

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 03/13/2026
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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the comprehensive care plan was reviewed and revised by an interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 2 of 4 residents (Resident #2 and Resident #4) reviewed for care plans. 1.The facility failed to ensure Resident #2's care plan was revised to reflect the resident's fall on 1/22/26. 2.The facility failed to ensure Resident #4's care plan was revised to reflect the resident's aggression toward another resident on 2/13/26. These failures could place residents at risk of their current needs not being met. Findings included: 1.Record review of Resident #2's admission Record, dated 3/11/26, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Crohn's Disease (a chronic inflammatory bowel disease), Asthma (condition in which airways become inflamed, narrow, and produce extra mucus, making it difficult to breathe), Dementia (group of thinking and social symptoms that interferes with daily functioning), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), and Hypertension (high blood pressure). Record review of Resident #2's quarterly MDS assessment, dated 2/26/26, revealed the resident had a BIMS score of 11, suggesting moderately impaired cognition. Further review of this assessment revealed the resident required supervision when walking up to 50 feet. Record review of Resident #2's Care Plan revealed: .The resident has had an actual fall with (No Injury, minor injury, serious injury) .11/25/25 - actual fall.). Further review of this document revealed there were no other falls documented. Record review of Resident #2's progress notes revealed: Effective Date: 01/22/2026 12:20 [12:20 pm] Note Text: [Resident #2] was outside on supervised smoke break. [Resident #2] went to throw away a cigarette butt that fell on the ground and [Resident #5] pushed her out of the way to get to it causing [Resident #2] to fall to the ground.Author: [DON]. Record review of the facility's incident log, dated 3/6/26, revealed Resident #2 had a witnessed fall on 1/22/26. An interview with Resident #2 was attempted on 3/10/26 at 3:10 pm. The resident was not in the facility at that time. 2. Record review of Resident #4's admission Record, dated 3/11/26, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Aphasia (disorder that affects a person's ability to communicate) , Memory Deficit, Cognitive Social or Emotional Deficit, and Cognitive Communication Deficit (difficulty with thinking and language). Record review of Resident #4's comprehensive MDS assessment, dated 2/27/26, revealed Resident #4 had a BIMS score of 14, suggesting intact cognition. Further review of this assessment revealed the resident displayed physical and verbal behaviors toward others. Record review of Resident #4's Care Plan revealed: . [Resident #4] has potential to demonstrate physical behaviors r/t Anger, Poor impulse control . Further review of this document revealed there were no updates following the incident on 2/13/26. Record review of Resident #4's progress notes revealed: Effective Date: 02/13/2026 16:51 [4:51 pm] Note Text: Staff intervened between residents and separated them.Author: [LVN A] . Record review of the facility's incident log, dated 3/6/26, revealed Resident #4 had verbal/physical aggression on (continued on next page)</p>

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/13/26. During an interview on 3/11/26 at 3:12 pm, Resident #4 said he did not remember the incident on 2/13/26. During an interview on 3/11/26 at 5:08 pm, the DON said she was not aware Resident #2's care plan had not been updated after the fall on 1/22/26, and Resident #4's care plans had not been updated after the incident on 2/13/26. The DON further stated the care plans should have been updated after the incidents. The DON said it was important for care plans to be accurate because if they were not current, the facility could not focus on what was going on with the residents and what their current level of need was. The DON said the MDS Nurse was responsible for updating the care plans after acute incidents. The DON further stated that the current MDS Nurse was not employed by the facility during the incidents. The DON said the facility held daily morning meetings during the week and clinical meetings were held after the morning meetings, and care plans were updated during the meetings as needed. The DON said incidents from the prior day were reviewed during each morning meeting, and incidents occurring over the weekend were reviewed at the Monday morning meeting. The DON said if care plans were not updated in a timely manner, medical or behavioral issues could be missed by the team. The DON further stated she was responsible for ensuring care plans were updated. Record review of the facility's policy, titled Care Planning Policy, revised December 2025, revealed: .It is the policy of the facility to develop, implement, and maintain an individualized, person-centered care plan for each resident that addresses the resident's medical, nursing, psychosocial, and functional needs. Purpose To ensure each resident receives coordinated, individualized care designed to attain or maintain the highest practicable, mental, and psychosocial well-being.Care plans will be reviewed and revised.When new problems or goals are identified.</p>		