CPR was initiated until EMS arrived and took over. He was resuscitated at 07:40 AM and rushed to the hospital for treatment, where he passed away shortly after.Review of Resident #86's neurological notes and observations sheet documented on paper dated [DATE] reflected LVN A initiated neuros on [DATE] at 05:45 PM and 06:05 PM. The family and physician notification was incomplete/blank. The remainer of the neuro checks were incomplete or not done. During an interview on [DATE] at 11:19 AM with Resident #86's FM, they stated the facility did not notify them that Resident #86 had a fall on [DATE]. FM stated the facility notified them on [DATE] that Resident #86 was being sent to the hospital. FM stated they observed Resident #86 at the hospital with blood residue in both his nostrils, a cut outer upper right lip, and bruises on the right side of his face on [DATE]. FM stated Resident #86 passed away in the hospital on [DATE]. During an interview on [DATE] at 2:15 PM with LVN A, she stated that on [DATE] around 5:45 PM, she heard from staff and other residents that Resident #86 fell. LVN A stated she helped Resident #86 back into his wheelchair after his unwitnessed fall. LVN A stated Resident #86 told her that he felt weak when transferring from his bed to wheelchair and fell. LVN A stated she assessed Resident #86 and observed he had redness on the back of his head/neck area. LVN A stated she did not ask Resident #86 if he hit his head during his fall. LVN A stated she could not recall notifying the physician after Resident #86 had his fall. LVN A stated she did not notify Resident #86's FM of Resident #86's fall. During an interview on [DATE] at 2:30 PM with RN K, he stated he observed Resident #86 was responsive on [DATE] around 2:00 AM. RN K stated he observed Resident #86 on [DATE] around 6:00 AM, tapped on Resident #86's shoulder, and Resident #86 was not responding. RN K stated LVN A did not communicate with him that Resident #86 had a fall on [DATE]. During an interview on [DATE] at 3:07 PM with the ADON, she stated the DON was responsible for ensuring nurses notified residents' FMs and physician after an unwitnessed fall. She stated she was unsure if LVN A notified Resident #86's FM and physician of his fall. She stated nurses were responsible for notifying residents' families and physicians that they fell. She also knew the importance of notifying family and physician and said, So they were aware of the change in

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 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, interview and record review, the facility failed to protect a resident's right to be free from neglect for 1 (Resident #86) of 5 residents reviewed for resident neglect. The facility failed to ensure Resident #86 was free from neglect when nursing staff failed to conduct ongoing neuro checks and monitor for delayed complications after an unwitnessed fall with head injury that occurred on [DATE]; and document in the residents' chart changes in condition, notify the family and physician, and follow facility fall protocol per policy and residents person centered care plan. He was found unresponsive around 6:30 AM on [DATE] and subsequently passed away. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:00 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures placed residents at risk for serious injuries, abuse, serious harm, and death.Findings include: Review of Resident #86's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle weakness, unsteadiness on feet, unspecified abnormalities of gait and mobility, cognitive communication deficit, and muscle wasting and atrophy. Review of Resident #86's last quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition was intact. Section GG for functional abilities indicated Resident #86 used a wheelchair. Functional abilities related to chair/bed transfer indicated partial moderate assistance. Walking 10 feet indicated resident required substantial assistance. MDS active diagnoses included muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. MDS assessment did not reflect Resident #86 was on hospice or end of life care. Resident #86 had no falls since admission. Review of Resident #86's care plan reflected a focus initiated on [DATE], Resident is at risk for falls related to deconditioning, gait/balance problems with interventions that included follow facility fall protocol. Review of Resident #86's progress note, created by LVN A on [DATE], reflected he had an unwitnessed fall at approximately 05:45 PM. After the nurse got him off the floor and into his wheelchair, an assessment was performed and there was redness on the back of his head/neck area. There was no documented evidence in the medical record that neuros were conducted and completed, and family and physician were notified. Review of Resident #86's progress note, created by RN K on [DATE], reflected nurse found him unresponsive around 06:33 AM. He was awakened but not responding. CPR was initiated until EMS arrived and took over. He was resuscitated at 07:40 AM and rushed to the hospital for treatment, where he passed away shortly after. Review of Resident #86's fall risk evaluations reflected there was no fall risk/post fall evaluation for the fall that occurred on [DATE], and the last evaluation conducted was dated [DATE]. Review of Resident #86's progress notes and EMR reflected no documented follow up for delayed complications related to the fall (generally completed for up to 48 hours post fall) and no assessments by nurse or PT for observing resident rise from chair post fall (to test if decline in strength/abilities or changes in status). Review of Resident #86's neurological notes and observations sheet documented on paper dated [DATE] reflected LVN A initiated neuros monitoring on [DATE] at 05:45 PM and 06:05 PM. The family and physician notification was incomplete/blank. The remainder of the neuro checks were incomplete or not done. Review of Resident #86's death in facility MDS dated [DATE] reflected entry/discharge reporting: death in facility. During an interview on [DATE] at 11:19 AM with Resident #86's FM, they stated the facility did not notify them that Resident #86 had a fall on [DATE]. FM stated the facility notified them on [DATE] that Resident #86 was being sent to the hospital. FM stated they observed Resident #86 at the hospital with blood residue in both his nostrils, a cut to his outer upper right lip, and bruises on the right side of his face on [DATE]. FM stated Resident #86 passed away in the hospital on [DATE] at 8:57 a.m. During an interview on [DATE] at 2:15 PM with LVN A, she stated that on [DATE] around 5:45 PM, she heard from staff and other residents that Resident #86 fell. LVN A stated she helped Resident #86 back into his wheelchair after his unwitnessed fall. LVN A stated Resident #86 told her that he felt weak when transferring from his bed to wheelchair and fell. LVN A stated she could not recall notifying the physician after Resident #86 had his fall. LVN A stated she did not notify Resident #86's FM of Resident #86's fall. LVN A stated she notified the DON when the incident happened. LVN A stated she assessed Resident #86 and observed he had redness on the back of his head/neck area. LVN A stated she did not ask Resident #86 if he hit his head during his fall. LVN A

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 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 interview and record review, the facility failed to assure that all nursing staff possess the competencies, and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being for 1 (Resident #86) of 5 residents reviewed. - The facility failed to ensure nursing staff were competent to conduct ongoing neuro checks, notify the family, and notify the physician after Resident #86 had an unwitnessed fall and hit his head on [DATE]. He was found unresponsive around 6:30 AM on [DATE] and subsequently passed away. - The facility failed to ensure nursing staff were competent to complete a fall risk assessment/ post fall evaluation For Resident #86 following a fall [DATE] (last one documented dated [DATE]).- The facility failed to ensure LVN A had competency on fall risk policies, procedures, conducting assessments, and knowledge of EMR system used. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 12:23 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures placed residents who have a fall at risk for a significant change in condition up to and including death. Findings included: Review of Resident #86's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle weakness, unsteadiness on feet, unspecified abnormalities of gait and mobility, cognitive communication deficit, and muscle wasting and atrophy. Review of Resident #86's death in facility MDS dated [DATE] reflected entry/discharge reporting: death in facility. Review of Resident #86's last quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Section GG for functional abilities indicated Resident #86 used a wheelchair. Functional abilities related to chair/bed transfer indicated partial moderate assistance. Walking 10 feet indicated resident required substantial assistance. MDS active diagnosis included muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. MDS assessment did not reflect Resident #86 was on hospice or end of life care. Review of Resident #86's care plan last revised [DATE] (cancelled date due to death) reflected a focus initiated on [DATE], Resident is at risk for falls related to deconditioning, gait/balance problems with interventions that included follow facility fall protocol. Review of Resident #86's progress note dated [DATE] reflected he had an unwitnessed fall at approximately 05:45 PM. After the nurse got him off the floor and into his wheelchair, an assessment was performed and there was redness on the back of his head/neck area. There is no documented evidence in the medical record that neuros were conducted, and family and physician were notified. Review of Resident #86's progress note dated [DATE] reflected nurse found him unresponsive around 06:33 AM. He was awakened but not responding. CPR was initiated until EMS arrived and took over. He was resuscitated at 07:40 AM and rushed to the hospital for treatment, where he passed away shortly after. Review of Resident #86's fall risk evaluations reflected there was no fall risk/post fall evaluation for the fall that occurred on [DATE], and the last evaluation conducted was dated [DATE]. Review of Resident #86's progress notes and EMR reflected no documented follow up for delayed complications related to the fall (completed for up to 48 hours post fall) and no assessments by nurse or PT for observing resident rise from chair post fall (to test if decline in strength/abilities or changes in status). Review of Resident #86's neurological notes and observations sheet documented on paper dated [DATE] reflected LVN A initiated neuros on [DATE] at 05:45 PM and 06:05 PM. The family and physician notification was incomplete/blank. The remainer of the neuro checks were incomplete or not done. During an interview on [DATE] at 11:19 AM, with Resident #86's FM, they stated the facility did not notify them that Resident #86 had a fall on [DATE]. The FM stated the facility notified them on [DATE] that Resident #86 was being sent to the hospital. The FM stated they observed Resident #86 at the hospital with blood residue in both his nostrils, a cut outer upper right lip, and bruises on the right side of his face on [DATE]. FM stated Resident #86 passed away in the hospital on [DATE]. During an interview on [DATE] at 2:15 PM with LVN A, she stated that on [DATE] around 5:45 PM, she heard from staff and other residents that Resident #86 fell. LVN A stated she helped Resident #86 back into his wheelchair after his unwitnessed fall. LVN A stated Resident #86 told her that he felt weak when transferring from his bed to wheelchair and fell. LVN A stated she could not recall notifying the physician after Resident #86 had his fall. LVN A stated she did not notify Resident #86's FM of Resident