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	06/04/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide specialized habilitation services and failed to obtain specialized durable medical equipment for one (Resident #1) of three residents reviewed for PASRR (Preadmission Screening Resident Review) services.The facility failed to request a customized wheelchair within 20 business days after the IDT meeting for Resident #1. This failure could put residents at risk of not receiving the needed care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.Findings included:Review of Resident #1's face sheet dated 06/03/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Spina Bifida (a neural tube defect that occurs when the fetal spine and spinal cord do not close completely during the first month of pregnancy, This opening can leave the spinal cord and nerves exposed, causing varying degrees of lifelong physical and intellectual disabilities), Paraplegia (a medical condition characterized by the partial or complete paralysis of the lower half of the body, including both legs and often the lower trunk), Scoliosis (a medical condition characterized by an abnormal, sideways curvature of the spine, often forming an S or C shape). Review of Resident #1's care plan revised 04/23/2026 reflected Resident #1 has an ADL Self Care Performance Deficit r/t spina bifida, paraplegia, scoliosis, depressive disorder, epilepsy(a chronic neurological disorder characterized by recurrent, unprovoked seizures), polyneuropathy(simultaneous malfunction of many peripheral nerves throughout the body), reduced mobility, was at risk for pain and requires pain management D/T chronic pain r/t neuropathy (damage or dysfunction of the nerves outside the brain and spinal cord), is PASRR positive and receives MI and IDD specialized services with intervention dated 02/18/2026 which reflected Resident #1 will be receiving a customized wheelchair. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score was not recorded. Section GG reflected mobility devices was wheelchair. Functional limitation in range of motion reflected impairment on both sides of upper and lower extremities. Review of Resident #1's PASRR Comprehensive Service Plan quarterly meeting dated 03/06/2026 reflected Resident #1 was positive for IDD and MI and Customized Manual Wheelchair was ongoing. During an interview on 06/03/2026 at about 10:52 am the DOR stated during Resident #1's IDT meeting in March of 2026, a customized wheelchair for Resident #1 was requested. The DOR stated she tried to request the wheelchair for Resident # 1 from DME but at the time, the facility was going through a receivership (is a court-ordered legal process where a neutral third party (a receiver) is appointed to take custody, manage, or liquidate the assets or business of a financially distressed entity.) and the facility had outstanding bills with the DME company and so the company did not want to continue with the process. The DOR stated the DME company wanted some payment before processing any request from the facility. The DOR stated that the facility's new management set up a payment plan with the DME company, by then it was already 30 days past Resident #1's evaluation for the Customized Wheelchair and the facility needed a new evaluation. The DOR stated she requested an IDT for Resident #1 for 5/26/2026 for re-evaluation, but it was cancelled due to the PASRR Representative. The DOR stated the evaluation had to be within 30 days for DME company to come (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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and do the measure for Medicare can pay. The DOR stated Resident #1 has not yet gotten the customized wheelchair; it would be very similar to what she has now, the difference is she would own it. During an interview on 06/03/2026 at 12:29 pm with two PASRR Representatives, they stated they were about to have an IDT meeting regarding Resident #1. They stated during the 12/11/2025 IDT meeting was when the initial Customized wheelchair order was placed and later placed during the 03/05/2026 meeting. The PASRR Representatives stated the Therapy Department was responsible for contacting the DME company. During an interview on 06/04/2026 at 10:16 am, Resident #1 stated she had been waiting for her customized wheelchair for couple of months and nothing had been done. Resident #1 stated she had no idea why she had not gotten the wheelchair. Resident #1 stated she had a working wheelchair she was using and did not want to talk about her customized wheelchair anymore. During an interview on 06/04/2026 at 12:59 pm, the Administrator stated he was made aware yesterday 06/03/2026 of Resident #1's customized wheelchair. The Administrator stated the facility was on hold with the DME company due to outstanding bills. The Administrator stated the facility had negotiated the bills and the problem will eventually be resolved. The Administrator stated he did not know about Resident #1's wheelchair but PASRR was identified by Rapid response team, and the facility was working on it. The Administrator stated the previous MDS Nurse was the one working on PASRR, but she quit without warning. The Administrator stated the new MDS Nurse and Social Worker had just started and had no idea about Resident #1's wheelchair. The Administrator stated the Therapy Department was addressing PASRR concerns. Review of facility's policy titled admission Criteria revised March 2019 reflected: Our facility admits only residents whose medical and nursing care needs can be met.Policy Interpretation and Implementation1. The objectives of our admission criteria policy are to:a. provide uniform criteria for admitting residents to the facility.b. admit residents who can be cared for adequately by the facility;c. address concerns of residents and families during the admission process;9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process.a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.(1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD.(2) The social worker is responsible for making referrals to the appropriate state-designated authority.c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.d. The state PASARR representative provides a copy of the report to the facility.e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation.f. Once a decision is made, the state PA [NAME] representative, the potential resident and his or her representative are notified.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent infection for one (Resident #2) of three residents reviewed for pressure ulcer in that: The facility failed to obtain order for Resident #2's wound vac (a specialized medical device used to accelerate the healing of large, deep, or difficult-to-heal wounds) when she was re-admitted to the facility on [DATE]. Resident #2 did not have dressing change with the wound vac for four days, from 04/08/2026 to 04/12/2026 until she was transferred to the local hospital for fever of 103. This deficient practice placed Resident at risk for worsening pressure ulcers, decreased quality of care, infection and hospitalization.Findings included:Review of Resident #2's face sheet dated 06/03/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Traumatic Subdural Hemorrhage with loss of consciousness (a medical emergency characterized by bleeding between the brain surface and the tough outer membrane (dura), Gastrostomy status (indicates the presence of an artificial opening in the stomach. It is used for long-term enteral nutrition, medication administration), Chronic Obstructive Pulmonary Disease -COPD (a progressive, irreversible lung disease that restricts airflow and makes it hard to breathe), Muscle weakness, End Stage Renal Disease (is the final stage of chronic kidney disease. It occurs when kidney function drops to less than 10% of normal capacity, leaving the kidneys unable to filter waste and excess fluid from the blood), Pressure Ulcer Sacral stage 3, vascular Dementia (a decline in thinking and reasoning skills caused by restricted or blocked blood flow to the brain), Anemia. Review of Resident #2's care plan initiated 02/13/2025 reflected Resident #2 needed hemodialysis (a medical procedure that uses a machine to filter waste products, toxins, and excess fluid from your blood when your kidneys are no longer able to do so) related to renal failure, NPO diet due to peg tube feeding, bladder/bowel incontinence r/t Dementia, Impaired Mobility, Physical limitations, ADL Self Care Performance Deficit r/t Muscle Weakness (Generalized) has an alteration in neurological status r/t diagnosis of traumatic subdural hemorrhage. Required wound care due D/T: Stage 3 sacrum Wound vac dated 04/10/2026 Review of Resident #2's discharge MDS assessment dated [DATE] reflected a BIMS score of 99 indicating assessment was not completed. Section GG reflected Resident #2 required mechanical lift and was dependent on staff for ADLs. Review of Resident #2's progress notes dated 04/08/2026 at 8:20 pm reflected: Resident re-admitted to facility, arrived at about 8:15 pm via stretcher with EMS. Dx: Sepsis (the body's extreme, life-threatening response to an infection, with symptoms of rapid heart rate, high or low body temperature, shivering, fatigue), Sacral Decubitus ulcer (localized damage to the skin and underlying tissue caused by prolonged, unrelieved pressure over the sacrum), Hypophosphatemia (a condition characterized by abnormally low levels of phosphate in the blood). Residents awake and alert, accompanied by family, Resident to have wound vac to sacral decubitus. Wound vac applied on by wound care, skin check done by wound care. Meds verified by NP. Review of Resident #2's admission skin assessment dated [DATE] reflected Resident #2 had sacral ulcer with wound vac in place. Review of Resident #2's Physician orders printed 06/03/2026 reflected no order for Resident #2's sacral wound with wound vac. Review of Resident #2's progress notes dated 04/12/2026 at 08:30 am reflected: Upon entering the room [number] resident heard moaning with face grimacing head warm to touch, temp read 103, prn oxycodone given, cool towel place to head, vitals: 147/63, 82, 18, 103.0, O2 sat 92n/c, NP on call notified. Review of Resident #2's MAR for the month of April 2026 reflected: Wound vac to sacrum at 125mmHG every day shift every Mon for wound care -Start Date- 04/13/2026 0700 -D/C Date- 05/13/2026 1021 which was after Resident #2 had been transferred to the ER for further treatment. During an interview on 06/03/2026 at 03:27 pm, the ADON stated she was the wound care nurse at the time Resident #2 was in the facility. The ADON stated/ Wound care nurse stated Resident #2 was readmitted to the facility (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE] with wound vac and she did the connection to the suction while the DON was present. The ADON stated the local hospital did not send an order for the wound vac when Resident #2 was being re-admitted to the facility. The ADON stated she put in an order on 4/08/2026 for the nursing staff to monitor the wound vac to ensure it was suctioning. The ADON stated facility staff called the local hospital for wound vac orders, and they never got a call back. The ADON stated she notified the Wound Doctor and was told by the Wound Care Doctor that the dressing should remain until her next visit on 04/13/2026. The ADON stated she did not document that she contacted the Wound Doctor. The ADON stated Resident #2 was sent to the ER on [DATE] before the Wound Doctor's visit so Resident #2's wound vac dressing was not changed.During a phone interview on 06/04/2026 at 12:36 pm, the Wound Doctor stated she did not get to see Resident #2 when she was readmitted to the facility with wound vac so she would not give a verbal order. The Wound Doctor stated she knew about the wound vac but because she did not see Resident #2, she did not give the wound care nurse/ADON order for the wound vac, and she did not ask the wound care nurse to wait until her next visit. The Wound Doctor stated the surgeon from the hospital should have sent orders, if not the facility staff should have followed up with the hospital. The Wound Doctor stated, if the hospital did not send orders for Resident #2's wound vac, the facility staff should have notified the NP in house to look at the wound and give orders until she saw Resident #2. The Wound Doctor stated because she did not see Resident #2's wound, she was not able to answer if not doing wound care for 4 would cause infection.During a phone interview on 06/04/2026 at 1:49 pm, the NP stated wound care orders were usually given by the hospital when a resident was being discharged from the hospital The NP stated when Resident #2 was re-admitted , he did not check her hospital orders for wound care orders because it is usually followed by the Wound Doctor and team, he checked her medications. The NP stated, if there were no orders from the hospital when Resident #2 was re-admitted , the facility staff were supposed to get an order from the hospital or inform him, he would have ordered wet to dry dressing daily or wound vac every 3 days. The NP stated not changing wound dressing for four days was a risk for infection. The NP stated the wound vac dressing should have been changed Friday 4/10/2026, worst case scenario on 4/11/2026. During an interview on 06/04/2026 at 2:29 pm, the DON stated she was present when Resident #2 was re-admitted to the facility on [DATE] and she assisted the Wound Care Nurse / ADON to connect the suction to the wound. The DON stated the facility did not get a wound care order for the wound vac when Resident #2 was re-admitted . The DON stated she told the admitting nurse to ensure they got orders but was told by the hospital staff that the wound vac orders were in the discharge orders. The DON stated she used to be a wound care nurse and wound vac dressing changes vary from once a week, twice a week and three times a week depending on the amount of drainage from the wound and the setting on the machine. The DON stated Resident #2 went to the ER on [DATE] due to fever and fever could be an indication of an infection of some kind. Review of facility's policy titled Wound Care dated 10/2025 reflected: A. Assessment & PreventionUpon admission, evaluate risk factors for skin breakdown or wound development(mobility, nutrition, comorbidities).For residents with or at risk for wounds/pressure injuries, implement preventive measures (e.g., repositioning, support surfaces, nutritional support) in order of preventing and minimize skin breakdown.B. Treatment & Skilled NeedFor wounds (including pressure injuries, surgical wounds, chronic ulcers), implement an individualized wound-care plan. It should include: Wound description (location, size, stage, wound bed, presence of undermining/tunneling, condition of peri-wound tissue, positioning and support surfaces). Physician or advanced practitioner orders for wound care (dressing changes, debridement, treatments, frequency).C. DocumentationDocument wound assessment at baseline (admission or when wound identified) and weekly (size, depth, presence of necrosis/tunneling/exudate, peri-wound skin, infection, pain status).If using advanced therapies (e.g., skin-substitute products), ensure documentation contains wound size 2:1 cm2, adequate circulation, evidence of healing progress/response.