STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675112	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for two of six residents (Resident #1 and Resident #2) reviewed for reporting of alleged violations. The Administrator failed to report a resident-to-resident altercation between Resident #1 and Resident #2, in which both residents were observed punching each other with closed fists, to the State Survey Agency. This failure could place residents at risk of not receiving timely and appropriate responses to alleged violations of abuse, neglect, and/or exploitation.Findings include: 1. Record review of Resident #1's Face Sheet, dated 04/27/26, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included cerebral palsy (a group of neurological disorders that permanently affect movement, posture, and muscle coordination, usually caused by abnormal brain development or injury before, during, or shortly after birth), moderate intellectual disabilities (a developmental condition marked by significant limitations in intellectual functioning and adaptive skills, often requiring ongoing support for daily living and social interactions), and impulse disorder (a group of disorders that are linked by varying difficulties in controlling aggressive behaviors, self-control, and impulses). Record Review of Resident #1's Quarterly MDS Assessment, dated 04/02/26, reflected he had a BIMS score of 3, which indicated he had severe cognitive impairment. Record review of Resident #1's Care Plan, dated 11/07/25, reflected he had impaired cognition due to his medical conditions, as well as difficulty understanding others at times. The Care Plan noted Resident #1 tended to get frustrated when he felt rushed, hurried, or not listened to by others. Interventions included asking simple yes/no questions, allowing Resident #1 time to make choices, avoiding overstimulation, providing supervision as needed, referring for counseling and medication management, etc. Record review of Resident #1's General Progress Notes (Nurse's Notes), written by LVN B and dated 03/14/26, reflected, .Was informed by nurse that there was a resident to resident incident. Nurse states she saw resident coming around the corner down the hallway, [Resident #1] was wheeling backwards and accidentally hit other resident's [Resident #2] wheelchair. [Resident #2] attempted to push [Resident #1's] wheelchair forward, [Resident #1] stopped wheelchair with his feet and continued to try and wheel backwards. [Resident #2] then hit [Resident #1] twice in the face and [Resident #1] responded by hitting this resident back. This nurse and weekend supervisor came around nurse station to separate residents while residents continued to hit each other. Once separated, this nurse completed head to toe assessments on this resident. Redness noted to left hand knuckle area resident c/o pain 7/10 PRN Tylenol given per order. Vitals BP Pt tolerated well. DON and Administrator notified of incident. 1 on 1 monitoring initiated. MD notified. Message left for RP. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #1 on 04/27/26 at 10:10 AM revealed he displayed no obvious signs or symptoms of distress nor any observed behaviors. There were no concerning marks or bruises noted on his person. An interview with Resident #1 on 04/27/26 at 10:10 AM was attempted but was unsuccessful due to Resident #1's cognitive impairment. Resident #1 did not appear to recall the incident or any previous issues with Resident #2. 2. Record review of Resident #2's Face Sheet, dated 04/27/26, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included vascular dementia (the second most common form of dementia, caused by impaired blood flow to the brain, which deprives brain cells of oxygen and nutrients) and adjustment disorder (a short-term, stress-related mental health condition triggered by a significant life change or event, such as divorce, job loss, or illness). Record review of Resident #2's Quarterly MDS Assessment, dated 04/17/26, reflected he had a BIMS score of 15, which indicated he was cognitively intact. Record review of Resident #2's Care Plan, dated 04/03/26, reflected, .Resident #2 has potential to demonstrate physical behaviors of hitting, striking at or punching other residents when triggered. Interventions included analyzation of key times, places, circumstances, triggers, and what de-escalates behaviors; assessing and anticipating the resident's needs; cognitive assessments; providing physical and verbal cues to alleviate anxiety and encouraging him to seek out a staff member when agitated; referring for counseling and medication management, etc. Record review of Resident #2's General Progress Notes (Nurse's Notes), dated 03/14/26, reflected Resident to resident incident. Nurse saw [Resident #2] coming around the corner down the hallway, [Resident #1] was wheeling backwards and accidentally hit [Resident #2's] wheelchair. [Resident #2] attempted to push [Resident #1's] wheelchair forward, [Resident #1] stopped wheelchair with his feet and continued to try and wheel backwards. [Resident #2] then hit [Resident #1] twice in the face and [Resident #1] responded by hitting [Resident #2] back. This nurse and Weekend Supervisor came around nurse station to separate Residents while residents continued to hit each other. Once separated, this nurse completed head to toe assessment on [Resident #2]. Redness noted to [right] side of forehead, resident c/o pain 2/10 but declines PRN pain medication. DON and Administrator notified of incident. Q15 monitoring initiated. MD notified. Message left with RP. Observation of Resident #2 on 04/27/26 at 10:40 AM revealed he displayed no obvious signs or symptoms of distress nor any observed behaviors. There were no concerning marks or bruises noted on his person. During an interview with Resident #2 on 04/27/26 at 10:40 AM, he stated he had been involved in an isolated resident-to-resident incident involving Resident #1. He stated Resident #1 initiated the altercation by hitting him; he then hit Resident #1 back. He stated facility staff promptly intervened and separated the residents. Resident #1 stated he was placed on increased supervision/monitoring rounds. He denied any injury and stated this was an isolated incident. He denied any mental anguish or being fearful following the incident. During an interview with LVN A on 04/27/26 at 12:06 PM, she stated she witnessed the resident-to-resident altercation between Resident #1 and Resident #2 on 03/14/26. LVN A explained Resident #1 commonly ambulated backwards in his wheelchair. At the time of the incident, Resident #1 was ambulating backwards out of a common area as Resident #2 was ambulating via wheelchair nearby. Resident #1 backed into Resident #2; Resident #2 then pushed Resident #1's wheelchair (non-aggressively; it appeared as though he was just trying to move the wheelchair out of the way). Resident #1 then purposefully pushed his wheelchair against Resident #2. Resident #1 and Resident #2 then began punching each other in the face and arms with closed fists. She stated they appeared to be willfully hitting each other. LVN A stated the incident escalated very quickly; she believed they each hit each other approximately 3-4 times. LVN A stated as soon as she saw the incident begin to escalate, she immediately intervened and separated them. She stated the head-to-toe assessments revealed Resident #2 had a red mark on his face, but it had gone away by the end of the shift. She stated Resident #1 was placed on 1:1 supervision/monitoring, and Resident #2 was placed on scheduled 15-minute rounds/monitoring. The Administrator and the DON were immediately notified. All other appropriate parties, which included the physician and responsible (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	parties were also notified. LVN A stated this was an isolated incident and she was not aware of either resident having a history of physical behaviors. During an interview with the Administrator on 04/27/26 at 2:21 PM, he stated he was made aware of the incident that occurred between Resident #1 and Resident #2 on 03/14/26. He stated he was advised Resident #1 was ambulating backwards out of a common area as Resident #2 was ambulating via wheelchair nearby. Resident #1 collided into Resident #2; Resident #2 attempted to non-aggressively stop Resident #1's wheelchair by pushing it away. Resident #1 then pushed Resident #2, and they began hitting each other. The Administrator stated LVN A witnessed the incident and immediately separated the two residents and placed them on increased supervision/monitoring. He stated all appropriate parties were notified, which included the physician and responsible parties. Lab work was obtained on both residents, and it was found Resident #2 had a UTI; he received treatment for this illness. Facility staff were in-serviced following the incident on abuse/neglect and resident rights, which included resident-to-resident behaviors. The Administrator stated any instances of abuse, neglect, or exploitation were considered reportable to the State Survey Agency and that, as the Administrator, he was responsible for reporting such incidents. He said this included any willful acts of resident-to-resident altercations. The Administrator stated the facility did not feel the incident between Resident #1 and Resident #2 was willful, which was why the incident was not reported. The Administrator stated the risk of not reporting incidents as required included the potential for facility non-compliance and physical/mental harm to residents. During an interview with the Regional [NAME] President of Operations on 04/27/26 at 2:35 PM, he stated he was made aware of the incident that occurred between Resident #1 and Resident #2 on 03/14/26. He said it was his understanding the incident was more of a reaction (as though one of the residents had been startled and unintentionally swung his hands at the other resident) as opposed to a willful/intentional altercation. The Regional [NAME] President of Operations stated his understanding was that willful intent meant someone had to purposefully attempt to hurt or injure someone else, and that person had to have the mental cognition to recognize their actions. The Regional [NAME] President of Operations stated if the incident between Resident #1 and Resident #2 should have been reported, then the facility misinterpreted the Provider Letter referencing reportable incidents. The Regional [NAME] President of Operations stated the risk of not reporting incidents as required included the potential for resident harm. Record review of a file of evidence which was presented to the state surveyor by the Administrator on 04/27/26 reflected the facility investigated the resident-to-resident altercation between Resident #1 and Resident #2 (incident date 03/14/26). Following the resident-to-resident altercation, facility staff immediately intervened and separated the residents. Head-to-toe assessments were completed and identified no major injuries. The residents were placed on increased supervision/monitoring (Resident #1 was placed on 1:1 supervision/monitoring; Resident #2 was placed on scheduled 15-minute rounds/monitoring). All appropriate parties were notified, including the residents' physician and responsible parties. The residents were interviewed and witness statements obtained. Additional lab work was completed, and it was determined Resident #2 had a UTI; treatment was initiated. Facility staff were in-serviced on abuse/neglect/exploitation and resident rights. It was noted that there had been no history of aggression between the residents and there were no pre-meditation or threats leading to the altercation. It was determined that the incident was an unplanned behavioral interaction between the two residents and, per the facility's determination, did not meet the criteria for a reportable incident. Record review of Provider Letter 2024-14, dated 08/29/24, reflected, .Do report: abuse (with or without serious bodily injury. and When to report: Immediately, but not later than two hours after the incident occurs or is suspected. The Provider Letter also reflected, .Allegations or incidents of resident-to-resident behavior may or may not meet the definition of abuse depending on whether a resident acted willfully. As the CFR states: ?Willful, as used in the definition of 'abuse,' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm'. Record review of the facility's undated, Abuse Prevention and Prohibition Program policy, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected, .The facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime. i. Immediately, but no later than 2 hours after forming the suspicion - if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation). iv. The Administrator will provide the state survey agency, law enforcement and the Ombudsman (if applicable per state regulation) with a copy of the investigative report within 5 days of the incident.