

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2025
NAME OF PROVIDER OR SUPPLIER  Coral Rehabilitation and Nursing of Austin		STREET ADDRESS, CITY, STATE, ZIP CODE  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 - Minimal harm or potential for actual harm  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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to extend to the resident representative the right to make decisions on behalf of the resident for 1 of 12 residents (Resident #8) reviewed for resident representative rights. Resident #8 eloped from the facility on 12/5/25 between the period 7:15 p.m. to 7:30 p.m. and the Guardian was not contacted immediately. This failure could lead to the facility making decisions without the resident's right to designate a surrogate or representative to make treatment or transfer decisions for the resident; and could deny the resident through the resident representative their wishes and preferences. The findings include: Record review of Resident #8's face sheet, dated 12/06/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and eloped on 12/5/25 and readmitted [DATE]. Resident #8 diagnoses included: encephalopathy (primary)-stroke, cerebral infarction (stroke), (admitting diagnosis), HTN, lack of coordination, cognitive deficits, acute kidney failure, heart disease, and schizophrenia (mental illness). The RP was listed as: a Guardian. Record review of Resident#8's quarterly MDS, dated [DATE], reflected a BIMS score of 3 indicative of severe impairment in cognition. The ADLs for: B/B was listed as continent. Transfer and Mobility was listed as set-up. ROM: no impairments. Assistive devices: none. Section E - Behavior- none. Wandering was listed as none. Record review of Resident #8's Letters of Guardianship, dated 11/14/25, reflected the state was granted guardianship with a Guardship Agency recognized to accept Resident #8. Record review of Resident# 8's Care Plan, revised 10/7/25 revealed: resident had a goal of elopement/wanderer based on evidenced of impaired safety awareness. Interventions listed included: re-direction and identify pattern of wandering. Record review of Resident #8's incident report dated 12/5/25 at 7:30 p.m., authored by LVN B reflected the resident during rounds at 7:30 p.m. Resident #8 was missing in her room, and a search was started for her; and she was not located. The Administrator, DON family and 911 were notified. [RP/Guardian was not mentioned as notified of the elopement]. Record review of Resident #8's ER report dated 12/8/25 at 10:58 a.m., reflected resident presented as an eloped resident with history of strokes. The resident was found on a bus on 12/8/25. Resident was confused and could not answer questions and explain her whereabouts the last 4 days. Presenting problem was found on bus. Diagnoses assigned to the resident included: stroke, hypertension, and history of stroke with aphasia needing placement. Recommendation: inpatient admission for assessment and future placement in a secure unit. During an observation and interview on 12/9/25 at 1:26 p.m., Resident #8 was in a hospital bed, alert and oriented X3 (person, place, and time). The resident was confused and neutral in her disposition and accepting an interview. Resident #8 stated she eloped from the door left opened by EMS; but could not remember the date and time. Resident # 8 stated she made no efforts to contact family or the Guardian. During a joint interview on 12/6/25 at 8:50 a.m., the Administrator stated and confirmed by the DON that Resident #8 had been missing from the facility on 12/5/25. The DON stated the Resident #8 had no family in the state and the nearest family lived in different state. The Administrator stated the resident was last seen at 7:30 PM when her medications had been administered. The Administrator stated the grounds and facility were searched and the resident could not be found. The Administrator stated law enforcement was notified on 12/5/25. The Administrator stated he was not certain of the date and time the RP/Guardian was notified of the incident. During an interview on 12/06/2025 at 11:16 a.m., the DON stated as of 12/06/25 at 11:21 a.m. Resident #8 had not been located; also, law enforcement had not located the missing resident. The DON stated she was familiar with the care of Resident #8. The DON stated the resident's closest family lived in another state. The DON stated she was not certain of the date and time the RP/Guardian was notified of the incident but was certain the RP/Guardian was contacted. During a telephone interview on 12/6/25 at 4:23 p.m., LVN B stated during her rounds at 7:30 p.m. on 12/5/25 she could not locate the resident and called the DON, family, and the Administrator. LVN B stated she did not know how the resident had eloped, and the resident had never shown exit seeking behavior or any negative behaviors. LVN B stated she did not know when the RP/Guardian was notified of the elopement and assumed someone in management would contact the RP/Guardian. LVN B stated she assumed the DON or the Administrator would notify the Guardian. During an interview on 12/06/25 at 4:40 p.m., the Administrator stated he was notified around on 12/05/25 around 8:30 p.m. that Resident #8 had eloped and stated the facility followed its elopement policy. The Administrator stated the policy would include notifying RP/Guardian. The Administrator stated nursing staff was responsible for notifying the Guardian as soon as</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, and misappropriation of property for 1 of 12 residents (Resident #8) reviewed for neglect. The facility neglected to follow its process for elopement when they failed to monitor an exit door when the alarm was bypassed by staff during EMS entry/exit. Resident #8 eloped from the facility's Unit 3 vicinity hall 100 door between 7:15 p.m. and 7:30 p.m. on 12/5/25 and was found by law enforcement on a bus on 12/9/25. Resident #8 had severe cognitive impairment, impaired safety awareness, and a history of strokes. An IJ (Immediate Jeopardy) was identified on 12/07/25. The IJ template was provided to the facility on [DATE] at 2:45 p.m. While the immediacy was removed on 12/10/25, the facility remained out of compliance at a scope of isolated and 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 further rehearse their elopement procedure and ensure all the door alarms worked. This failure could lead to residents experiencing serious injury, serious harm, serious impairment to include death. The findings include: Record review of Resident #8 's face sheet, dated 12/06/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and eloped on 12/5/25 and readmitted [DATE]. Resident #8 had diagnoses which included: encephalopathy (primary)-stroke, cerebral infarction (stroke), (admitting diagnosis), HTN, lack of coordination, cognitive deficits, acute kidney failure, heart disease, and schizophrenia (mental illness). The RP was listed as: a Guardian. Record review of Resident #8's quarterly MDS, dated [DATE], reflected a BIMS score of 3 indicative of severe impairment in cognition. The ADLs for: B/B was listed as continent. Transfer and Mobility was listed as set-up. ROM: no impairments. Assistive devices: none. Section E - Behavior- none. Wandering was listed as none. Record review of Resident #8's Letters of Guardianship dated 11/14/25 reflected the state [state and county name] was granted guardianship with a Guardship Agency recognized to accept Resident #8. Record review of Resident #8's elopement risk dated 7/18/25 reflected score was 9 (low risk for elopement) and no evidence of resident exit seeking prior to the incident. However, R#8 was confused and had to be re-directed when wandering into her previous room in a previous hall. Record review of Resident# 8's Care Plan, revised 10/7/25 revealed: resident had a goal of elopement/wanderer based on evidenced of impaired safety awareness. Interventions listed included: re-direction and identify pattern of wandering. Record review of Resident #8's physician orders, dated December 2025, reflected: Lisinopril Oral Tablet 10 MG (Lisinopril, a high blood pressure medication), once per day for HTN. Record review of Resident #8's MAR, dated December 2025 reflected: resident received her HTN medication and there were no refusals. The record reflected Resident #8 received her medication on 12/5/25 at 09:00 a.m. Record review of Resident #8's incident report dated 12/5/25 at 7:30 p.m., authored by LVN B reflected the LVN made rounds at 7:30 p.m. and could not locate the resident in her room or the facility. Incident report reflected, Resident #8 was missing from her room, and a search was started for her; and she was not located. The Administrator, DON, family and 911 were notified. Record review of Resident #8's photo given to law enforcement on 12/5/25 reflected the following description: [Resident #8] .May or may not have glasses.5'3 [height; feet and inches] .150 lbs.Jeans.no shoes-Hospital socks.Ponytail. Observation on 12/06/25 from 9:55 a.m. to 10:30 a. m. revealed Resident #8 was not found or located in the facility or the grounds of the facility. Observation likewise reflected all 15-second delay exit doors triggered at 8 locations. The 15-second delay system at Unit 3 vicinity hall 100 did not trigger and required a keypad code to open the door. The door alarm did not sound when forced open following a 15-second delay. Observation also reflected a resident entering the keypad code to the said exit door and left to the backyard. Observation on 12/06/25 at 1:12 p.m., revealed the front door had a sign present to alert visitors not to assist any resident out of the facility and to see nursing staff for any questions. Observation on 12/06/25 at 5:30 p.m. revealed Resident #8's room was about 30 feet from the door EMS used. [Note: the door could only be opened by a code, and it would sound when left open. The door appeared to require repair to allow for the 15-second delay.] [DON during entrance conference expressed the opinion that Resident #8 might have eloped from the door used by EMS on the day of the incident when the door was bypassed and door alarm was not working. The DON stated the EMS were assisted by staff for entry and exit but the door was not monitored during that time.] During a joint interview on 12/06/25 at 8:50 a.m., the Administrator stated and confirmed by the DON that Resident #8 had been missing from the facility on 12/5/25. The DON stated the resident had no family in the state and the nearest</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain medical records that were complete and accurately documented for 1 of 6 (Resident #1) residents reviewed, in that: There was no physician order for the use of the continuous positive airway pressure machine for Resident #1. This failure could result in inadequate care due to incomplete and inaccurate medical records. The findings were: Record review of Resident #1's face sheet dated 12/4/2025 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: chronic obstructive pulmonary disease (a lung condition that makes breathing hard due to inflamed, narrowed airways), bipolar disorder (a disorder causing extreme mood shifts), and generalized anxiety disorder (a mental health condition marked by excessive, uncontrollable worry about various everyday things). Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 15, indicating intact cognition. Record review of Resident # 1's Quarterly MDS , dated 11/1/2025 , revealed under section O : Special Treatments , Procedures,and Programs use of continuous positive airway pressure machine . Record review of Resident #1's progress notes for 11/17/2025 at 1239 p.m; revealed RN (A) entered the resident's room to check the resident's continuous positive airway pressure machine. Record review of Resident # 1's care plan, dated 11/11/2025, revealed a care plan with interventions use continuous positive airway machine at night. Record review of Physician monthly orders for November 2025 did not reveal orders for a continuous positive airway pressure machine. Record review of the hospital discharge summary for Resident #1, dated 11.7.2025, revealed orders for a continuous positive airway pressure machine at bedtime. Interview with RN (A) on 12/4/2025 at 2 PM revealed that she had previously cared for Resident #1 and confirmed Resident #1 used a continuous positive airway pressure machine. She was unaware of why there was no physician order for the constant positive airway pressure machine. During an interview and observation with Resident #1 on 12/5/2025 at 10:44 a.m., Resident #1 confirmed that she is on a continuous positive airway pressure machine but could not recall for how long . Observed revealed a constant positive airway pressure machine at bedside. During an interview with the DON on December 5, 2025, at 11:10 a.m., the DON made it clear that all resident clinical records, including physician orders, must be complete and accurate. She stated that the discharge and subsequent re-admission of Resident #1 may have resulted in the order being overlooked and not reactivated. The DON, who has been in her role for 30 days, acknowledged that she has not yet had the opportunity to audit orders for all Residents. She emphasized the admitting nurse missed the physician's order for a constant positive airway pressure machine. She said moving forward, she will audit physician orders for all Residents weekly for 30 days, and quality management will conduct audits at random. Record review of the facility policy, medication and treatment orders, dated 2001, revealed that drug and biological orders must be recorded on the physician's order sheet in the residents' chart</p>		