

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/30/2025
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 - 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. **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 remainder 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 (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 condition. Physician would not be able to intervene or initiate orders if they were unaware. Family would not be able to be aware of their resident hurting themselves. During an interview on [DATE] at 4:20 PM with the Physician, he stated he was not notified Resident #86 had a fall on [DATE]. He expected to be notified of residents' falls and said, Resident could be at risk of head bleeding and head trauma and respiratory issues. During an interview on [DATE] at 2:02 PM with the DON, she stated nurses were required to notify the physician and FM after an unwitnessed fall. She knew it was important to notify family and physician after unwitnessed fall and said, Important for physician to give orders. Important for family to know so they could respond to facility or hospital. Review of the facility Abuse and Neglect Clinical Protocol last revised in [DATE] reflected:- The nurse will report findings to the physician and monitor residents. Review of the facility Change in a Residents Condition or Status policy last revised [DATE] reflected:- Physician and representative must be notified when there is an incident or accident involving the resident. These failures resulted in an identification of an Immediate Jeopardy (IJ) on [DATE] at 12:23 p.m. The DON was notified of the IJ and provided the IJ template. The POR F580 was approved [DATE] at 08:16 AM and reflected the following: Plan of Removal F580 Immediate Jeopardy On [DATE], regulatory services determined that The Facility failed to meet the requirements of tag F580, resulting in an Immediate Threat to resident health and safety. Action: Action: Immediate Notification Protocol Implementation Start Date: [DATE] Completion Date: [DATE] Responsible: Consultant Registered Nurse (RN)/Director of Nursing (DON) Target Audience: All licensed nursing staff Details: DON was educated by Consultant RN on change of conditions and F580. An audit checklist was created by Consultant RN and DON; and used to review the last 72 Hour Report for keywords pain, fall, fever, all Vital Signs, blood glucose monitoring, weights, variances, and last 14 days incident reports. These were all printed for review and notations made on report. Any change of conditions found were worked by DON and Consultant RN to verify DON comprehension. A standardized notification checklist was implemented for all incidents involving changes in resident condition. The checklist includes time-stamped documentation of family and physician contact. Charge nurses must verify completion and submit to DON daily. Evaluation: Daily audits of incident reports and 24hr report for 14 days. Daily IDT review for compliance and documentation. Nurse staff comprehension was verified and documented on competency form with comprehension statement signed by nursing staff and either DON or Consultant RN. Action: Action: Staff Education on Notification Requirements Start Date: [DATE] Completion Date: [DATE] Responsible: DON and Consultant RN Target Audience: All licensed nursing staff and new hires ongoing Details: Mandatory in-service training on F580 regulations and facility policy. Evaluation: (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Post-training competency quiz (pass rate ^ 90%). Random chart audits for 30 days to verify proper notification, includes documentation of audit by printing and notations to 24hr report and progress notes and/or incident report reviewed. Action: Action: Policy Review and Quality Assurance Performance Improvement Start Date: [DATE] Completion Date: [DATE] Responsible: Administrator & DON Target Audience: All licensed nursing staff and IDT Details: Facility policies on change in condition and fall response reviewed. Daily EMR audit specific to Incidents and Accidents for tracking family/physician contacts and documentation. Will be documented on Compliance Monitoring Audit. Evaluation: Monthly policy compliance audits. EMR usage reports reviewed monthly during QAPI X3 months or until a revised sustainable plan for safety is achieved. Comprehension verified and documented as above for nursing staff with same Post-training competency quiz (pass rate ^ 90%) for all IDT members . The POR was monitored in the following ways : In an interview on [DATE] at 01:00 PM with the DON she confirmed that on [DATE] she was in-serviced by the CEO (Chief Executive Officer) prior to beginning the education with all licensed nursing staff. The ADON made the decision to return to work as a floor nurse and not continue the responsibilities as a ADON and was not in-serviced by the CEO, the MDS coordinator did receive the training at the same time as the DON the in-service stated that all licensed nursing staff will receive mandatory re-education with verbal discussion and sign in sheet on the facility's fall response protocol, change in condition procedures, and abuse/neglect clinical protocols. Nurses have been directed to notify DON when any resident refuses evaluation by EMS (emergency medical services) and a post-quiz will be used for determining understanding after education is provided. In an interview on [DATE] at 01:59 PM with the DON confirmed that she was in-serviced by the NC prior to in-servicing the facility nursing staff on regarding changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON, they reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family, She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the assessments necessary, they also discussed the of care planning and updating the resident's care plans to include falls. In an interview on [DATE] at 02:54 PM with the DON she stated for the moment they have to move forward with EMS assessments until she is absolutely comfortable with the nurses ability to assess residents to make sure that residents stay safe in the event of a fall, EMS is a fall back safety measure, she can provide staff education and make them do competencies all day long - the staff need to respond with a sense of emergency, and be able to reflect they have the knowledge of what they do, right now she is using EMS for assessments until staff exhibit they can do everything appropriately. In an interview on [DATE] at 01:31 PM with NC she confirmed that she in-serviced DON prior to the DON in-servicing the nursing staff regarding changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON, they reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family, She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessments necessary. They also discussed the of care planning and updating the resident's care plans to include fallsIn an interview on [DATE] at 11:45 AM DON stated most of the nurses are trained and retrained on neuro check and post fall evaluation. She stated they were trained on reporting to physician and family in a timely manner. DON stated the daily meeting the fall and other related issues evaluated, and necessary actions taken. There was no fall or incident of any significant changes in condition. Resident #3 had a fall on [DATE] and was reviewed and all the necessary steps were taken after the fall. She stated during the review it was revealed the care plans were not updated, not just for fall but also for various other issues. She stated the care plans were updated accordingly. The external NC will be supervising and monitoring the activities to ensure things are going in the right track.In an interview on [DATE] at 03:12PM with NC, she stated she in serviced and trained DON . She stated she had interviewed the nursing staff in the weekends as well to make sure they learnt everything that they supposed to. She stated she was happy with the outcome and will monitor and guide them to optimize their competencyThe following nurses were interviewed and observed working on PCC completing neuro checks and post fall evaluation. They were able to navigate the neuro check and post fall evaluation form on E H R (PCC). They were able to explain how to fill them out and the rationale and significance of the findings during the evaluation . They were able to identify a significant change and when to notify a physician /or call EMS Able to answer randomly asked post training quiz questions. See below:In an interview on [DATE] at 01:00 PM with RN O, - Full time started [DATE] During the interview stated: Got received the training [DATE] trained . Previously was doing neuro checks on paper form and then hand over to DON. Now got trained to do directly on the EH R.In an interview on [DATE] at 01:15 PM RN G - PRN -[DATE] During the interview stated: Trained on [DATE] and was trained on neuro check, post fall evaluation and incident report was to be completed. Neuro check to be continued for 3 days, she stated she was previously doing on paper , now on both , first on paper and then on PCC. Stated confident to do neuro and post fall evaluation. Neuro check initially every 15minutes.In an interview on [DATE] at 01:45 PM with LVN I Trained on [DATE]. During the interview stated: Interview over the phone, able to answer quiz questions. Able to explain neuro check and post fall process and procedures. Stated able to coordinate care independently.In an interview on [DATE] at 01:55 PM with LVN B, Trained on [DATE]. During the interview stated : She was doing after the fall evaluation and neuro check before too. Stated she was confident enough to conduct oneIn an interview on [DATE] at 02:35 PM with MDS Coordinator, LVN Trained on [DATE]. During the interview stated she received the trainings for the post fall procedures and how to enter the information in the E H R. In an interview on [DATE] at 02:35 PM with LVN P Interview over the phone. Nurse for 7 years. Done post fall evaluation and neuro checks before. Received the training on [DATE] from the facility. Stated she was able to conduct a post fall procedure independentlyReview of the facility's in-services and post-training quizzes reflected staff were reeducated and returned demonstration of competencies with F580 and facility protocols. Additionally, the following care plans/ assessments had been updated by the facility - Resident #65Resident #100Resident #66Resident #49Resident #27Resident #3Resident #7Resident #19Resident #11Resident #14Resident #6Resident #12These failures resulted in an identification of an Immediate Jeopardy (IJ) with the DON notified and IJ Template provided 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.		

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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. **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 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 stated she believed she initiated neurological monitoring on Resident #86. LVN A stated nurses were responsible for initiating and conducting ongoing neurological monitoring on residents every 30 minutes when they have an unwitnessed fall. LVN A stated the ADON and DON were responsible for ensuring nurses initiated and conducted ongoing neurological monitoring after a resident had an unwitnessed fall. LVN A stated she knew the importance of initiating and conducting ongoing neurological monitoring for residents with falls and said, To make sure their vitals were stable. Resident could be at risk of a blood clot. She could not recall if not initiating and conducting ongoing neuro checks after an unwitnessed fall and not notifying family and physician was neglect. She defined neglect as not taking care of a resident or abusing a resident. 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]. RN K stated he did not initiate and conduct neurological monitoring on Resident #86 because he did not know Resident #86 had a fall on [DATE]. RN K stated nurses were responsible for initiating and conducting ongoing neurological monitoring on residents if residents had an unwitnessed fall. RN K explained nurses were responsible for following the neurological monitoring frequency listed on the neurological monitoring sheet when initiating and conducting ongoing neurological monitoring. RN K stated the DON was responsible for ensuring the nurses initiated and conducted ongoing neurological monitoring after a resident had an unwitnessed fall. RN K stated he told the DON that LVN A needed to be put back on training due to not performing neurological monitoring on Resident #86 after the fall. RN K stated he knew the importance of initiating and conducting ongoing neurological monitoring for residents with falls and said, Because resident could have hit his head and had a brain injury and to know that resident did not have damage to his head and to determine if resident needs to go to the hospital. Resident could be at risk of brain injury. He believed not initiating and conducting ongoing neurological monitoring after a resident had an unwitnessed fall was neglect. He defined neglect as failure of NF not providing care and services to a resident. During an interview on [DATE] at 3:07 PM with the ADON, she stated she was unable to find Resident #86's neurological monitoring sheets after his fall on [DATE]. She stated Resident #86's neurological monitoring sheets were started on [DATE] by LVN A and were not finished. She stated RN K was supposed to continue Resident #86's neurological monitoring. She stated nurses were responsible for initiating and conducting ongoing neurological monitoring after a resident had an unwitnessed fall and followed the frequency on the neurological monitoring sheet. She stated the DON was responsible for ensuring nurses initiated and conducted ongoing neurological monitoring on residents and 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 knew the importance of initiating and conducting ongoing neurological monitoring on residents after an unwitnessed fall and said, Because resident could have brain injury, brain bleeding, abnormal vital signs, pain or fracture from fall. Residents could be at risk of going unconscious, brain bleed that staff unaware of, fracture, stroke, and develop infection if not completing neuro checks on them. She also stated nurses were responsible for notifying residents' families and physicians that they fell. She also knew the importance of notifying family and physician (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and said, So they were aware of the change in condition. Physician would not be able to intervene or initiate orders if they were unaware. Family would not be able to be aware of their resident hurting themselves. Not initiating and conducting ongoing neurological monitoring after a resident had an unwitnessed fall was neglect. She defined neglect as not caring or not carrying out duties as a nurse, and not tending to the resident. During an interview on [DATE] at 3:26 p.m., LVN M stated nurses were responsible for initiating and conducting ongoing neurological monitoring after an unwitnessed fall. LVN M stated nurses were responsible for documenting neurological monitoring, submitting the completed sheets to the MR, and the MR uploads the sheets in the resident's EMR. LVN M stated the ADON or DON were responsible for ensuring nurses initiated and conducted ongoing neurological monitoring after a resident had an unwitnessed fall. LVN M stated he knew the importance of initiating and conducting ongoing neurological monitoring on residents after an unwitnessed fall and said, Because resident could be on blood thinners or for signs or symptoms of change in condition so they could be sent out to the hospital or they could have high blood pressure. Residents could be at risk of brain bleed, fracture, and other injuries. LVN M stated not initiating and conducting ongoing neurological monitoring after a resident had an unwitnessed fall was neglect. LVN M stated he defined neglect as when not showing up for the resident in a way they needed to be shown up for and not tending to residents' needs. During an interview on [DATE] at 4:20 PM with the Physician, he stated he was not notified Resident #86 had a fall on [DATE]. He expected to be notified of residents' falls. He stated nurses were required to initiate neurological monitoring after an unwitnessed fall and said, Resident could be at risk of head bleeding and head trauma and respiratory issues. During an interview on [DATE] at 10:35 AM with the DON, she stated she did not believe the fall protocol was followed in this case. She stated it is the expectation that post fall assessments are completed and documented after a fall and that the nurse assessing the fall or PT assess the resident's ability to rise from his/her wheelchair. She stated a negative outcome of not following the fall protocol/ procedures are negative deficits are increased up to and including death. DON stated LVN A completed neurological checks for the time left on her shift (only 1 hour) and were documented on paper not on the resident's chart as it should have been. She stated the checks that should have occurred after LVN A left were not completed. During an interview [DATE] at 11:13 AM with LVN A, she stated Resident #86 was able to stand and self-transfer from his bed to his wc on a normal day. She stated after his fall on [DATE] redness was noted to his head and she suspected head injury. LVN A stated after the fall Resident #86 refused to go to the hospital and instead went outside. LVN A stated she documented the fall in the nursing progress notes but did not do an incident report as the charge nurse on duty, and only provided an oral report to the DON. She stated she was aware of the care plan intervention but did not have the knowledge of the facility's fall protocol or procedures and was not aware of the assessments she had to complete. LVN A also stated she lacked the knowledge of using the EMR system for the facility and only received 3 days of training before being allowed on the floor as the charge nurse. She stated therefore she did not know how to properly document the assessments required after a fall and lacked the knowledge of what assessments were required. LVN A stated she only completed checks on Resident #86 for the 1 hour she had left on her shift and left at 7pm. She stated those were documented on paper and not the resident's chart. In an interview on [DATE] at 12:57 PM with the ADON, she stated it was the expectation that all falls were documented on the EMR and post fall assessments and incident reports completed. She stated she is not sure why it was not documented in there by LVN A. ADON stated that if LVN A does not know how to conduct the assessments from the EMR system that it was her expectation that LVN A asked for assistance. ADON stated the nurse doing the assessment on the resident post fall should also do the wc stand up assessment to test any decline in strength or abilities. She stated the care plan reflects the care that is supposed to be provided to residents, and it was not followed in this case since following the fall protocol was an intervention. ADON stated post fall assessments include neuro checks, vitals such as pulse, respirations, checking motor skills, pupils reaction, overall alertness and any changes to (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	baseline. She stated a potential negative outcome to the resident if the fall protocols and procedures are not followed would be the resident can have a brain bleed, internal issues they are not aware of, fractures, or infections from fractures. In an interview on [DATE] at 03:00 PM with the DON, she reiterated that the fall protocol was not followed as it pertained to the incident on [DATE] with Resident #86. The DON stated that it was her expectation that the nurses were competent in following a resident's care plan because failure to follow it would result in the residents not getting the care they need. She stated it was her expectation that if a nurse encounters something they do not know how to do such as assessments, placing orders, or working in the EMR that they ask for help. She stated staff should be reaching out to her to get instructions on how to do it. In an interview on [DATE] at 03:38 PM with the ADM, she stated it was her expectation that before a nurse goes to the floor to work with residents she is provided competencies that include training on where you go in the EMR to generate assessments, knowledge on the facility's policies and procedures, and know that they must ask questions if there is something they don't know. The ADM stated that failure to have competent nurse staffing, not completing assessments, following care plans, or facility policy results in residents not having the opportunity to be provided appropriate care. She stated that as the new ADM she is providing the facility with her expectations on the education that must be completed to ensure residents are being provided the appropriate care, and ongoing education that will be provided to direct care staff. Review of the facility Care Plans, Comprehensive Person Centered last revised [DATE] reflected: Policy statement: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. - The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive person-centered care plan will: o describe the services to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. o Incorporate identified problem areas. o Identify the professional services that are responsible for each element of care. - Assessments of the residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. Review of the facility Abuse and Neglect Clinical Protocol last revised in [DATE] reflected: - Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to- provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or- emotional distress.- The nurse will report findings to the physician and monitor residents. Review of the facility Change in a Residents Condition or Status policy last revised [DATE] reflected: - Physician and representative must be notified when there is an incident or accident involving the resident. Review of the facility Falls-Clinical Protocol last revised [DATE] reflected: - A nurse shall assess and document/ report the following: vital signs, musculoskeletal function, observing changes in normal range of motion, weight bearing etc., change in cognition or level of consciousness, neurological status, pain.- Monitoring and follow up: the staff with the physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. Review of facility Assessing Falls and Their Cause policy revised [DATE] reflected: Purpose- to provide guidelines for assessing a resident fall and to assist staff in identifying causes of the fall. - After a fall- observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. - Document any observed signs or symptoms of swelling, bruising, deformity, and/or decreased mobility and any changes to level responsiveness/ consciousness and overall function. Note the presence or absence of significant findings. - Complete an incident report for resident falls (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	no later than 24 hours after the fall occurs. The incident report should be completed by the nursing supervisor on duty at the time and submitted to the DON. Performing a post fall evaluation:- After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and return to sitting, and will document the results of this effort. If the individual has no difficulty or unsteadiness, no further evaluation is needed at that time. If the individual has difficulty or is unsteady in performing this test, additional evaluation may be initiated as warranted. These failures resulted in an identification of an Immediate Jeopardy (IJ) On [DATE] at 05:00 PM. The ADM was notified of the IJ and provided the IJ template on [DATE] at 5:00 p.m. The POR F600 was approved [DATE] at 06:07 PM and reflected the following: Plan of Removal (POR) Immediate Jeopardy - F600: Neglect On [DATE], an abbreviated survey was initiated at The Facility. On [DATE], The surveyor determined that the Facility was in Immediate Jeopardy (IJ) due to noncompliance with Tag F600 - Neglect, resulting in the death of Resident #86. The facility failed to follow its own policies and procedures regarding post-fall assessments, including conducting ongoing neurological checks, notifying the resident's family, and notifying the physician after an unwitnessed fall on [DATE]. Resident #86 was found unresponsive the following morning and passed away shortly thereafter. Date of Immediate Jeopardy Notification: [DATE] Tag: F600 - The facility must ensure residents are free from neglect. Immediate Jeopardy Summary: On [DATE], Resident #86 experienced an unwitnessed fall and hit his head. The facility failed to conduct ongoing neurological checks, notify the family, and notify the physician. The resident was found unresponsive the following morning and passed away shortly after. Interviews and documentation revealed systemic failures in communication, assessment, and adherence to facility protocols, constituting neglect. Actions to Remove Immediate Jeopardy Action 1: Immediate Staff Education and Re-Education Description: DON (Director of Nursing) will be re-educated by CEO (Chief Executive Officer) prior to beginning of education with all licensed nursing staff, including PRN and possible agency staff prior to next shift worked. ADON (Assistant Director of Nursing) and MDS (Minimum Data Set) Nurse will be initially educated by DON after DON education. All licensed nursing staff will receive mandatory re-education with verbal discussion and sign in sheet on the facility's fall response protocol, change in condition procedures, and abuse/neglect clinical protocols. Nurses have been directed to notify DON when any resident refuses evaluation by EMS (emergency medical services). A Post- Quiz will be used for determining understanding after education is provided. Start Date: [DATE] Completion Date: [DATE] Responsible: Director of Nursing (DON)/MDS Coordinator/ADON Action 2: Implementation of Neuro Check Audit System Description: A neuro check audit log will be implemented to ensure all required neurological assessments are completed and documented following any fall, especially unwitnessed ones or known head injuries. All licensed nursing staff have been notified by mass group messaging app- response in acknowledgement has been requested. If no response- DON/Designee will complete calls to each nurse who fails to acknowledge and send report of follow up call to administrator for tracking purposes. ADON will be responsible for maintaining Neuro log. DON has educated ADON on completing and maintaining Neuro Audit Log, including how to fill out audit form during clinical review in morning clinical meeting. ADON will provide overview of log during fall review component of morning clinical meeting; it will only be completed on residents with unwitnessed falls or with known head injuries. Should the ADON be unavailable, DON will maintain and provide overview. Start Date: [DATE] Completion Date: [DATE] Responsible: Assistant Director of Nursing (ADON)/DON Action 3: Mandatory Notification Protocol Enforcement Description: All nursing staff will be required to notify the physician and family immediately following any fall. A notification checklist is included in the incident report form to ensure compliance. This is a checklist only and does not require competencies to be completed for training. Only notification of implementation- via secure messaging app with read receipts turned on. It will also be added to the Neuro audit logs for review each morning during the clinical meeting. Initial notice was provided via mass group messaging app. Re-education on fall protocol, neuro implementation, log and risk management checklist will be (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided from DON to Designee and then to all other licensed nursing staff (including new hires and possible agency) prior to next shift worked. A comprehensive post-Quiz with included topics will be used for determining understanding after education is provided. Nursing has also been reminded of policy to complete walking rounds and review of shift change over (24 hour report) and group acknowledgement has been required as above. When nursing is observed out of compliance by DON/ADON, 1 on 1 disciplinary action will ensue. Start Date: [DATE] Completion Date: [DATE] Responsible: DON/Designee Action 4: Daily Clinical Review of All Falls Description: The interdisciplinary team will conduct daily reviews of all falls to verify that neuro checks, notifications, and documentation are complete and timely. IDT consists of entire leadership team depending on availability: Administrator, DON, ADON, therapy, social services, activities, dietary and housekeeping/maintenance. This will be documented on an Audit Log daily until system maintenance is achieved and plan is completed per QAPI below. Start Date: [DATE] Completion Date: [DATE] Responsible: DON, ADON, Administrator Action 5: Quality Assurance and Performance Improvement (QAPI) Integration Description: The incident and corrective actions were reviewed during ad hoc QAPI meeting. A root cause analysis will be conducted, and long-term strategies will be developed to prevent recurrence. A second ad hoc took place on [DATE] via teleconference to directly review policy on nursing communication; committee agreed that policy changes do not need to take place at present; nursing will be held accountable by disciplinary action for variance from required walking rounds and review of 24 hour report during shift change over. Will continue to be reviewed in monthly QAPI x3 or until revised plan is reached to sustain ongoing maintenance. Start Date: [DATE] Completion Date: [DATE] Responsible: CEO/Administrator The POR was monitored in the following ways: In an interview on [DATE] at 12:20 PM with CEO and DON, they notified surveyors LVN A had resigned effective [DATE] and would no longer be coming in. In an interview on [DATE] at 01:00 PM with the DON she confirmed that on [DATE] she was in-serviced by the CEO (Chief Executive Officer) prior to beginning the education with all licensed nursing staff. The ADON made the decision to return to work as a floor nurse and not continue the responsibilities as a ADON and was not in-serviced by the CEO. The MDS coordinator did receive the training at the same time as the DON. The in-service stated that all licensed nursing staff will receive mandatory re-education with verbal discussion and sign in sheet on the facility's fall response protocol, change in condition procedures, and abuse/neglect clinical protocols. Nurses have been directed to notify DON when any resident refuses evaluation by EMS (emergency medical services) and a post-quiz will be used for determining understanding after education is provided. In an interview on [DATE] at 01:59 PM with the DON confirmed that she was in-serviced by the NC prior to in-servicing the facility nursing staff on changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON. They reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family. She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the assessments necessary. They also discussed the care planning and updating the resident's care plans to include falls. In an interview on [DATE] at 02:54 PM with the DON she stated for the moment they have to move forward with EMS assessments until she is absolutely comfortable with the nurses' ability to assess residents to make sure that residents stay safe in the event of a fall. EMS is a fall back safety measure. She can provide staff education and make them do competencies all day long - the staff need to respond with a sense of emergency, and be able to reflect they have the knowledge of what they should do. Right (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	now she is using EMS for assessments until staff exhibit they can do everything appropriately. In an interview on [DATE] at 01:31 PM with NC she confirmed that she in-serviced DON prior to the DON in-servicing the nursing staff regarding changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON. They reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family. She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the assessments necessary. They also discussed the care planning and updating the resident's care plans to include falls. In an interview on [DATE] at 11:45 AM DON stated most of the nurses are trained and retrained on neuro check and post fall evaluation. She stated they were trained on reporting to physician and family in a timely manner. DON stated that during their daily meeting falls and other related issues were evaluated, and necessary actions were taken. There was no fall or incident of any significant changes in condition. Resident #3 had a fall on [DATE] and was reviewed and all the necessary steps were taken after the fall. She stated during the review it was revealed the care plans were not updated, not just for fall but also for various other issues. She stated the care plans were updated accordingly. The external NC will be supervising and monitoring the activities to ensure things are going in the right track. In an interview on [DATE] at 03:12PM with NC, she stated she in serviced and trained DON. She stated she had interviewed the nursing staff on the weekend as well to make sure they learned everything that they were supposed to. She stated she was happy with the outcome and will monitor and guide them to optimize their competency. The following nurses were interviewed and observed working on PCC completing neuro checks and post fall evaluation. They were able to navigate the neuro check and post fall evaluation form on E H R (PCC). They were able to explain how to fill them out and the rationale and significance of the findings during the evaluation. They were able to identify a significant change and when to notify a physician /or call EMS, additionally staff were able to answer randomly asked post training quiz questions. See below: In an interview on [DATE] at 01:00 PM with RN O, - Full time started [DATE] During the interview she stated: she received the training [DATE]. She stated she was previously doing neuro checks on paper form and then would hand it over to DON. Now she got trained to do the documentation directly on the EH R. She stated she knew to immediately report ANE to the ANE coordinator who was the ADM. In an interview on [DATE] at 01:15 PM RN G - PRN -[DATE] During the interview stated: she received training on [DATE] and was trained on neuro check, post fall evaluation and incident report was to be completed. Neuro check to be continued for 3 days, she stated she was previously doing charting on paper, now on both, first on paper and then on PCC. Stated she is confident in doing neuro and post fall evaluations. She stated neuro check are complet[TRUNCATED]		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 5 residents (Resident #86 and Resident #33) reviewed for care plans. 1. The facility failed to implement Resident #86's care plan intervention which included follow fall protocol (which consisted of ongoing neuro checks, post fall assessments, and notifying RP and physician) after Resident #86 sustained an unwitnessed fall with a head injury on [DATE]. Resident #86 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 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 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. 2. The facility failed to identify Resident #33's diagnosis of bipolar disorder in her care plan . This failure could place residents at risk of individualized medical and nursing needs not being met resulting in injury or death. Findings included:1.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 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 remainder 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 (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[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 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 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 believed she initiated neurological monitoring on Resident #86. LVN A stated nurses were responsible for initiating and conducting ongoing neurological monitoring on residents every 30 minutes when they have an unwitnessed fall. LVN A stated the ADON and DON were responsible for ensuring nurses initiated and conducted ongoing neurological monitoring after a resident had an unwitnessed fall. LVN A stated she knew the importance of initiating and conducting ongoing neurological monitoring for residents with falls and said, To make sure their vitals were stable. Resident could be at risk of a blood clot. 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]. RN K stated he did not initiate and conduct neurological monitoring on Resident #86 because he did not know Resident #86 had a fall on [DATE]. RN K stated nurses were responsible for initiating and conducting ongoing neurological monitoring on residents if residents had an unwitnessed fall. RN K stated the DON was responsible for ensuring the nurses initiated and conducted ongoing neurological monitoring after a resident had an unwitnessed fall. RN K stated he told the DON that LVN A needed to be put back on training due to not performing neurological monitoring on Resident #86 after the fall. RN K stated he knew the importance of initiating and conducting ongoing neurological monitoring for residents with falls and said, Because resident could have hit his head and had a brain injury and to know that resident did not have damage to his head and to determine if resident needs to go to the hospital. Resident could be at risk of brain injury. During an interview on [DATE] at 3:07 PM with the ADON, she stated she was unable to find Resident #86's neurological monitoring sheets after his fall on [DATE]. She stated Resident #86's neurological monitoring sheets were started on [DATE] by LVN A and were not finished. She stated RN K was supposed to continue Resident #86's neurological monitoring. She stated nurses were responsible for initiating and conducting ongoing neurological monitoring after a resident had an unwitnessed fall. She stated the DON was responsible for ensuring nurses initiated and conducted ongoing neurological monitoring on residents and 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 knew the importance of initiating and conducting ongoing neurological monitoring on residents after an unwitnessed fall and said, Because resident could have brain injury, brain bleeding, abnormal vital signs, pain or fracture from fall. Residents could be at risk of going unconscious, brain bleed that staff unaware of, fracture, stroke, and develop infection if not completing neuro checks on them. She also 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 condition. Physician would not be able to intervene or initiate orders if they were unaware. Family would not be able to be aware of their resident hurting themselves. During an interview on [DATE] at 4:20 PM with the Physician, he stated he was not notified Resident #86 had a fall on [DATE]. He expected to be notified of residents' falls. He stated nurses were required to initiate neurological monitoring after an unwitnessed fall and said, Resident could be at risk of head (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	bleeding and head trauma and respiratory issues. During an interview on [DATE] at 10:35 AM with the DON she stated she did not believe the fall protocol was followed in this case. She stated it is the expectation that post fall assessments are completed and documented after a fall and that the nurse assessing the fall or PT assess the resident's ability to rise from his/her wheelchair. She stated a negative outcome of not following the fall protocol/ procedures are negative deficits are increased up to and including death. DON stated LVN A completed neurological checks for the time left on her shift (only 1 hour) and were documented on paper not on the residents chart as it should have been, she stated the checks that should have occurred after LVN B left were not completed. During an interview [DATE] at 11:13AM with LVN A she stated Resident #86 was able to stand and self-transfer from his bed to his wc on a normal day. She stated after his fall on [DATE] redness was noted to his head and she suspected head injury. LVN A stated after the fall Resident #1 refused to go to the hospital and instead went outside. LVN A stated she documented the fall in the nursing progress notes but did not do an incident report as the charge nurse on duty, and only provided an oral report to the DON. She stated she was aware of the care plan intervention but did not have the knowledge of the facilities fall protocol or procedures and was not aware of the assessments she had to complete. LVN A also stated she lacked the knowledge of using the EMR system for the facility and only received 3 days of training before being allowed on the floor as the charge nurse, she stated therefore she did not know how to properly document the assessments required after a fall and lacked the knowledge of what assessments were required. LVN A stated she only completed checks on Resident #86 for the 1 hour she had left on her shift and left at 7pm, she stated those were documented on paper and not the resident's chart. In an interview on [DATE] at 12:57 PM with the ADON she stated it was the expectation that all falls were documented on the EMR and post fall assessments and incident reports completed, she stated she is not sure why it was not documented int here by LVN A. ADON stated that if LVN A does not know how to conduct the assessments from the EMR system that it was her expectation that LVN A asked for assistance. ADON stated the nurse doing the assessment on the resident post fall should also do the wc stand up assessment to test any decline in strength or abilities. She stated the care plan reflects the care that is supposed to be provided to residents, and it was not followed in this case since following the fall protocol was an intervention. ADON stated post fall assessments include neuro checks, vitals such as pulse, respirations, checking motor skills, pupils reaction, overall alertness and any changes to baseline. She stated a potential negative outcome to the resident if the fall protocols and procedures are not followed would be the resident can have a brain bleed, internal issues they are not aware of, fractures, or infections from fractures. In an interview on [DATE] at 03:00 PM with the DON she reiterated that the fall protocol was not followed as it pertained to the incident on [DATE] with Resident #86. The DON stated that it was her expectation that the nurses were competent in following a residents care plan because failure to follow it would result in the residents not getting the care they need. She stated it was her expectation that if a nurse encounters something they do not know how to do such as assessments, placing orders, or working in the EMR that they ask for help. She stated staff should be reaching out to her to get instructions on how to do it. In an interview on [DATE] at 03:38 PM with the ADM she stated it was her expectation that before a nurse goes to the floor to work with residents she is provided competencies that include training on where you go in the EMR to generate assessments, knowledge on the facilities policies and procedures, and know that they must ask questions if there is something they don't know. The ADM stated that failure to have competent nurse staffing, not completing assessments, following care plans, or facility policy results in residents not having the opportunity to be provided appropriate care. She stated that as the new ADM she is providing the facility with her expectations on the education that must be completed to ensure residents are being provided the appropriate care, and ongoing education that will be provided to direct care staff. Review of the facility Care Plans, Comprehensive Person Centered last revised [DATE] reflected:Policy statement: A comprehensive person-centered care plan that includes measurable objectives and (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. - The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive person-centered care plan will: o describe the services to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being.o Incorporate identified problem areas.o Identify the professional services that are responsible for each element of care. - Assessments of the residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. Review of the facility Abuse and Neglect Clinical Protocol last revised in [DATE] reflected:- The nurse will report findings to the physician.Review of the facility Change in a Residents Condition or Status policy last revised [DATE] reflected:- Physician and representative must be notified when there is an incident or accident involving the resident. Review of the facility Falls-Clinical Protocol last revised [DATE] reflected:- A nurse shall assess and document/ report the following: vital signs, musculoskeletal function, observing changes in normal range of motion, weight bearing etc., change in cognition or level of consciousness, neurological status, pain.- Monitoring and follow up: the staff with the physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. Review of facility Assessing Falls and Their Cause policy revised [DATE] reflected: Purpose- to provide guidelines for assessing a resident fall and to assist staff in identifying causes of the fall. - After a fall- observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. - Document any observed signs or symptoms of swelling, bruising, deformity, and/or decreased mobility and any changes to level responsiveness/ consciousness and overall function. Note the presence or absence of significant findings. - Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report should be completed by the nursing supervisor on duty at the time and submitted to the DON.Performing a post fall evaluation:- After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and return to sitting, and will document the results ofthis effort. If the individual has no difficulty or unsteadiness, no further evaluation is needed at that time. If the individual has difficulty or is unsteady in performing this test, additional evaluation may be initiated as warranted.These failures resulted in an identification of an Immediate Jeopardy (IJ) with the ADM and DON notified and the IJ Template provided on [DATE] at 12:23 PM. The POR F656 was approved [DATE] at 08:16 AM and reflected the following:Plan of Removal F656 Immediate JeopardyOn [DATE] regulatory services determined that The Facility failed to meet the requirements of tag F656, resulting in an Immediate Threat to resident health and safety.Action:Action: Care Plan Audit and Re-TrainingStart Date: [DATE]Completion Date: [DATE]Responsible: MDS Coordinator, DON, Consultant RNTarget Audience: Nursing staff and IDT membersDetails: Audit of care plans to ensure interventions are specific and actionable. Re-training on interpreting and implementing care plans. Evaluation: 100% care plan audit of residents with a fall in the last 90 days completed. Of the 27 incidents from [DATE] thru [DATE] multiple care plans were found to be out of compliance; interventions reviewed and updated. This was documented on the Audit Results: Incidents by incident type: witnessed and unwitnessed falls. 1 resident with unwitnessed fall on [DATE]. Staff competency validation through direct observation during EMR documentation and noted on Care Plan Competency Checklist. Action:Action: Fall Protocol Enforcement and EMR AlertsStart Date: [DATE]Completion Date: [DATE]Responsible: DON, Consultant RNTarget Audience: Licensed nursing staff and new hires ongoing. Details: Fall protocol (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	initiated as a standing order; educated on usage and initiation. Validated and documented on competency check for order placement in PCC. Evaluation: EMR alert usage tracked weekly. Incident response audits for 30 days documented on Incident and Fall Audit LogAction:Action: Interdisciplinary Monitoring and Quality Assurance Performance ImprovementStart Date: [DATE]Completion Date: [DATE]; ongoingResponsible: QAPI CommitteeTarget Audience: IDT membersDetails: Daily IDT meetings to review care plan adherence. Immediate revision of plans when gaps are identified. Initial Ad hoc meeting via teleconference for notification and assistance with deficiency correction planning. Evaluation: Meeting minutes reviewed monthly during QAPI X3 months or until revisions reach a sustainable plan for safety. The POR was monitored in the following ways:In an interview on [DATE] at 12:20 PM with CEO and DON, they notified surveyors LVN A had resigned effective [DATE] and would no longer be coming in. In an interview on [DATE] at 01:00 PM with the DON she confirmed that on [DATE] she was in-serviced by the CEO (Chief Executive Officer) prior to beginning the education with all licensed nursing staff. The ADON made the decision to return to work as a floor nurse and not continue the responsibilities as a ADON and was not in-serviced by the CEO, the MDS coordinator did receive the training at the same time as the DON the in-service stated that all licensed nursing staff will receive mandatory re-education with verbal discussion and sign in sheet on the facility's fall response protocol, change in condition procedures, and abuse/neglect clinical protocols. Nurses have been directed to notify DON when any resident refuses evaluation by EMS (emergency medical services) and a post-quiz will be used for determining understanding after education is provided. In an interview on [DATE] at 01:59 PM with the DON confirmed that she was in-serviced by the NC prior to in-servicing the facility nursing staff on regarding changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON, they reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family, She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the assessments necessary, they also discussed the of care planning and updating the resident's care plans to include falls.In an interview on [DATE] at 02:54 PM with the DON she stated for the moment they have to move forward with EMS assessments until she is absolutely comfortable with the nurses ability to assess residents to make sure that residents stay safe in the event of a fall, EMS is a fall back safety measure, she can provide staff education and make them do competencies all day long - the staff need to respond with a sense of emergency, and be able to reflect they have the knowledge of what they do, right now she is using EMS for assessments until staff exhibit they can do everything appropriately.In an interview on [DATE] at 01:31 PM with NC she confirmed that she in-serviced DON prior to the DON in-servicing the nursing staff regarding changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON, they reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family, She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the assessments necessary. They also discussed the of care (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	planning and updating the resident's care plans to include fallsIn an interview on [DATE] at 11:45 AM DON stated most of the nurses are trained and retrained on neuro check and post fall evaluation. She stated they were trained on reporting to physician and family in a timely manner. DON stated the daily meeting the fall and other related issues evaluated, and necessary actions taken. There was no fall or incident of any significant changes in condition. Resident #3 had a fall on [DATE] and was reviewed and all the necessary steps were taken after the fall. She stated during the review it was revealed the care plans were not updated, not just for fall but also for various other issues. She stated the care plans were updated accordingly. The external NC will be supervising and monitoring the activities to ensure things are going in the right track.In an interview on [DATE] at 03:12PM with NC, she stated she in serviced and trained DON . She stated she had interviewed the nursing staff in the weekends as well to make sure they learnt everything that they supposed to. She stated she was happy with the outcome and will monitor and guide them to optimize their competency.The following nurses were interviewed and observed working on PCC completing neuro checks and post fall evaluation. They were able to navigate the neuro check and post fall evaluation form on E H R (PCC). They were able to explain how to fill them out and the rationale and significance of the findings during the evaluation . They were able to identify a significant change and when to notify a physician /or call EMS, staff were also able to answer randomly asked post training quiz questions. See below:In an interview on [DATE] at 01:00 PM with RN O, - Full time staff started [DATE] During the interview stated: she received the training [DATE] trained on neuros and fall protocol. She stated she was previously doing neuro checks on paper form and then would hand over to DON. Now got trained to do directly on the EH R so its documented in the medical record.In an interview on [DATE] at 01:15 PM RN G - PRN -[DATE] During the interview stated: she was trained on [DATE] and was trained on neuro check, post fall evaluation and incident report to be completed. Stated neuro checks to be continued for 3 days after a fall occurs, she stated she was previously doing on paper , now on both , first on paper and then on PCC. She stated she felt confident to do neuro and post fall evaluation independently. Neuro checks were to be completed initially every 15minutes.In an interview on [DATE] at 01:45 PM with LVN I Trained on [DATE]. Interview completed over the phone, able to answer quiz questions asked of her. She was able to explain neuro check and post fall process and procedures. She stated she is able to coordinate care independently.In an interview on [DATE] at 01:55 PM with LVN B, Trained on [DATE]. During the interview stated : She stated she was already completing post fall assessments and neuros in the electronic record but was retrained on it again. Stated she was confident enough to conduct assessments.In an interview on [DATE] at 02:35 PM with MDS Coordinator, LVN Trained on [DATE]. During the interview stated she received the trainings for the post fall procedures and how to enter the information in the E H R. In an interview on [DATE] at 02:35 PM with LVN P Interview over the phone. Nurse for 7 years. Done post fall evaluation and neuro checks before. She stated she received the training on [DATE] from the facility. Stated she was able to conduct a post fall procedure independently Review of the facility's in-services and post-training quizzes reflected staff were reeducated and returned demonstration of competencies with EMR documentation and interpreting and implementing care plans. Additionally, the following care plans/ assessments had been updated by the facility - Resident #65Resident #100Resident #66Resident #49Resident #27Resident #3Resident #7Resident #19Resident #11Resident #14Resident #6Resident #12These failures resulted in an identification of an Immediate Jeopardy (IJ) with the ADM and DON notified and IJ Template provided on [DATE] at 12:23 PM. While the IJ was removed on [DATE] and the ADM notified, 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. 2.Record review of Resident #33's face sheet dated [DATE] revealed a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included congestive heart failure, muscle weakness, lack of coordination, cognitive communication deficit, (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diabetes mellitus, presence of cardiac pacemaker, hypertension, anxiety disorder and bipolar disorder (onset date: [DATE]).Record review of Resident #33's quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating her cognition was intact. The MDS indicated she had bipolar and anxiety disorders and over the last two weeks she felt down, depressed and hopeless nearly every day and felt bad about herself most of the days. Record review of Resident #33's care plan dated [DATE] revealed there was no care plan and interventions for her diagnosis of bipolar disorder. Record review of the geriatric progress note dated [DATE] authored by geriatric specialist reflected Resident #33 was diagnosed with bipolar disorder. Record review of the psychiatric initial assessment dated [DATE] reflected Resident #33 was already on treatment for moderate depressed episode of bipolar disorder. Record review of the physician's order reflected: 1. Lamotrigine Oral Tablet 25 MG (Lamotrigine): Give 2 tablet by mouth two times a day related to bipolar disorder, current episode depressed, mild or moderate severity, unspecified -Start Date- [DATE]. 2. Levetiracetam Oral Tablet 250 MG (Levetiracetam): Give 1 tablet by mouth two times a day for bipolar disorder -Start Date-[DATE]. During an observation and interview on [DATE] at 3:10pm Resident #33 was in her wheelchair in her room. She stated she was not getting along well with one resident at the facility due to her unhygienic behavior. Resident #33 stated she had flexible mood sometimes and received medications regularly for her mental wellbeing. In an interview on [DATE] at 03:00 PM with the DON she stated that it was her expectation that the nurses were competent in following a residents care plan because failure to follow it would result in the residents not getting the care they need. She stated care plans should be accurate and represent the needs of the resident. In an interview on [DATE] at 03:38 PM with the ADM she stated it was her expectation that before a nurse goes to the floor to work with residents she is provided competencies that include training on where you go in the EMR to generate assessments, knowledge on the facilities policies and procedures, and know that they must ask questions if there is something they don't know. The ADM stated that failure to have competent nurse staffing, not completing assessments, following care plans, or facility policy results in residents not having the opportunity to be provided appropriate care. She stated that as the new ADM she is providing the facility with her expectations on the education that must be completed to ensure residents are being provided the appropriate care, and ongoing education that will be provided to direct care staff. Review of the facility Care Plans, Comprehensive Person Centered last revised [DATE] reflected:Policy statement: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. - The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive person-centered care plan will: o describe the services to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being.o Incorporate identified problem areas.o Identify the professional services that are responsible for each element of care. - Assessments of the residents are ongoing and care plans are revised as information about the resident and the[TRUNCATED]		

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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. **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 remainder 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 (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[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 #86's fall. 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 believed she initiated neurological monitoring on Resident #86. LVN A stated nurses were responsible for initiating and conducting ongoing neurological monitoring on residents every 30 minutes when they have an unwitnessed fall. LVN A stated the ADON and DON were responsible for ensuring nurses initiated and conducted ongoing neurological monitoring after a resident had an unwitnessed fall. LVN A stated she knew the importance of initiating and conducting ongoing neurological monitoring for residents with falls and said, To make sure their vitals were stable. Resident could be at risk of a blood clot. 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]. RN K stated he did not initiate and conduct neurological monitoring on Resident #86 because he did not know Resident #86 had a fall on [DATE]. RN K stated nurses were responsible for initiating and conducting ongoing neurological monitoring on residents if residents had an unwitnessed fall. RN K stated the DON was responsible for ensuring the nurses initiated and conducted ongoing neurological monitoring after a resident had an unwitnessed fall. RN K stated he told the DON that LVN A needed to be put back on training due to not performing neurological monitoring on Resident #86 after the fall. RN K stated he knew the importance of initiating and conducting ongoing neurological monitoring for residents with falls and said, Because resident could have hit his head and had a brain injury and to know that resident did not have damage to his head and to determine if resident needs to go to the hospital. Resident could be at risk of brain injury. During an interview on [DATE] at 3:07 PM with the ADON, she stated she was unable to find Resident #86's neurological monitoring sheets after his fall on [DATE]. She stated Resident #86's neurological monitoring sheets were started on [DATE] by LVN A and were not finished. She stated RN K was supposed to continue Resident #86's neurological monitoring. She stated nurses were responsible for initiating and conducting ongoing neurological monitoring after a resident had an unwitnessed fall. She stated the DON was responsible for ensuring nurses initiated and conducted ongoing neurological monitoring on residents and 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 knew the importance of initiating and conducting ongoing neurological monitoring on residents after an unwitnessed fall and said, Because resident could have brain injury, brain bleeding, abnormal vital signs, pain or fracture from fall. Residents could be at risk of going unconscious, brain bleed that staff unaware of, fracture, stroke, and develop infection if not completing neuro checks on them. She also 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 condition. Physician would not be able to intervene or initiate orders if they were unaware. Family would not be able to be aware of their resident hurting themselves. During an interview on [DATE] at 4:20 PM, with the Physician, he stated he was not notified Resident #86 had a fall on [DATE]. He expected to be notified of residents' falls. He stated nurses were required to initiate neurological monitoring after an unwitnessed fall and said, Resident could be at risk of head (continued on next page)		

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 09/30/2025
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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	bleeding and head trauma and respiratory issues. During an interview on [DATE] at 10:35 AM, with the DON, she stated she did not believe the fall protocol was followed in this case. She stated it is the expectation that post fall assessments are completed and documented after a fall and that the nurse assessing the fall or PT assess the resident's ability to rise from his/her wheelchair. She stated a negative outcome of not following the fall protocol/ procedures are negative deficits are increased up to and including death. DON stated LVN A completed neurological checks for the time left on her shift (only 1 hour) and were documented on paper not on the residents chart as it should have been, she stated the checks that should have occurred after LVN A left were not completed. During an interview [DATE] at 11:13AM, with LVN A, she stated Resident #86 was able to stand and self-transfer from his bed to his WC on a normal day. She stated after his fall on [DATE] redness was noted to his head and she suspected head injury. LVN A stated after the fall Resident #1 refused to go to the hospital and instead went outside. LVN A stated she documented the fall in the nursing progress notes but did not do an incident report as the charge nurse on duty, and only provided an oral report to the DON. She stated she was aware of the care plan intervention but she did not have the knowledge of the facilities fall protocol or procedures and was not aware of the assessments she had to complete. LVN A also stated she lacked the knowledge of using the EMR system for the facility and only received 3 days of training before being allowed on the floor as the charge nurse, she stated therefore she did not know how to properly document the assessments required after a fall and lacked the knowledge of what assessments were required. LVN A stated she only completed checks on Resident #86 for the 1 hour she had left on her shift and left at 7pm, she stated those were documented on paper and not the resident's chart. In an interview on [DATE] at 12:57 PM, with the ADON, she stated it was the expectation that all falls were documented on the EMR and post fall assessments and incident reports completed, she stated she is not sure why it was not documented in here by LVN A. The ADON stated that if LVN A does not know how to conduct the assessments from the EMR system that it was her expectation that LVN A asked for assistance. The ADON stated the nurse doing the assessment on the resident post fall should also do the WC stand up assessment to test any decline in strength or abilities. She stated the care plan reflects the care that is supposed to be provided to residents, and it was not followed in this case since following the fall protocol was an intervention. The ADON stated post fall assessments include neuro checks, vitals such as pulse, respirations, checking motor skills, pupil reaction, overall alertness and any changes to baseline. She stated a potential negative outcome to the resident if the fall protocols and procedures are not followed would be the resident can have a brain bleed, internal issues they are not aware of, fractures, or infections from fractures. In an interview on [DATE] at 03:00 PM, with the DON, she reiterated that the fall protocol was not followed as it pertained to the incident on [DATE] with Resident #86. The DON stated that it was her expectation that the nurses were competent in following a residents care plan because failure to follow it would result in the residents not getting the care they need. She stated it was her expectation that if a nurse encounters something they do not know how to do such as assessments, placing orders, or working in the EMR that they ask for help. She stated staff should be reaching out to her to get instructions on how to do it. In an interview on [DATE] with the ADM she stated it was her expectation that before a nurse goes to the floor to work with residents she is provided competencies that include training on where you go in the EMR to generate assessments, knowledge on the facilities policies and procedures, and know that they must ask questions if there is something they don't know. The ADM stated that failure to have competent nurse staffing, not completing assessments, following care plans, or facility policy results in residents not having the opportunity to be provided appropriate care. She stated that as the new ADM she is providing the facility with her expectations on the education that must be completed to ensure residents are being provided the appropriate care, and ongoing education that will be provided to direct care staff. Review of the facility Abuse and Neglect Clinical Protocol last revised in [DATE] reflected:- The nurse will report findings to the physician. Review of the facility Change in a Residents Condition or Status (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	policy last revised [DATE] reflected:- Physician and representative must be notified when there is an incident or accident involving the resident. Review of the facility Falls-Clinical Protocol last revised [DATE] reflected:- A nurse shall assess and document/ report the following: vital signs, musculoskeletal function, observing changes in normal range of motion, weight bearing etc., change in cognition or level of consciousness, neurological status, pain.- Monitoring and follow up: the staff with the physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. Review of facility Assessing Falls and Their Cause policy revised [DATE] reflected: Purpose- to provide guidelines for assessing a resident fall and to assist staff in identifying causes of the fall. - After a fall- observe for delayed complications of a fall for approximately 48 hours after an observed or suspected fall and will document findings in the medical record. - Document any observed signs or symptoms of swelling, bruising, deformity, and/or decreased mobility and any changes to level responsiveness/ consciousness and overall function. Note the presence or absence of significant findings. - Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report should be completed by the nursing supervisor on duty at the time and submitted to the DON.Performing a post fall evaluation:- After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and return to sitting, and will document the results ofthis effort. If the individual has no difficulty or unsteadiness, no further evaluation is needed at that time. If the individual has difficulty or is unsteady in performing this test, additional evaluation may be initiated as warranted. These failures resulted in an identification of an Immediate Jeopardy (IJ) the ADM and DON were notified and provided the IJ Template on [DATE] at 12:23 PM. The POR F726 was approved [DATE] at 08:16 AM and reflected the following:Plan of RemovalImmediate ThreatOn [DATE], HHSC determined that Coral Rehab failed to meet the requirements of tag F726, resulting in an Immediate Threat to resident health and safety.Action:Action: Competency Assessment and Temporary ReassignmentStart Date: [DATE]Completion Date: [DATE]Responsible: DON & Consultant RNTarget Audience: RNs, LVNs and new hiresDetails: Immediate assessment of staff competency in fall protocols and EMR use. Staff with deficiencies reassigned until retraining is complete. DON trained by Consultant RN prior to initiating staff training; verified on competency check list; signed by Consultant RN. ADON demoted and disciplinary action provided for direct violation of policy and notification of DON. Re-education followed using competency checklist. Evaluation: Competency checklist signed by DON. Staff reassigned only after passing post-training evaluation. No staff reassignments were necessary; both staff which required re-education for this instance have resigned and resignation was accepted immediately. And, ADON as above. Action:Action: Targeted Training Start Date: [DATE]Completion Date: [DATE]Responsible: DON & Consultant RNTarget Audience: RNs, LVNs and new hiresDetails: Training on clinical fall protocol, fall risk assessments, neuro checks, and EMR documentation. New hires will continue to be educated using competency checklist ongoing. Evaluation: 7-day and 30-day follow-up competency re-check. Documented on Competency Monitoring spreadsheet. Action:Action: Policy Review and Quality Assurance Performance ImprovementStart Date: [DATE]Completion Date: [DATE]Responsible: Administrator, DON and Consultant RNTarget Audience: Interdisciplinary TeamDetails: Enforcement of disciplinary actions for protocol violations. Review of policies and procedures for fall protocol and EMR documentation. Post-training competency quiz (pass rate ~ 90%) based on Fall protocol and EMR documentation requirements. Evaluation: Incident trend analysis X 3 months in QAPI The POR was monitored in the following ways: In an interview on [DATE] at 12:20 PM with CEO and DON, they notified surveyors LVN A had resigned effective [DATE] and would no longer be coming in. In an interview on [DATE] at 01:00 PM with the DON she confirmed that on [DATE] she was in-serviced by the CEO (Chief Executive Officer) prior to beginning the education (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with all licensed nursing staff. The ADON made the decision to return to work as a floor nurse and not continue the responsibilities as a ADON and was not in-serviced by the CEO, the MDS coordinator did receive the training at the same time as the DON the in-service stated that all licensed nursing staff will receive mandatory re-education with verbal discussion and sign in sheet on the facility's fall response protocol, change in condition procedures, and abuse/neglect clinical protocols. Nurses have been directed to notify DON when any resident refuses evaluation by EMS (emergency medical services) and a post-quiz will be used for determining understanding after education is provided. In an interview on [DATE] at 01:59 PM with the DON confirmed that she was in-serviced by the NC prior to in-servicing the facility nursing staff regarding changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON. They reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family. She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the assessments necessary. They also discussed the of care planning and updating the resident's care plans to include falls. In an interview on [DATE] at 02:54 PM with the DON she stated for the moment they have to move forward with EMS assessments until she is absolutely comfortable with the nurses ability to assess residents to make sure that residents stay safe in the event of a fall, EMS is a fall back safety measure. She can provide staff education and make them do competencies all day long - the staff need to respond with a sense of emergency, and be able to reflect they have the knowledge of what they do, right now she is using EMS for assessments until staff exhibit they can do everything appropriately. In an interview on [DATE] at 01:31 PM with NC she confirmed that she in-serviced DON prior to the DON in-servicing the nursing staff regarding changes in resident conditions, falls, neuro fall risk assessments, and notification to RP and MD and DON, they reviewed facility policy on acute change condition protocol, and the importance of timely and accurate documentation and notification of changes in resident conditions and identifying and documenting and communicating the changes according to facility policy. The DON said she was aware that the changes in conditions must be reported, according to the facility policy to the DON, MD/NP and RP/family, She was aware and agreed to use the action tab for risk management and follow through with documentation. She received training and education relevant to acute care planning needs and to relay all information to the ADM, DON, ADON, and MDS to make sure all acute care planning needs will be met. She received training and education on completing required resident assessments and confirmed she is competent to perform the assessments necessary. They also discussed the of care planning and updating the resident's care plans to include falls. In an interview on [DATE] at 11:45 AM DON stated most of the nurses are trained and retrained on neuro check and post fall evaluation. She stated they were trained on reporting to physician and family in a timely manner. DON stated during their staff daily meeting falls and other related issues are evaluated, and necessary actions are taken. There was no fall or incident of any significant changes in condition. Resident #3 had a fall on [DATE] and was reviewed and all the necessary steps were taken after the fall. She stated during the review it was revealed the care plans were not updated, not just for fall but also for various other issues. She stated the care plans were updated accordingly. The external NC will be supervising and monitoring the activities to ensure things are going in the right track. In an interview on [DATE] at 03:12PM with NC, she stated she in serviced and trained the DON. She stated she had interviewed the nursing staff in the weekends as well to make sure they learned everything that they were supposed to. She stated she was happy with the outcome and will monitor and guide them to optimize their (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	competencyThe following nurses were interviewed and observed working on PCC completing neuro checks and post fall evaluation. They were able to navigate the neuro check and post fall evaluation form on E H R (PCC). They were able to explain how to fill them out and the rationale and significance of the findings during the evaluation. They were able to identify a significant change and when to notify a physician /or call EMS Able to answer randomly asked post training quiz questions. See below:In an interview on [DATE] at 01:00 PM with RN O - Full time started [DATE] During the interview stated: Got received the training [DATE] trained. Previously was doing neuro checks on paper form and then hand over to DON. Now got trained to do directly on the EH R.In an interview on [DATE] at 01:15 PM RN G - PRN -[DATE] During the interview stated: Trained on [DATE] and was trained on neuro check, post fall evaluation and incident report was to be completed. Neuro check to be continued for 3 days, she stated she was previously doing on paper, now on both, first on paper and then on PCC. Stated confident to do neuro and post fall evaluation. Neuro check initially every 15minutes.In an interview on [DATE] at 01:45 PM with LVN I Trained on [DATE]. During the interview stated: Interview over the phone, able to answer quiz questions. Able to explain neuro check and post fall process and procedures. Stated able to coordinate care independently.In an interview on [DATE] at 01:55 PM with LVN B, Trained on [DATE]. During the interview stated: She was doing after the fall evaluation and neuro check before too. Stated she was confident enough to conduct oneIn an interview on [DATE] at 02:35 PM with MDS Coordinator, LVN Trained on [DATE]. During the interview stated she received the trainings for the post fall procedures and how to enter the information in the E H R. In an interview on [DATE] at 02:35 PM with LVN P Interview over the phone. Nurse for 7 years. Done post fall evaluation and neuro checks before. Received the training on [DATE] from the facility. Stated she was able to conduct a post fall procedure independentlyReview of the facility's in-services and post-training quizzes reflected staff were reeducated and returned demonstration of competencies with clinical fall protocol, fall risk assessments, neuro checks, and EMR documentation and use.Additionally, the following care plans/ assessments had been updated by the facility - Resident #65Resident #100Resident #66Resident #49Resident #27Resident #3Resident #7Resident #19Resident #11Resident #14Resident #6Resident #12 These failures resulted in an identification of an Immediate Jeopardy (IJ) and the ADM and DON were notified 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 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.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was implemented so the facility was free of pests and rodents for 1 of 1 facility reviewed for pest control. The facility failed to keep an effective pest control program to ensure the residents' rooms including bathrooms, halls, and recreation room (where resident activities are held) were free of roaches, flies, spiders, and water bugs. This failure could place residents at risk for reduced quality of life and poor sanitary environment. Findings included: Review of Resident #11's face sheet dated 09/10/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included major depressive disorder, bacteremia (bacteria in the blood), thrombocytopenia (low platelet count), and hepatic encephalopathy (brain disfunction caused by liver disfunction). Review of Resident #11's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Review of Resident #53's face sheet dated 09/10/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included major depressive disorder, heart failure, and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Review of Resident #53's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident #70's face sheet dated 09/11/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included hemiplegia (paralysis affecting one side) unspecified affecting the right dominant side, muscle weakness, muscle wasting and atrophy, and pressure ulcer of left buttock stage 2. Review of Resident 70's quarterly MDS dated [DATE] reflected a BIMS was not assessed due to resident is rarely/ never understood. In an interview on 09/09/25 at 11:57 AM with Resident #11, he stated he has asked staff for roach spray to spray roaches he sees in his room and staff will not provide one to him. He stated he sees very small roaches that he believed were freshly hatched. Resident #11 stated he has begun to use soapy water to spray them when he sees them in his room to stop them. He stated he has brought up these concerns to the DON but the issue has not been resolved and does not recall the last time pest control was seen. He stated he sees the roaches almost every day. In an interview and observation on 09/09/25 at 02:33 PM with Resident #53 he stated, we have big cockroaches in this place, and they haven't gotten rid of them. He stated he has [NAME] it up to multiple staff and was advised they would spray but has not seen anyone spray for pests. Resident #53 stated there was presently a big one in the bathroom; in an observation of Resident #53's bathroom, surveyor observed a large live roach next to the resident's bathroom sink and images were obtained. In a confidential resident group interview and observation on 09/10/25 at 02:20 PM, 8 of 8 residents complained about seeing pests that included big fat roaches and flies in their rooms and restrooms, the dining room during mealtimes, and the recreational room during activities. At this time surveyor also observed flies around the room during the group meeting landing on residents. In an observation on 09/10/25 at 02:30 PM in the facility recreational room, a blue-light fixture was observed with bugs that included flies, small roaches and spiders, and filled with spider webs. Located next to the light fixture was a handwashing station with a single sink observed with multiple dead bugs on the countertop of the same bugs. In an observation on 09/11/25 at 10:35 AM in hall 100, a large roach was observed crawling on the name plate to Resident #70's room. Resident #70 is not cognitively intact or able to be interviewed about the pests. In an interview on 09/12/25 at 01:50 PM with the MTA he stated he is in charge of pest control now since there was not currently a maintenance director. The MTA stated if there was a pest control issue it needed to be logged by staff in the pest control logs in the pest control binder. The MTA stated the last time pest control treated the facility was in June of 2025. He stated he is not sure why they have not come more recent, he stated if pest control issues were logged, he would notify the ADM and he believed the ADM would contact pest control. He stated previously the Maintenance Director would call pest (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	control services out himself, but they haven't had a Maintenance Director for over a month. The MTA stated a negative outcome of pests in the building was residents could get an infection. In an interview on 09/12/25 at 03:00 PM, the DON stated she had not seen pests herself but heard residents complaining of pests in their rooms. She stated when there is a report of pests the process is for it to get logged in the pest control book so that pest control can get called to come out. She stated she believed it was the MTA who is responsible for contacting pest control and was not sure why they have not come. The DON stated that since she had started on 08/06/25 she had not seen pest control come to the building. She stated pests in rooms was an infection control issue to the residents. She stated pest control should be coming and providing enough treatment so that there was not as many complaints as they have had. In an interview on 09/12/25 at 03:38 PM, the ADM stated she had not seen pests herself but had heard staff and residents speaking about roaches. The ADM stated she is responsible for pest control and placed a phone call to pest control after hearing those reports today and they would be coming Monday 09/15/25. The ADM stated pests like roaches can be a housekeeping issue as well as an infection control issue. The ADM stated that the last time pest control was in the building was June of 2025. She stated she is not sure why they were not here more regularly and believed it to be an issue that was lost in communication with the changes in Administrators the facility has had. The ADM had advised she had only recently started at the facility on 09/09/25. She stated she was aware of the pest control binder and logs but stated the book was not being updated or utilized by staff as should have been. In an interview and observation on 09/12/25 at 05:20 PM, during end of day meeting with ADM and DON in the administrative offices, during the meeting the ADM jumped from behind her desk and screamed while pushing herself away from the desk and standing up saying she saw a large roach and said she does not do roaches Review of the facility pest control log reflected last logbook check/service was dated 06/20/25. Review of facility Pest Control policy last revised May 2008 reflected: Our facility shall maintain an effective pest control program. This facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. Maintenance services assist when appropriate and necessary in providing pest control services.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive assessment accurately reflected the resident's status for 3 (Resident #1, Resident #17, and Resident #70) of 5 residents reviewed for accuracy of assessments. The facility failed to ensure the MDS dated [DATE] was updated to reflect an active pressure wound for Resident #1. The facility failed to ensure the MDS dated [DATE] was updated to reflect an active pressure wound for Resident #17. The facility failed to ensure the MDS dated [DATE] was updated to reflect an active pressure wound for Resident #70. This failure could place residents at risk of inaccurate assessments and not receiving appropriate care according to their status. Findings include: Review of Resident #1's face sheet dated 09/11/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included pressure ulcer of right buttock stage 3, pressure ulcer of sacral region stage 4, unspecified protein calorie malnutrition, and cognitive communication deficit. Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected a BIMS was not assessed due to resident is rarely/ never understood. Section M for skin conditions reflected is this resident at risk of developing pressure ulcers/injuries was marked yes and does this resident have one or more unhealed pressure ulcers/injuries was marked no. Review of Resident #1's care plan last revised 08/20/25 reflected there was no focus care planned for pressure ulcers. Review of Resident #1's progress note reflected a nursing note dated 08/28/25, staff notified this nurse that resident was bleeding during shower. On inspection resident observed to have stage 2 coccyx measuring 2cm x 2cm, 1cm depth NP notified. Review of Resident #1's progress note reflected a NP skin and wound care note dated 09/10/25 that reflected current wounds included left buttock, pressure ulcer, stage 3; sacrum, pressure ulcer, stage 3; and right buttock, pressure ulcer, stage 3. Review of Resident #17's face sheet dated 09/11/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that included lymphedema, protein calorie malnutrition, morbid severe obesity due to excess calories, and edema (fluid buildup in the body). Review of Resident #17's admission MDS dated [DATE] reflected a BIMS of 15 indicating cognition intact. Section M for skin conditions reflected is this resident at risk of developing pressure ulcers/injuries was marked yes and does this resident have one or more unhealed pressure ulcers/injuries was marked no. Review of Resident #17's care plan last revised 08/13/25 reflected, Resident #17 has potential impairment to skin integrity related to lymphedema. The care plan did not contain a focus on any current active pressure ulcers. Review of Resident #17's progress notes reflected a nursing note dated 08/26/25, wound NP here to see resident, resident has open area to L buttock area measures 1cm in diameter. Review of Resident #17's progress notes reflected eMAR note dated 09/11/25 indicated ongoing wound care to pressure ulcer cleanse L buttock with wound cleanser, apply triad paste and collagen mixture, leave open to air QD and PRN, every day/shift for wound care performed by wound care nurse. Review of Resident #70's face sheet dated 09/11/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included hemiplegia unspecified affecting the right dominant side, muscle weakness, muscle wasting and atrophy, and pressure ulcer of left buttock stage 2. Review of Resident #70's quarterly MDS dated [DATE] reflected a BIMS was not assessed due to resident is rarely/ never understood. Section M for skin conditions reflected is this resident at risk of developing pressure ulcers/injuries was marked yes and does this resident have one or more unhealed pressure ulcers/injuries was marked no. Review of active diagnosis included pressure ulcer of left buttock stage 2. Review of Resident #70's reentry MDS dated [DATE] reflected pressure injuries were not assessed. Review of Resident #70's care plan initiated 10/14/24 reflected he had a deep tissue injury and his left heel was unstageable. Resident #70 also had poor nutrition. Review of Resident #70's care plan last revised 08/20/25 reflected Resident #70 continues on wound management for left heel pressure injury stage 4 facility acquired. Review of Resident #70's progress notes reflected a nursing progress note dated (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/29/25, Resident was readmitted to retirement.nurse observed resident head to toes, noted left deep tissue injuries on the heal.redness on the bottom, small ulcer on the right thigh. Review of Resident #70's progress notes reflected a nursing progress note dated 09/02/25, skin assessment completed, resident has open pressure ulcer to R buttock. Area with scant exudate, no depth, measures at 2.5cm x 3cm. NP notified . Review of Resident #70's progress notes from 08/25/25 through 08/29/25 reflected he went to another facility for unknown reasons. Review of Resident #70's skin assessment dated [DATE] reflected his left heel closed up, skin preparation was applied, and care was provided Review of Resident #70's skin assessment dated [DATE] and 08/25/25 reflected no information related to his left heel. Review of Resident #70's physician order dated 09/10/2025 reflected:clean L heel with wound cleanser, apply skin prep to blister every day and PRN every day shift for wound treatment. Review of the facility resident matrix (CMS-802) dated 09/09/25 reflected Resident #1, Resident #17, and Resident #70 were not marked for current/ active pressure ulcers. In an interview on 09/12/25 at 01:00 PM with the MDS Coordinator, she stated she is responsible for MDS assessments and ensuring completeness and accuracy of the assessments. She stated she had taken over that position and had been in her role at the facility for 3 weeks but is also the corporate MDS nurse. The MDS Coordinator stated that it is her expectation that assessments are 100% accurate, complete, and up to date. She stated a pressure ulcer is considered a significant change and that an MDS needs to be updated to reflect a resident's current condition. The MDS Coordinator stated the matrix pulls information related to the MDS from the last quarter and reflects residents' current condition from the last 92 days which should have reflected Resident #1, Resident #17 and Resident #70's active pressure ulcers. She stated the current matrix does not reflect the residents pressure ulcers and that is inaccuracy. The MDS Coordinator stated a potential negative outcome of the MDS assessment being inaccurate is there is potential for other assessments to be inaccurate and stated the care plan is an example of another assessment it could affect. She stated it would then affect residents negatively because they would not get the treatment they need. In an interview on 09/12/25 at 03:00 PM with the DON, she stated it was the MDS coordinators responsibility to ensure completion and accuracy of an MDS assessment. She stated it was her expectation that assessments are done completely, accurately, and timely. She stated she would consider a pressure ulcer a significant change in the residents' condition that would require updating the MDS assessment. She stated upon identifying a change such as a pressure ulcer it was her expectation significant change should be documented immediately and MDS should be working on the significant change and updating the assessment right away. The DON stated if the MDS assessment is inaccurate it would affect the vast majority of other assessments as they are connected. She stated the care plan is an example of an assessment it would negatively affect, which would then affect the resident negatively because they would not get the care they need. The DON stated in reviewing the resident matrix, which pulls from resident assessments such as the MDS, it was not accurate because it did not reflect Resident #1, Resident #17, or Resident #70's current condition as it relates to pressure ulcers. In an interview on 09/12/25 at 03:38 PM, the ADM stated the MDS coordinator (nurse) is responsible for the MDS assessments, and it was her expectation that they were documenting accurate information, capturing everything that needs to be captured, and is timely- it should not be lagging and needs to be updated as often as possible and reviewed as often as possible. The ADM stated the MDS assessment affects everything and getting it wrong affects the care provided to residents. She stated the wrong care could potentially be provided. The ADM stated she would consider a pressure ulcer a significant change and stated care plans, MDS assessments should be updated immediately if a pressure ulcer is identified she stated a pressure ulcer can change in a matter of hours and progress needs to be reviewed, it can turn deadly really quick. In an interview on 09/30/25 at 11:41 AM with the NP, he stated Resident #70's left heel was being managed by the wound care NP and healed at one point. The NP stated Resident #70 was at risk of developing wounds due to him being bed bound despite having preventative devices, such as boots. During an observation (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 09/30/25 at 11:56 AM, Resident #70's left heel was closed dark in color and there was no evidence of stage VI pressure ulcer. Review of the facility Resident Assessment Instrument policy last revised September 2010 reflected:- The assessment coordinator is responsible for ensuring that the interdisciplinary assessment team conduct timely resident assessments and reviews according to the following schedule: o Within 14 days of the resident's admission to the facility; o When there has been a significant change in the residents condition; o At least quarterly; [NAME] One every 12 months.- Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. Review of the Comprehensive Assessment and the Care Delivery Process policy last revised December 2016 reflected:- Assessment and information collection includes (WHAT, WHERE and WHEN?). The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information about a patient.- Complete the Minimum Data Set within 14 days after admission, within 14 days after it is determined that the resident has had a significant change in physical or mental condition, and annually.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents who was unable to carry out Activities of Daily Living received the necessary services to maintain grooming and personal hygiene for 3 of 8 residents (Resident #9, Resident #18, and Resident #44) reviewed for Activities of Daily Living's. The facility failed to ensure Resident #9 and Resident #44's fingernails were trimmed. The facility failed to ensure Resident #18's facial hair was shaved. This failure was evident and could place residents at risk of not receiving care services, diminished quality of life, and decreased self-esteem. Findings included: Record review of Resident #9's Face Sheet dated 09/11/2025 reflected a [AGE] year-old-male admitted to the facility on [DATE] with a diagnoses that included Schizoaffective Disorder (a mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, and mood disorder symptoms), Bipolar (a mental health condition that causes extreme mood swings), Idiopathic Aseptic Necrosis of Left Femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death), Essential Hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause), Combined Forms of Age-Related Cataract (cloudy areas that form on the lens of your eye), Cognitive Communication Deficit (when someone has trouble with one or more cognitive processes involved in communication, such as attention, memory, or reasoning), Chronic Angle-Closure Glaucoma (progressive eye condition marked by the gradual closure of the anterior chamber angle), Muscle Weakness (a lack of muscle strength), and Legal Blindness (having corrected visual acuity of 20/200 or less in the better eye). Record review of Resident #9's quarterly MDS dated [DATE] reflected a BIMS of 13, which indicated he was cognitively intact and needed supervised to moderate assistance with all ADL's. Record review of Resident #9's Care Plan dated 08/07/2025 reflected Resident #9 was dependent and is to be provided assistance and verbal encouragement with mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs. The goals were for Resident #9 to maintain current level of function with assistance in his daily living care needs. Record review of Resident #18's Face Sheet dated 09/11/2025 reflected a [AGE] year-old-female admitted to the facility on [DATE] with a diagnosis that included Syncope and Collapse (a loss of consciousness for a short period of time due to a sudden change in blood flow to the brain), Muscle Weakness (a lack of muscle strength), Cognitive Communication Deficit (when someone has trouble with one or more cognitive processes involved in communication, such as attention, memory, or reasoning), Speech and Language Deficits Following Cerebral Infarction (a language disorder that affects your ability to communicate), Schizoaffective Disorder (a mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, and mood disorder symptoms), Bipolar (a mental health condition that causes extreme mood swings), Generalized Anxiety Disorder (a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things), Depressive Episodes (involves persistent sadness, fatigue, and loss of interest in activities), and Memory Deficit (issue with forming, storing or recalling memories). Record review of Resident #18's quarterly MDS dated [DATE] reflected a BIMS of 14, which indicated to be cognitively intact and needed supervised to moderate assistance with all ADL's. Record review of Resident #18's Care Plan dated 08/05/2025 reflected Resident # 18 is dependent and is to be offered assistance as needed and verbal encouragement as needed with mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs while encouraging independence. The goals were for Resident #18 to maintain current level of function with assistance in his daily living care needs. Record review of Resident #44's Face Sheet dated 09/11/2025 reflected a [AGE] year-old-male admitted to the facility on [DATE] with a diagnosis that included Asperger's Syndrome (a diagnostic label that has historically been used to describe a neurodevelopmental disorder characterized by significant difficulties in social interaction (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and nonverbal communication), Anemia (occurs when you have a low number of red blood cells), Cognitive Communication Deficit (when someone has trouble with one or more cognitive processes involved in communication, such as attention, memory, or reasoning), Type 2 Diabetes Mellitus (occurs when your body's cells resist the normal effect of insulin), Muscle Weakness (a lack of muscle strength), and Reduced Mobility (person whose mobility is reduced when using transport because of any physical disability). Record review of Resident #44's MDS dated [DATE] reflected a BIMS of 12, which indicated to be cognitively intact and is independent with all ADL's. Record review of Resident #44's Care Plan dated 09/11/2025 reflected Resident # 44 is dependent and is to be offered assistance as needed and verbal encouragement as needed with mobility, bathing, hygiene, toileting, dressing, grooming, eating, and all assisted daily living care needs while encouraging independence. The goals were for Resident #44 to maintain current level of function with assistance in his daily living care needs. In an interview on 09/09/2025 at 11:52 AM with Resident #18, she stated that she had some facial hair on her chin in which staff always shave it. Resident #18 stated she is a woman and not a man, but she grows facial hair. Resident #18 stated it bothers her sometimes. Resident #18 stated that she will ask to have a staff member shave it. Resident #18 had multiple long hairs on her chin approximately 2-inch's-long. In an interview on 09/09/2025 at 12:01 PM with CNA C, she stated the following: residents get shaved during shower times or when providing care to residents. CNA C stated she worked with Resident #18 often. CNA C stated Resident #18 gets shaved every other week. CNA C stated sometimes she does not have a shaving razor and that is why she is not able to shave residents. CNA C stated even if Resident #18 refuses showers, she still asks if she wants a shave. CNA stated she understands it can make Resident #18 feel sad if she is not shaved or offered other times. CNA C stated she does not recall when the last time Resident #18 was shaved. CNA C stated Resident #44 who is diabetic gets his nails trimmed by a Nurse, but she does not remember if Resident #44 is diabetic or not as well as she hasn't asked the Resident about fingernail trims. CNA stated she doesn't know where she can ask or see if Resident #44 is diabetic in order to offer fingernail trimming. CNA C stated she hasn't asked to see if Resident #44 is diabetic. CNA C stated Resident #9 fingernails are long from what she can see. CNA C stated that Resident #44 changes his mind about fingernails being trimmed or not. CNA C stated she feels the Resident #44 and Resident #9 can get upset if their fingernails aren't trimmed and food gets underneath fingernails. CNA C stated resident's fingernails get trimmed 3 different times out of the week. In an interview on 09/09/2025 at 12:02 PM with Resident #9, he stated that he does not like his fingernails long and wants them trimmed. Resident #9 stated the staff last trimmed his fingernails 3 weeks ago, he thinks, and cannot recall when exactly. Resident #9 stated his fingernails not being trimmed makes him feel upset. Resident #9 stated that his fingernails get food under his nails and it's because the staff have not trimmed them. Resident #9's fingernails are approximately an inch long past his nailbed. In an interview on 09/09/2025 at 2:38 PM with Resident #44, he stated his fingernails are untrimmed. Resident #44 stated staff have not trimmed them or ask him to trim them. Resident #44 stated he told staff before but does not remember when or to who he told about his fingernails. Resident #44 stated he feels like the staff are not monitoring to trim his fingernails and ignoring his care treatment. Resident #44 stated it makes him feel upset. Resident #44 stated the last time he had his fingernails trimmed was a long time ago; he does not know how long it's been but has been awhile his fingernails are approximately a half an inch long past his nailbed. Observation on 09/10/2025 at 9:20 AM revealed Resident #18 had her facial hair shaved. Observation on 09/10/2025 at 10:20 AM revealed Resident #9 was sleeping. Observation revealed Resident #9 still had untrimmed fingernails. Observation on 09/10/2025 at 10:26 AM revealed Resident #44's fingernails were still untrimmed. In an interview on 09/10/2025 at 10:27 AM with Resident #44, he stated due to his fingernails being long, he scratches himself accidentally or bends fingernails. Resident #44 stated it makes him feel upset that the staff are not doing anything about his fingernails. Record review of Resident #9's chart reflected ADLs were being completed daily through dates 08/13/2025 to 09/11/2025 in which there was no (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	specification for fingernails being trimmed. Record review of Resident #18's chart reflected ADLs were being completed daily through dates 08/13/2025 to 09/10/2025 in which there was no specification for shaving. Record review of Resident #44's chart reflected ADLs were being completed daily through dates 08/13/2025 to 09/11/2025 in which there was no specification for fingernails being trimmed. In an interview on 09/11/2025 at 12:07 PM with Resident #44, he stated he still did not have his fingernails trimmed by nursing staff. Resident #44 stated he had told staff about his fingernails and now one of his fingernails is hanging off cracked due to being too long. Resident #44 stated it hurts. Resident #44 stated the staff does not trim his fingernails and does not care. Observation on 09/11/2025 at 12:12 PM of Resident #9, he was observed in activities with peers in which his fingernails were still untrimmed. In an interview on 09/11/2025 at 12:15 PM with Resident #18, she stated facility staff shaved her, and it felt good to not have facial hair anymore. In an interview on 09/11/2025 at 12:33 PM with CNA D, she stated the following: she had been working at this facility for 4 years. and last got abuse and neglect training 3 days ago. CNA D stated she has been trained in ADL's for shaving residents and not trimming resident's fingernails. CNA D stated resident's fingernails can be trimmed by CNA's unless residents are diabetic in which nurses have to do those residents fingernails. CNA D stated sometimes facility staff ask family for permission to trim resident's fingernails or shave them. CNA D stated facility staff will shave residents as needed or when requested by residents. CNA D stated some residents refuse when asked to be shaved or fingernails trimmed. CNA D stated residents are supposed to be shaved and have fingernails trimmed each week. CNA D stated it's the CNA and nurse responsibility to make sure all residents are shaved and have fingernails trimmed. CNA D stated it's ultimately the DON and ADMs responsibility to make sure all staff are maintaining all residents ADL's. CNA D stated ADLs are documented in residents PCC files. CNA D stated not shaving and trimming resident's fingernails affects the resident's quality of life as it can affect them in not having maintained hygiene. In an interview on 09/11/2025 at 12:37 PM with LVN B, she stated the following: she had been working at this facility for over 2 years. LVN B stated she has been trained in abuse and neglect. LVN B stated she learned in the abuse and neglect training that if there is suspicion of abuse or neglect, facility staff are to report it regardless of resident on resident or staff to resident. LVN B stated as a nurse, she would do assessments and monitor the resident should there be abuse or neglect and report it to the Administrator and all responsibility parties. LVN B stated she last received abuse and neglect, and resident rights training a few weeks ago. LVN B stated she has been trained in resident rights in which residents have the right to treatment, right to refuse treatment, and right to voice concerns. LVN B stated she has been trained in ADL's, shaving residents, and providing nailcare. LVN B stated all nursing staff have been trained to conduct ADL's and she recalls getting reminder trainings for ADL's approximately a month ago. LVN B stated residents are to be shaved during shower days, and nailcare treatment are done once a week or PRN. LVN B stated CNA do shaving and nail trimmings, but not if residents are diabetic. LVN B stated it's the CNA responsibility and overall, Nurse responsibility to make sure fingernails and shaving is done for all residents. LVN B stated nursing staff document nailcare and shaving residents in PCC. LVN B stated nursing staff educate the residents the importance of nail trimming and shaving. LVN B stated residents having long fingernails is an infection control issue since germs can stay under the fingernails. LVN B stated residents can accidentally scratch themselves or cut skin causing infection. LVN B stated she noticed Resident #18 had chin hairs that wasn't shaved but was shaved by a CNA the other day. LVN B stated she doesn't know how long or why Resident #18 wasn't shaved for a long period of time. LVN B stated Resident #9 grows longer fingernails in a fast manner and doesn't know how long or why it's been a long time not being trimmed; she can't speak on that. LVN B stated Resident #44 has long fingernails and can't speak as to why they haven't been trimmed regularly and wasn't aware that Resident #44 had a hanging broken fingernail along with long fingernails. LVN B stated not shaving and trimming resident's fingernails affect residents quality of life by making the resident feel psychologically diminished or neglected. In (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on 09/11/2025 at 2:55 PM with DON, she stated the following: she had worked at this facility for a month. DON stated she has been trained in abuse and neglect, she is to ensure residents are safe and report it to the ADM or make a report herself if the ADM isn't available. DON stated she has been trained in resident rights in which she learned from resident right training that residents have all rights, right to do whatever they want, be free from harm, and right to refuse. DON stated she has been trained in ADLs, shaving residents, and fingernail trainings including all staff are trained. DON stated it's the resident's preference and ideally nursing staff want to cut resident fingernails to keep them clean and maintain facial hair for the resident's preferred appearance. DON stated some female residents with facial hair and long nails is in their rights unless stating otherwise, nursing staff would encourage and educate residents based on the cleanliness. DON stated it's the responsibility of the CNA and nursing staff to maintain facial hair and nailcare treatment, but only nurses are able to do residents nail treatment should the resident be diabetic. DON stated ADLs are documented in PCC and if it was bad, CNA will advise nursing staff to get residents groomed and fingernails trimmed. DON stated all nursing staff are responsible, but she is ultimately in charge of overseeing all residents ADL treatment. DON stated she wasn't aware of Resident #18 had chin hairs that wasn't shaved for a long period. DON stated she doesn't know how long or why Resident #18 wasn't shaved for a long period of time. DON stated wasn't aware Resident #9 had long and not trimmed fingernails nor knows how long it's been like that. DON stated she wasn't aware Resident #44 had long fingernails and doesn't know why they haven't been trimmed regularly and wasn't aware that Resident #44 had a hanging broken fingernail. DON stated not shaving and trimming fingernails affect residents if residents are wanting those services as it can cause a decrease in quality of life. In an interview on 09/11/2025 at 3:21 PM with ADM, she stated the following: she had worked at this facility since Monday, 09/08/2025. ADM stated she has been trained in abuse and neglect and she is the abuse and neglect coordinator. ADM stated it's her responsibility to ensure residents are safe at all times and making sure to evaluate residents daily. ADM stated she is trained in resident rights, and she is the one who trains it to facility staffing. ADM stated resident have the right to a safe environment and be aware of their surroundings. ADM stated she was last trained for resident rights, abuse and neglect, and ADLs in March 2025 through continuing education and no one from the facility has trained her prior to employment. ADM stated she has been trained in ADLs for shaving men, and women including trimming nails. ADM stated the ADL training goes over shaving as well as to maintain nail treatment for ongoing resident care treatment. ADM stated staff and residents don't know what can be under resident's fingernails and expose to infection control issues should not being properly maintained. ADM stated residents are to be maintained by nursing staff once a week when providing nailcare and facial hair grooming. ADM stated it's the responsibility of the clinical staff and she ultimately oversees to ensure all residents are appropriately taken care of to be in regulatory compliance. ADM wasn't aware of Resident #18 having chin hairs that wasn't shaved for a long period. ADM stated she doesn't know how long or why Resident #18 wasn't shaved for a long period of time. DON stated she wasn't aware Resident #9 had long and not trimmed fingernails nor knows how long it's been like that. ADM stated she wasn't aware Resident #44 had long fingernails and doesn't know why they haven't been trimmed regularly and wasn't aware that Resident #44 had a hanging broken fingernail. ADM stated not shaving and trimming fingernails affect residents and their quality of life as it can cause residents depression, feel neglected and or abused, and feel isolated. Record review of facility in-services were reviewed and there were no specific in-services for ADL's completed. Record review of facility Activities of Daily Living (ADL) Supporting policy with revised date March 2018 reflected: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record reviews, the facility failed to ensure all drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 2 (Medication storage room- Hall 100, Medication storage room-Hall 200) of 2 Medication storage rooms and 1 (Nurses' med cart - Hall 100) of 4 medication carts reviewed for medication storage. The facility failed to ensure :1. The medications stored in the hall 100 and hall 200 medication storage rooms were not expired .2. The content in a medication bottle in the hall 200 medication storage room was the medication labelled on the bottle.3. No mobile phone was stored in the hall 100 nurses' medication cart.4. Food items were not stored in the medication refrigerator in the hall 100 medication storage room. These deficient practices could place residents at risk for adverse effects and not receiving the therapeutic effects of the medication or treatment.The findings included:During an observation of the facility's medication storage room in the Hall 200 on 09/09/2025 at 8:50am it was revealed there was:1. One bottle of Mucus relief (guaifenesin 400mg+ Dextromethorphan 20mg) with one pink round shaped tablet and 3 pink oval shaped tablets in it.2. One bottle of Convatec Stomahesive Protective Powder 1 Oz with expired date 04/01/25 printed on it. During an interview on 09/09/2025 at 8:55am LVN H stated there should not be two different medications in one bottle. The content of a medication bottle should be the medication that was labelled on the bottle. He added, the same way the medications that are expired should be discarded in a timely manner as well. He stated wrong medications, and expired medication could adversely affect the residents as they could cause allergies or fail to achieve therapeutic effects. During an observation of the facility's Medication storage room in Hall 100 on 09/09/2025 at 9: 20am it was revealed there was:One bottle of oyster shell calcium 500mg was stored among other OTC medications. Label indicated: Best by 04/25. In the medication refrigerator:1. 3 packets of influenza vaccine (Flucelvax) 5ml multi dose vial - Label indicated: Exp-2025 June 30.2. One bottle of strawberry juice 3. One packet of strawberry yogurt During an interview on 09/09/2025 at 9:25am LVN A stated there should not be food items in refrigerator for storing temperature sensitive medications. She stated expired medications should be removed from the medication storages. LVN A said wrong medications, and expired medications could cause allergies or be ineffective therapeutically.During an observation of the Nurse's Med Cart in hall 100 on 09/09/2025 at 9:30am it was revealed there was a mobile phone stored in the last drawer of the med cart with the medications. During an interview on 09/09/25 at 9:35am RN G stated there should not be other items other than residents' medications in the med cart. She stated the mobile phone did not belong to her and had no idea how it got in there. She stated personal items like mobile phones were a threat to spreading diseases through cross contamination of medications. In an interview on 09/12/25 at 3:30pm, the DON stated expired medications and a bottle with a mixture of different medications should have been thrown away. It was against facility policy to store them with other active medications as expired medications could harm residents. She said no food items should be stored with medications in refrigerator due to the risk of contamination. The DON stated the mobile phone in the med cart belonged to one of the residents who passed away recently. She stated she was the one who suggested to save it in the cart to one of the nurses and it was a mistake from her side. She stated her action could cause cross contamination of the medications in the cart. Record review of facility policy Storage of Medications revised in April 2019 reflected: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews; the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation. 1. The facility failed to dispose of open stored perishable food products. 2. The facility failed to properly label and date food products in one of two freezers. 3. The facility failed to properly label and date food products in two of two kitchen pantries. 4. The facility failed to properly label and date food products throughout one of one kitchen. These failures could place residents who were served from the kitchen at risk for consuming contaminated food and developing foodborne illnesses. Findings include: Observation on 09/09/2025 at 10:20 AM during a walk-through of the facility kitchen revealed three large industrial facility refrigerators, two large industrial facility freezers, and two kitchen pantries. Observation revealed there was an open bag of undated and not labeled frozen dinner roll found in one of two freezers. Observation revealed there was open undated and not labeled bag of spaghetti noodles found in one of the two kitchen pantries. Observation revealed there was five loafs of bread undated and not labeled found in one of the two kitchen pantries. Observation revealed that there was a box full of potatoes in which were undated and not labeled on a kitchen storage rack. Observation revealed there was two boxes full of bananas in which were undated and not labeled on a kitchen storage rack. Observation revealed there was ten onions undated and not labeled on a kitchen storage rack. Observation on 09/10/2025 at 10:58 AM during a walk-through of the facility kitchen revealed there was an open undated and not labeled bag of spaghetti noodles found in one of the two kitchen pantries. a box full of potatoes in which were undated and not labeled on the kitchen storage rack. In an interview on 09/10/2025 at 11:04 AM with CK E, she stated the following: she had worked at this facility for 3 years. CK E stated she has been trained in labeling and dating foods that are in the kitchen. CK E stated she last received the labeling and dating training four months ago. CK E stated all food products in the kitchen needs to be labeled and dated at all times. CK stated not having food labeled and dated can be bad if a resident eats it. CK E stated food that isn't labeled and dated is an infection control issue for the residents. CK E stated if she sees someone not label and date foods, she will label and date the foods. CK E stated it can be bad for residents to eat undated or not labeled food as it will get them sick if they consume the food. CK E stated food that isn't labeled or dated gets thrown out. CK E stated its all-kitchen staff responsibility to throw away undated and not labeled foods in the facility kitchen. CK E stated it can negatively affect residents in terms of them getting sick eating not fresh foods or undated and not labeled foods. In an interview on 09/10/2025 at 11:13 AM with CK F, she stated the following: she had worked at this facility for 6 years. CK F stated she has been trained in resident rights in which residents have all their rights such as if a resident request a certain food the kitchen staff accommodates the residents right. CK F stated she had been trained in labeling and dating food products in the kitchen in which all foods need to be labeled and dated. CK F stated any food that is opened needs to be labeled and dated as well as put upfront to be used first. CK F stated the food needs to remain fresh for all residents or residents can get sick eating undated and not labeled foods in the kitchen. CK F stated if a resident eats bad, undated, and not labeled food they can potentially go to the hospital. CK F stated food that is not labeled or dated goes in the trash because the kitchen staff won't know when it was opened, cooked, or if it's good to give to residents without them getting sick. CK F stated it can affect residents' quality of life if residents eat undated or not labeled foods by potentially going to the hospital if the food is bad. CK F stated it's the responsibility of the all-kitchen staff to make sure all foods are labeled and dated in the kitchen. In an interview on 09/10/2025 at 11:19 AM with the DM, she stated the following: she had been working at this facility for 7 years, and she had been trained in resident rights. The DM stated resident have rights to be accommodated based off their dietary needs and if they want certain foods. The DM stated she has (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been trained in labeling and dating food in the kitchen and all food products in the kitchen need to be labeled and dated. The DM stated all foods in pantry, refrigerator, and freezer need to be labeled and dated to keep track of the food consumption timeframes. DM stated any food that expired is to be thrown away and this includes any foods that is not labeled or dated. DM stated food not labeled or dated shouldn't be served to residents as the kitchen staff won't know how long it's been stored and if there are bacteria on the food as well as it can cause residents to get sick. The DM stated its expected that all kitchen staff are in charge of labeling and dating foods that are in the facility kitchen as well as to not serve not labeled and date foods. The DM stated it's ultimately the responsibility of the DM and the Dietician to make sure all food products are labeled and dated at all times. The DM stated the kitchen staff put label and dates on the foods found by Investigator. The DM stated she threw away foods found by the investigator that were undated and not labeled when she conducted a food check. The DM stated the food labels and dates must have come off the foods. The DM stated the foods in boxes probably had dates and labels at the bottom in which they threw away the boxes to confirm. The DM stated any foods that is not labeled and dated then given to residents will get residents sick such as, residents may go to the hospital and get a food-borne illnesses. The DM stated it can pose a negative outcome or affect residents' quality of life since the residents would eat potentially expired or not fresh foods due to not having a label and date on the foods, which would lead to sickness, potentially hospitalize, and or cause a resident to pass away. A telephone interview was attempted on 09/11/2025 at 11:15 AM with RD, no answer. In an interview on 09/11/2025 at 12:33 PM with CNA D, she stated the following: she had been working at this facility for 4 years. CNA D stated she had been trained on labeling and dating foods in which all staff need to label and date foods. CNA D stated it is the responsibility of the kitchen staff and the DM to ensure all foods are labeled and dated, but everyone is responsible for labeling and dating. CNA D stated residents are not to be served food not labeled and dated in which facility staff throws it away or take it back to the kitchen. CNA D stated not labeling or dating foods negatively affects residents and their quality of life as it will get a resident sick, so it needs to be thrown away. In an interview on 09/11/2025 at 12:37 PM with LVN B, she stated the following: she has been working at this facility for over 2 years. LVN B stated she has been trained in labeling and dating foods. LVN B stated she makes sure all food is labeled and dated at all times. LVN B stated for example, if nursing staff are using foods such as, apple sauce that is expired she would throw it away. LVN B stated it's all staff and kitchen responsibility to make sure all food is labeled and dated before giving it to residents. LVN B stated providing residents undated and not labeled food can cause a resident to get sick such as, diarrhea, nausea, vomiting, and it's the facility staff's responsibility to prevent that by maintaining and catching undated and not labeled foods. LVN B stated residents eating not labeled or dated foods negatively affects residents and their quality of life as it will cause food poisoning and foodborne pathogens potentially leading to hospitalization. In an interview on 09/11/2025 at 2:55 PM with DON, she stated the following: she has worked at this facility for a month. DON stated she had been trained in labeling and dating foods that are being stored. The DON stated all foods need to have label and dates at all times. The DON stated it's the responsibility of the kitchen staff to ensure all food is labeled and dated as well as nursing staff if there is food out that needs to be labeled and dated. The. The DON stated she would not serve any food that could be expired or not have a label and date on it. The DON stated not labeling or dating foods negatively affect residents and their quality of life as it can get a resident ill and potentially be an infection control issues depending how long the food has been past its expired date. In an interview on 09/11/2025 at 3:21 PM with ADM, she stated the following: she had worked at this facility since Monday, 09/08/2025. The ADM stated she was last trained for labeling and dating foods in March 2025 through continuing education and no one from the facility has trained her prior to employment. The ADM stated Dietary Manager, and the kitchen staff are responsible to make sure food is labeled and dated. The ADM stated any, and all food not labeled or dated will get trashed and not served to residents. ADM stated if it is not documented then it did not (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happen when it comes to food not being labeled or dated. The ADM stated if there is no date or labeling on the food, then there would not be timeframes for the food to eat. The ADM stated her expectation is for all food to be accurately labeled and dated. TheADM stated she just started and will be making sure to monitor by auditing the kitchen daily to prevent foods that aren't labeled or dated potentially being served to residents. ADM stated not labeling or dating foods negatively affect residents and their quality of life as it can cause food poisoning to residents, cause additional health issues, or lead to potentially dying from bacteria. Record review of facility Dietary in-services reflected kitchen staff were educated on food storage on 06/05/2025 and 04/11/2024. Record review of facility Food Receiving and Storage policy with revised date July 2014 reflected: foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Food items and snacks kept on the nursing units must be maintained as indicated, all foods belonging to residents must be labeled with the resident's name, the item and the use by date. Record review of facility Refrigerators and Freezers policy with revised date December 2014 reflected: this facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 (Resident #18) of 8 residents reviewed for sanitary rooms. The facility failed to ensure Resident #18's floor was not sticky on 09/09/25 at 12:14 PM and 3:30 PM. This failure could place residents at risk for reduced quality of life and poor sanitary environment. Findings included: Review of Resident #18's admission Record, dated 09/09/25, reflected she was an [AGE] year-old female who was readmitted to the facility on [DATE] with diagnoses including muscle weakness, lack of coordination, cognitive communication deficit, schizoaffective disorder, anxiety disorder, vascular dementia, and depressive disorders. Review of Resident #18's Quarterly MDS, dated [DATE], reflected a BIMS score of 14, which indicated she was cognitively intact. During an observation of Resident #18's room on 09/09/25 at 12:14 PM, she was not in her room. The floor was sticky. During an observation and interview of Resident #18 on 09/09/25 at 3:30 PM, she was lying in her bed in her room. The floor was still sticky. The surveyor attempted to interview her, but she did not answer the surveyor's questions. During an observation and interview on 09/09/25 at 3:31 PM with LVN H, he walked into Resident #18's room and said, The floor was sticky. LVN H stated housekeeping staff were responsible for mopping residents' floors. LVN H stated housekeeping mopped Resident #18's floor a couple minutes before the surveyor's observation on 09/09/25 at 3:30 PM. During an observation and interview on 09/09/25 at 3:38 PM with HKS, she walked into Resident #18's room and said, The floor is sticky. HKS stated housekeepers were responsible for cleaning residents' rooms before breakfast, after lunch, and after dinner. She stated housekeepers mopped residents' floors 2-3 times daily. She stated housekeepers did not document mopping residents' floors. She stated she oversaw and ensured housekeepers mopped floors daily by checking residents' rooms once daily and said, Yeah I missed this room during my rounds. She knew the importance of residents having clean rooms and said, It's their right. They must have clean rooms. Residents could be at risk of infection and accidents if their rooms weren't cleaned. During an observation and interview on 09/09/25 at 3:41 P.M. with HK N, he walked into Resident #18's room and said, The floor is sticky. He stated he mopped the floors 2-3 times daily. He stated the HKS oversaw to ensure housekeepers mopped. He stated he knew the importance of residents having clean rooms and said, It's very important. Residents could be at risk of accidents. Review of the facility's Resident Rights policy, revised December 2016, reflected, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: A. a dignified existence. Review of the facility's Floors policy, revised December 2009, reflected, Policy Statement: Floors shall be maintained in a clean, safe, and sanitary manner. Policy Interpretation and Implementation: 1. All floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures. 2. Floor cleaning procedures are maintained by the Environmental Services Director. 3. Inquiries concerning floor care should be directed to the Director of Housekeeping Services.		

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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 refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 (Resident #33) of 5 residents reviewed for PASRR. The facility failed to perform a new PASRR level 1 assessment on Resident #33 for the diagnosis of bipolar disorder. This failure could place residents at risk of not receiving needed services and support. Findings Included: Record review of Resident #33's face sheet dated 09/10/25 revealed a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included congestive heart failure, muscle weakness, lack of coordination, cognitive communication deficit, diabetes mellitus, presence of cardiac pacemaker, hypertension, anxiety disorder and bipolar disorder (onset date: 01/13/23). Record review of Resident #33's quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating her cognition was intact. The MDS indicated she had bipolar and anxiety disorder and over the last two weeks she felt down, depressed and hopeless nearly every day and felt bad about herself most of the days. Record review of Resident #33's care plan dated 06/08/25 revealed there was no care plan and interventions for her diagnoses of bipolar disorder and anxiety disorder. Record review of Resident #30's PASRR level 1 assessment dated [DATE] and 09/05/24 revealed she was noted to be negative for dementia and mental illness. Record review of the geriatric progress note dated 01/25/23 authored by geriatric specialist reflected Resident #33 was diagnosed with bipolar disorder and not diagnosed with dementia. Record review of the psychiatric initial assessment dated [DATE] revealed Resident #33 was already on treatment for moderate depressed episode of bipolar disorder. There was no indication of the diagnosis of dementia. Record review of the physician's order reflected: 1. Lamotrigine Oral Tablet 25 MG (Lamotrigine): Give 2 tablet by mouth two times a day related to bipolar disorder, current episode depressed, mild or moderate severity, unspecified -Start Date- 06/18/2025. 2. Levetiracetam Oral Tablet 250 MG (Levetiracetam): Give 1 tablet by mouth two times a day for bipolar disorder -Start Date-09/14/2024. During an interview on 09/11/25 at 3:00pm the MDS nurse stated she was the one responsible for identifying PASRR eligible residents. She stated she was not aware Resident #33 was diagnosed with bipolar disorder and Resident #33 was eligible for PASRR if she had a diagnosis of mental illness. MDS nurse stated, at the facility she was overwhelmed with multiple tasks and could not concentrate on auditing the medical records of residents at the facility with mental illness for their eligibility for PASRR. During an interview on 09/11/25 at 3:30pm the DON stated residents might miss out on services they need if they were not newly assessed based on a qualifying diagnosis. The DON stated she thought if Resident #33 was screened as negative for mental illness prior to admission she did not need a new PASRR level 1 assessment despite having a qualifying diagnosis because she presumably had the diagnosis prior to admission and at the time of the original screening. During an interview on 09/11/25 at 4:10pm the ADM stated the MDS nurse is responsible to identify residents who were eligible for PASRR. She stated, not performing a new PASRR level 1 assessment on a resident with a qualifying diagnosis could result in a resident not receiving the PASRR services they are entitled. The ADM said she was new at the facility and was in the process of sorting out all the deficiencies related to resident care at the facility. Record review of facility policy admission Criteria revised in March 2019 reflected the necessity of the pre-admission and subsequent level II screening, however the requirement of re-screening residents based on qualifying diagnoses was not included in the policy. 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 (PASRR) process. a. The facility conducts a Level I PASRR screen for all potential admissions, regardless of payer source, to determine if the individual (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 PASRR 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 PASRR 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 PASRR 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 PASRR representative, the potential resident and his or her representative are notified.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident's baseline Care Plan to include the minimum healthcare information necessary to properly care for a resident for 1 of 6 residents (Resident #55) whose records were reviewed for baseline care plans. The facility failed to ensure Resident #55 has a baseline care plan for the Jackson Pratt drain (a medical device used to remove excess fluid from a surgical site or wound, preventing swelling and promoting healing) and skin care at the incision site, since his admission on [DATE]. This failure could place residents at risk of not receiving required care. Findings included: Record review of Resident #55's face sheet dated 09/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included encephalopathy (disturbance in brain function), acute pancreatitis (inflammation in pancreas) with infected necrosis (tissue death), hepatic fibrosis (scar tissues in the liver), acute respiratory failure, muscle weakness, lack of coordination and reduced mobility. Record review of Resident #55's initial MDS dated [DATE] revealed a BIMS interview yet to be conducted. Record review of Resident #55's care plan dated 06/08/28 revealed there was no care plan for the Jackson Pratt drain (a medical device used to suction and collect fluid from a surgical site to promote healing and prevent infection) that was inserted on Resident #55. Record review of the progress note dated 9/03/25 authored by LVN A reflected: Resident arrived today at approximately 16:15[4:15pm] transferred by EMS. LLQ has accordion [Jackson Pratt] drain still, described as brown with no smell possible from the liver. Record review of the progress note dated 09/04/25 authored by Geriatric Post-Acute Specialists reflected: . Three of four pancreatic drains were removed, with one remaining drain producing approximately 200 mL/day of brown fluid. Record review of the physician's order on 09/11/25 revealed there was no order for the wound care of the incision site and management of the Jackson Pratt drain. Record review of the TAR , MAR, and progress notes for Resident #55, revealed there was no documentation of any care provided for the JP drain and skin since Resident #55's admission on [DATE]. Record review of the facility's resident roster on 09/30/25 reflected there were no residents at the facility who required JP drain care. During an observation and interview on 09/09/25 at 12:50 p.m., Resident #55 was in his room in his wheelchair and then transferred himself to the bed. He had a JP drain inserted to the LLQ of his torso. Resident #55 stated it was for draining fluid from his pancreas. The bulb of the equipment was secured in a plastic bag. Resident #55 stated the bulb was leaking for the last 4 days and was not replaced by the facility yet. He stated the staff reported to him that an order for the bulb was placed and waiting for its delivery. He said the staff was attentive, however they did not know how to manage his condition due to lack of experience in dealing with JP drains. He stated most of the time he only drained the fluid from the bulb. During an interview on 09/11/25 at 1:13 p.m., the ADON stated she was regularly checking the incision cite and emptying the fluid time to time, however, it did not document anywhere. She stated it was the first time she was dealing with a JP drain. She stated she did not receive any training from the facility before or after Resident #55's admission. The ADON stated whenever she was on duty she cared for Resident 55 closely however had not documented anywhere. She stated she did not look at the care plan or call the physician to get a JP drain and incision site management orders. The ADON stated she was not sure if other nurses were taking care of the JP drain and incision site of Resident #55. During a phone interview on 09/11/25 at 1:35 p.m., RN G stated she drained the JP drain whenever she was on duty. She said there was no physician's order for the management of the JP drain. She stated she was handling a JP drain the first time and did not receive any training at the facility. She said she learned how to manage the JP drain from Resident #55's FM as she demonstrated to her how to manage it. She stated she did not call the NP to get order for the JP drain management. During a phone interview on 9/11/25 at 2:30 p.m., LVN A stated she started working at the facility about 10 (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days ago. She said it was her first job as an LVN after receiving her LVN license. LVN A stated she was the nurse who admitted Resident #55 on 09/03/25. She stated she received a hand over instructions from the hospital nurse, over the phone. She stated there was no instruction from the hospital for JP drain management specifically. LVN A stated she did not request an order from the physician for the management of the JP drain and the wound care for the incision site. She stated she did not do a baseline care plan as well as she did not know it was mandatory. She stated one day in the morning when she was on duty the FM had complained that bulb of the JP drain was full, and she drained it. She stated she did not do any documentation about what she did. LVN A stated she believed she was assigned with various nursing tasks without receiving proper training and support. During an interview on 09/11/25 at 2:30 p.m., the MDS coordinator stated she made a care plan for Resident # 55, however, did not do any care plan for the JP drain management as no one reported to her about it. She stated she made a care plan based on what the nurses reported to her. The MDS coordinator stated she believed a care plan is very important, especially in the initial days of the admission to ensure quality of care. She stated the care for Resident #55 might have been compromised due to the lack of a care plan for his condition. During an interview on 09/12/25 at 3:45 p.m., the DON stated the responsibility of ensuring a baseline care plan was of the nurse who did the admission process however ultimately it was the responsibility of the MDS coordinator to make sure the admission nurse completed a baseline care plan in a timely manner. The DON stated the lack of a baseline care plan affect the quality of care that the residents receive. During an interview on 09/30/25 at 11:41 a.m., the NP stated Resident #55 was at the facility for a brief amount of time. He stated nurses were providing care for Resident #55's JP drain. The NP stated Resident #55 should have had orders for his JP drain. The NP stated Resident #55 was not at risk of potential or actual harm because the staff were providing care for his JP drain. Record review of the facility policy titled Care Plans - Baseline revised in December 2016 reflected: 1. To ensure that the residents' immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.2. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the residents' immediate care needs including but not limited to: a. Initial goals based on admission orders. b. Physician orders. c. Dietary orders. d. Therapy services. e. Social services; and f. PASARR recommendation, if applicable. 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and development an interdisciplinary person-centered care plan. 4. The residents and their representatives will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident. b. A summary of the residents' medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive care plan for 1 resident (Resident #55) of 5 residents reviewed for treatments. The facility failed to ensure Resident #55 received a continuous quality Jackson Pratt drain care and skin care at the incision site, since his admission on [DATE]. This failure could lead to outcomes, including pancreatic fistulas (an abnormal opening or tunnel that forms in the pancreas and allows pancreatic fluid to leak into surrounding tissues or organs), infections and hemorrhage. Findings included: Record review of Resident #55's face sheet dated 09/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included encephalopathy (disturbance in brain function), acute pancreatitis (inflammation in pancreas) with infected necrosis (tissue death), hepatic fibrosis (scar tissues in the liver), acute respiratory failure, muscle weakness, lack of coordination and reduced mobility. Record review of Resident #55's initial MDS dated [DATE] revealed a BIMS interview had yet to be conducted. Record review of Resident #55's care plan dated 06/08/25 revealed there was no care plan for the Jackson Pratt drain (a medical device used to suction and collect fluid from a surgical site to promote healing and prevent infection) that was inserted on Resident #55. Record review of the progress note dated 9/03/25 authored by LVN A reflected: Resident arrived today at approximately 16:15[4:15pm] transferred by EMS. LLQ has accordion [Jackson Pratt] drain still, described as brown with no smell possible from the liver. Record review of the clinical progress note dated 09/04/25 reflected: . Three of four pancreatic drains were removed [at the hospital], with one remaining drain producing approximately 200 mL/day of brown fluid. Record review of the physician's order on 09/11/25 revealed there was no order for the wound care of the incision site and management of Jackson Pratt drain. Record review on 09/10/25 of TAR, MAR and progress notes of Resident #55 revealed there was no documentation of any care provided for JP drain and skin since Resident #55's admission on [DATE]. During an observation and interview on 09/09/25 at 12:50pm Resident #55 was in his room in his wheelchair and then transferred himself to the bed. He had a Jackson Pratt drain inserted at the left lower quadrant of his torso. Resident stated it was for draining fluid from his pancreas . The bulb of the equipment was secured in a plastic bag. Resident #55 stated the bulb was leaking for the last 4 days and was not replaced by the facility yet. He stated the staff reported to him that an order for the bulb was placed and waiting for its delivery. He said the staff were attentive however they did not know how to manage his condition due to lack of experience in dealing with Jackson Pratt drain. He stated most of the time he only drained the fluid from the bulb. Observation of the incision site revealed there was no sign of infection. During a telephone interview on 09/10/25 at 12:35pm the FM stated she had trained a staff member how to drain the fluid from Jackson Pratt . She stated the nurse at the hospital taught her how to do it. The FM stated Resident #55 believed the right place for him was the hospital so that he could get better care . She stated Resident #55 reported to her that the staff at the facility were caring and compassionate however they did not have skills to deal with his condition. During an interview on 09/11/25 at 1:13pm ADON stated she was regularly checking the incision site and emptying the fluid time to time however did not document anywhere. She stated it was the first time she was dealing with Jackson Pratt drain. She stated she did not receive any training from the facility before or after Resident #55's admission. The ADON stated whenever she was on duty she cared Resident #55 closely however did not document the care anywhere. she did not look at the care plan or call the physician to get a JP drain and incision site management orders. The ADON stated she was not sure if other nurses were taking care of the JP drain and incision site of Resident #55. During a phone interview on 09/11/25 at 1: 35pm RN G stated she drained the JP drain whenever she was on duty. She said there was no physician's order for the management of JP drain . She stated she was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handling a JP drain for the first time and did not receive any training at the facility. She said she learnt how to manage the JP drain from Resident #55's FM as she demonstrated to her how to manage it. She stated she did not call the NP to get order for the JP drain management. During a phone interview on 9/11/25 at 2:30pm LVN A stated she started working at the facility about 10 days ago . She said it was her first job as an LVN after receiving her LVN licensure. LVN A stated she was the nurse who admitted Resident #55 on 09/03/25. She stated she received a hand over instruction from the hospital nurse, over the phone. She stated there was no instruction from the hospital for JP drain management specifically. LVN A stated she did not request an order from the physician for the management of the JP drain and the wound care for the incision site. She stated one day in the morning when she was on duty the FM had complained that bulb of the JP drain was full, and she drained it . She stated she did not do any documentation of what she did. LVN A stated she did not make any baseline care plan as she was not aware of it, and thought it was the job of MDS coordinator. LVN A stated she believed she was assigned with various nursing tasks without receiving proper training and support. During an interview on 09/11/25 at 2:11pm NP stated the responsibility of placing orders for any initial care should come from the admission nurse. He stated he had a concern of admitting Resident #55 with JP drain. He said he requested DON and the management to admit Resident #55 only after the arrangements were done to make sure, he got quality care and suggested to arrange all the replacement items for JP drain prior to his admission. He stated the drain and incision management were supposed to be done daily to avoid complications. When the investigator pointed out that Resident #55 was using a plastic bag as the bulb of the drain was leaking the NP stated that should have been replaced as soon as it was found defective. Record review of the facility policy titled Comprehensive Assessment and the Care Delivery Process revised in December 2016 reflected: Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions.2. Assessment and information collection includes (WHAT, WHERE and WHEN?). The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information about a patient.a. Assess the individual.(1) Gather relevant information from multiple sources, including:(a) Observation;(b) Physical assessment;(c) Symptom or condition-related assessments(d) Resident and family interview;(e) Hospital discharge summaries;(f) Consultant reports;(g) Lab and diagnostic test results; and(h) Evaluations from other disciplines (for example, dietary, respiratory, social services, etc.). Record review of the website https://www.hopkinsmedicine.org/-/media/transplant/caring-for-your-jp-drain.pdf, accessed on 09/19/25 reflected : A Jackson Pratt drain, JP drain, or Bulb drain provides a constant low suction to pull air or excess fluid from your surgical site for faster healing and prevention of complications. You will need to learn how to care for your drain. It will remain in place until you return to see your provider. An appointment should be made to remove the drain.1) Wash your hands thoroughly with soap and water before touching drain. 2) Gather your supplies. They do not have to be sterile. 3) Remove the old dressing. Unpin the drain from your clothing. (Only when instructed to do so, squeeze (strip) the drain tubing with alcohol swab toward the bulb prior to emptying it as instructed by nurse or provider.) 4) Open the stopper slowly (away from your face). Empty the contents into the measuring container at least twice daily or when drain is about half full. Record the amount. 5) Note the color and type of the drainage. 6) Squeeze the bulb while it is uncapped. While squeezing, recap the bulb to create suction. 7) Pin the bulb drain back to your clothing by the plastic tag to avoid accidental pulling. 8) Discard the drainage into the toilet. Rinse and wash the measuring container with soap and water. 9) Wash your hands with soap and water.Starting the day after surgery, change your dressing daily or when it becomes soiled with drainage. (some drains may be left open to air if instructed by provider) 1) Wash your hands with soap and water. Remove old dressing carefully. Rewash hands. 2) Clean the skin around the drain tube site with Normal Saline-soaked cotton tipped (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applicator (or gauze) in circular motion. Please be careful not to tug on sutures. 3) Check the skin around the drain tube site for redness, tenderness, swelling, warmth, unusual drainage and leakage. 4) Place clean, dry gauze over the drain tube insertion site and secure it with tape. 5) Wash your hands with soap and water.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, including hand hygiene, designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #70) of 6 residents reviewed for infection control practices, in that: The facility failed to:1. Ensure LVN I and CNA J changed dirty gloves when handling clean items and sanitized the surfaces while providing peri care and wound care to Resident #70. This failure could place residents at risk for healthcare associated cross-contamination and infections. Findings Included: Record review of Resident #70's face sheet dated 09/10/25 revealed a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included hemiplegia (paralysis of one side of the body), aphasia (inability to communicate), muscle weakness, muscle wasting and atrophy, pressure ulcer of left buttock- stage 2, cognitive communication deficit, retention of urine, hepatitis c, hypertension, chronic kidney disease and need for assistance with personal care. Record review of Resident #70's MDS dated [DATE] revealed the BIMS interview could not be conducted as the resident was rarely/never understood. Record review of Resident #70's care plan dated 07/10/25 reflected he would continue to receive wound management services r/t bilateral buttock incontinence associated dermatitis and relevant intervention was providing wound care per treatment order. Record review of the physician's order reflected: Cleanse right buttock with wound cleanser, pat dry, apply collagen, triad paste mixture, and QD, and prn every day shift for wound care.-Start Date-09/03/2025 During an observation on 09/10/25 at 9:40am LVN I and CNA J were providing peri care and wound care to Resident #70. CNA J put on gloves after washing his hands. He opened the brief and cleaned Resident #70's back to remove feces, with wet wipes dispensed directly from the packet. In that process he handled the whole wipe packet multiple times with the gloves soiled with feces. LVN I was holding Resident #70 sideways so that CNA J could clean off the feces from Resident #70's body. After the cleaning was completed LVN I provided wound care to the pressure ulcer at the buttocks area. LVN I used the same overbed table with the contaminated wet wipe on it, for placing the wound care items. She did not use a disposable cloth or paper towel on the overbed table as a barrier. After the completion of the peri care and wound care CNA JJ and LVN I left the room without sanitizing the overbed table that Resident #70 used for other purposes, with the contaminated wet wipe packet on it. During an interview on 09/10/25 at 10:20am CNA J stated he was a CNA for many years and was diligent in following infection control protocol. When the surveyor walked through the entire process CNA J stated he was not aware that he was contaminating the whole packet. He stated his negligence cross contaminated the packet, and he should have thrown away the entire packet. CNA J said he was risking of spreading diseases by handling clean packet with contaminated gloves. CNA J stated he could not remember if he received any in services on peri care in the recent past. During an interview on 09/10/25 at 10:25am LVN I stated she had not realized CNA J was contaminating the whole packet or else she would have redirected CNA J. She stated she should have used a barrier on the table after sanitizing it and thrown away the contaminated packet, as Resident #70 used the overbed table for eating food and placing his other personal items. She stated she and CNA J's compromised infection control practices were detrimental to the residents as they could spread diseases. During an interview on 09/12/25 at 2:25pm the DON stated CNA J should not have handled the wet wipe packet with soiled gloves. She stated CNA J was supposed to throw away the contaminated wet wipe packet and sanitize the overbed table before leaving the room. The DON said LVN I should have redirect CNA J when he was breaking the infection control protocol. She stated in practice both CNA J and LVN I compromised residents' health by not following the right procedure of wound care and peri care. The DON stated she identified deficiencies in infection control practices through observation during routine rounds in the facility. She stated if any deficiencies were (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed the related staff would be retrained and in serviced. The DON stated she could not remember exactly when the staff received in services on infection control. Review of the in-service records from 05/01/25 to 09/10/25 revealed there were 2 separates in services on hand hygiene and using gloves during nursing care. There were no in-services on wound care and peri care during this period. Record review of facility's policy Wound care Revised in October 2010 reflected: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the Procedure1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 19. Use clean field saturated with alcohol to wipe overbed table.20. Return the overbed table to its proper position.21. Wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart. Record review of facility's policy Infection Control Guidelines for All Nursing Procedures revised in August 2012 reflected: Purpose, to provide guidelines for general infection control while caring for residents. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes.		