STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on observation, interview and record review, the facility failed to immediately inform and consult with the physician with a significant change in resident physical status and a need to alter treatment for 1 of 25 residents (Resident #9) reviewed for physician notification. The facility failed to: Ensure that LVN A and RN B notified Physician C when Resident #9's right foot was noted to have swelling, redness and warmth on 09/14/22 and 09/15/22; Resident #9 was sent to a local hospital where she received emergency services to include intravenous antibiotics and removal of a foreign body from her right foot. This failure could affect residents by placing them at risk for not receiving appropriate care and interventions. Findings included Record review of Resident #9's electronic face sheet, dated 09/22/2022 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include, .Chronic Pain, Cellulitis of Right Lower Limb, Dementia with behavioral disturbances, anxiety disorder, Major Depressive Disorder . According to the Centers for Disease Control and Prevention, (CDC), Cellulitis is .Cellulitis is a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin. If untreated, it can spread and cause serious health problems.Cellulitis is treated with antibiotics. Most cellulitis infections can be treated with oral antibiotics (taken by mouth). More serious infections may need to be treated in the hospital with intravenous (IV) antibiotics, which are given directly into a vein . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #9's admission MDS dated [DATE] indicated a BIMS score of 13, which indicated minimal cognitive impairment. Section E did not indicate Resident #9 had exhibited any behaviors. Section G indicated Resident #9 required limited assistance by one staff member for transfers, extensive assistance for dressing by two persons, extensive assistance by one staff member for toileting, extensive assistance of two persons for personal hygiene and supervision by one staff for eating. Section H indicated she was frequently incontinent of bladder and occasionally incontinent of bowel. Section J indicated that she received scheduled pain medication. Section N revealed Resident #9 received antipsychotics, and an antidepressant. Record review of Resident #9's care plan dated 03/16/22 with a most recent care plan review date of 07/28/2022, revealed the following: .Problem: Start Date: 08/05/2022 Pain, I am at risk for pain related to the aging process .I will verbalize a decrease in pain over the next 2 weeks .Approach, I will be monitored for verbalization of pain or discomfort . Goal: Resident will be as alert and oriented as possible .Approach . assess for pain .R/O acute illness Observation and assessment with the DON on 09/15/2022 at 8:28 p.m. revealed Resident #9's right foot was noted to have swelling, redness, warmth and a wound on her right toe with a yellow substance that covered the wound bed. In addition, Resident #9's right foot had a small pinpoint darkened area on the bottom of her foot. In an interview on 09/16/2022 at 2:30 p.m., LVN A said she had performed the treatment to Resident #9's right second toe yesterday on 09/15/2022 after Resident #9 came out of the shower room and she recalled her foot was red, her skin was peeling, the wound itself looked wet, looked like slough (the yellow/white material in the wound bed) was around it. LVN A stated, It was absolutely not resolved; cannot recall what the order was but I think it was to clean and cover with just a basic order (clean with normal saline and apply dressing); it did occur to me that it might need a more thorough order from [Physician C,] but at the time I was doing the treatment, I was just trying to get so many things done at one time. LVN A said she was in the middle of her medication pass and it was impossible to try and be all these different places at once. LVN A said she did not have time to contact Physician C about Resident #9's right foot still showing signs of an infection during her shift on 09/15/2022. LVN A said she recalled Resident #9 being treated with antibiotics for a foot infection the last time I worked the secure unit, cannot recall exact date and honestly still thought she was receiving antibiotics . Record review of Resident #9's Medication Administration Record for September 2022 revealed the following: .Cephalexin (an antibiotic) capsule; 500mg Amount to Administer: 1; oral Frequency three times a day .Diagnosis [blank] .Start/End Date 09/03/2022-09/10/2022. Record revealed Resident #9 was administered the medication for seven days, three times a day with only one missed dose on 09/06/2022 for an unknown, undocumented reason. In an interview on 09/19/2022 at 2:17 p.m., RN B said she did not notify Physician C when she worked on 09/13/22 and 09/14/2022 regarding Resident #9's right foot still having signs of infection because she thought it was getting better, so it didn't alert me to contact the doctor. RN B said she felt it was still in the healing process and Physician C would look at it on his next visit at the facility but was unsure when that date would be. RN B said Physician C usually was in the facility on Thursday's or Friday's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/20/2022 at 3:58 p.m., Physician C stated he recalled being initially notified of Resident #9 having a possible infection to her right foot on 09/03/2022, he gave a telephone order for antibiotics. Physician C said he had not been contacted regarding the continued redness, warmth and swelling in Resident #9's right foot until Thursday evening on 09/15/2022, when he was contacted by the DON and a FaceTime video call was performed to evaluate Resident #9's right foot. Physician C said his expectation would be that if a foot continued with redness and warmth after completing a course of antibiotics, he would expect to be notified to ensure additional orders were not necessary. In an interview on 09/21/2022 at 5:10 p.m., the DON said her expectation for staff if a skin assessment revealed warmth, redness or swelling was for the physician to be notified and to chart it in a progress note. The DON said continued redness and warmth indicated that there was still inflammation and the doctor needed to be notified. The DON said, If not addressed, the condition could worsen. Record review of Resident #9's hospital emergency room records dated 09/15/2022 revealed the following: . Emergency Department note .Triage Chief Complaint Cellulitis right foot brought in from [nursing facility] home by ambulance. [Facility Name] called due to cellulitis on right foot XXX[AGE] year-old female presented to emergency department by ambulance from [Facility Name] for evaluation of right foot cellulitis. Upon exam patient's foot, notice there was a piece of metal shaving in patient's plantar/ball (on the bottom) aspect of the right foot. Piece of metal shaving was approximately 5mm in depth. Which was removed here in the ER. Dorsal aspect (on top of) of the right foot notice redness and swelling . Further review of emergency department records revealed Resident #9 had received intra venous antibiotics for the cellulitis in her right foot, a tetanus shot, was discharged back to the nursing facility with a prescription for oral antibiotics and to follow up with her primary care physician for further evaluation regarding the cellulitis in her right foot. Record review of the facility's policy entitled, Change in Resident's Condition or Status, dated 2001 Revised February 2021, revealed the following: .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; .i. specific instruction to notify the physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0684 Level of Harm - 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** 37012 Based on observation, interview, and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #9) of 25 residents reviewed for quality of care. The facility failed to: A. Identify that Resident #9 continued with an unresolved infection to her right foot that required additional medical attention, intravenous antibiotics, and the removal of a foreign body to her right foot in the emergency department. This failure placed residents at risk for medical complications related to a change in condition and injury which could results in worsening infections, pain, and the need for emergency medical treatment and hospitalization . Findings Included: Record review of Resident #9's electronic face sheet, dated 09/22/2022 revealed that she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include, .Chronic Pain, Cellulitis of Right Lower Limb, Dementia with behavioral disturbances, anxiety disorder, Major Depressive Disorder . According to the Centers for Disease Control and Prevention, (CDC), Cellulitis is .Cellulitis is a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin. If untreated, it can spread and cause serious health problems.Cellulitis is treated with antibiotics. Most cellulitis infections can be treated with oral antibiotics (taken by mouth). More serious infections may need to be treated in the hospital with intravenous (IV) antibiotics, which are given directly into a vein . Record review of Resident #9's admission MDS dated [DATE] indicated a BIMS score of 13, which indicated minimal cognitive impairment. Section E did not indicate Resident #9 had exhibited any behaviors. Section G indicated Resident #9 required limited assistance by one staff member for transfers, extensive assistance for dressing by two persons, extensive assistance by one staff member for toileting, extensive assistance of two persons for personal hygiene and supervision by one staff for eating. Section H indicated she was frequently incontinent of bladder and occasionally incontinent of bowel. Section J indicated that she received scheduled pain medication and indicated no fall history. Section M revealed resident was at risk for developing a pressure injury. Section N revealed Resident #9 received antipsychotics, and an antidepressant. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #9's care plan dated 03/16/22 with a most recent care plan review date of 07/28/2022, revealed the following: .08/05/2022 .Problem: Start Date: 08/05/2022 Delirium .Goal: Resident will be as alert and oriented as possible .Approach .assess for pain .R/O acute illness .Problem Behavioral Symptoms 08/02/2022 I frequently holler out to leave facility, and sometimes just randomly with no reason . Goal: I will communicate with staff what I am needing reducing my hollering to less than two times a day . Approach: Staff will redirect resident with likes and preferences .watching television, Dr. Pepper, food preferences, emotional attention and support, I will notify staff if I have trouble hearing .Problem 07/27/2022 Category Falls: Resident is at risk for falls due to history of falls .Goal I will have less than 3 actual falls over the next 90 days .Approach: I will have a low bed and fall mat next to my bed due to my behavior of crawling out on to the floor from my bed .09/04/2022 .Problem: 09/20/2022 Category Falls: I am at likely risk for falls as I do not notify staff via call light or verbally before I attempt to get out of bed or my wheelchair .Goal: I will not, to the extent practicable, experience more than 3 falls in 90 days .Approach: Keep bed in lowest position with brakes locked .Teach resident safety measures such as call light use and or verbal notification before attempting to exit bed or wheelchair . Observation on 09/15/2022 at approximately 8:15 p.m. revealed a voice from behind Resident #9's closed door yelling out. Upon opening the door by the surveyor Resident #9 was found lying on the tile floor on her right side. Resident #9 was yelling for help, the bed was in a low position and the fall mattress was in place; her call light was not in reach. Resident #9 had a fearful, grimaced look on her face. The [NAME] President of Operations was witness to the incident as well and notified the DON to provide assistance for Resident #9. Observation and assessment by the DON on 09/15/2022 at 8:28 p.m. revealed Resident #9's right foot was noted to have swelling, redness covering the entire dorsal (top part of foot) aspect of her foot, warmth was present and a wound on her right toe was observed on the second joint of her right toe that was circular in shape and there was a yellow substance that covered the entire wound bed. In addition, Resident #9's right foot had a small pinpoint darkened area on the bottom of her foot. Record review of the nursing progress notes for Resident #9 revealed the following: .09/10/2022 at 7:49pm Resident is being monitored for an active infection .Infection Type: Cellulitis .Location: [blank] .Resident is receiving Keflex 500mg, Oral Administration .The resident has experienced the following signs/symptoms of infection during this shift: Purulent discharge (white, yellow or brown fluid that might be slightly thick in texture) or drainage from wound electronically signed LVN Q. 09/06/2022 at 3:18pm .Resident is being monitored for an active infection .Infection Type Skin/Soft Tissue Infection Right toe .Resident is receiving antibiotic Keflex, resident has received treatment for 3 days .Skin hot to touch, pus from wound. electronically signed by LVN N 09/03/2022 at 3:49pm Dressing change to right second toe. Redness and yellow slough surrounding perimeter of approximately 3mm, red, wet, wound. Cleansed with NS and nurse [LVN A] applied silver gel to wound. Contacted [Physician C], awaiting orders at this time . electronically signed LVN A. 09/03/2022 at 5:07pm .Orders received. Keflex (an antibiotic, generic name Cephalexin)500mg TID for 7 days for right second toe wound. electronically signed by LVN A. Record review of Resident #9's Medication Administration Record for September 2022 revealed the following: .Cephalexin(an antibiotic) capsule; 500mg Amount to Administer: 1; oral Frequency three times a day .Diagnosis [blank] .Start/End Date 09/03/2022-09/10/2022. Record revealed Resident #9 was administered the medication for seven days three times a day with only one missed dose on 09/06/2022 for an unknown, undocumented reason. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #9's Treatment Administration Record for September 2022, revealed the following: .Wound Treatment Order: Location: Right second toe, clean with normal Saline/Wound Cleanse Cover with Primary Dressing (island dressing or gauze) .Daily; Diagnosis: [Blank] .Start/End Date: 09/03/2022-09/15/2022 (DC Date) .Treatment was not done on four dates for unknown, undocumented reasons .0907/22, 0908/22, 09/11/22, and 09/13/22). In an interview on 09/15/2022 at 8:28pm, Resident #9 voiced that she was in pain all over and could not recall how long she had been on the floor. In an interview on 09/15/2022 at 8:40 p.m., LVN D said she had been in to administer medications to Resident #9 and indicated that she had been exhibiting behaviors throughout the day and into the evening where she was intentionally putting herself on the floor. LVN D said she had observed her on the floor just a few minutes ago but that she figured that was where she wanted to be. LVN D stated she was aware that Resident #9 was on the tile floor and said that the floor is hard and is probably uncomfortable but did not feel it was neglectful due to the fact that Resident #9 was intentionally putting herself onto the floor. In an interview on 09/15/2022 at 8:45 p.m., the DON said, I thought she was still receiving antibiotics for cellulitis in her right foot but it [the MAR] shows she completed the course on 09/10/2022. The DON said RN B charted in a progress note that a skin assessment was done on 09/13/2022 but nothing was documented about redness, warmth or swelling to the right lower extremity or a wound on her right second toe. The DON did validate that Resident #9 had been verbal all day with screaming and that she had been throwing herself forward in her wheelchair and would end up on the floor but that if Resident #9 was found on the floor, her expectation is that staff should have assisted her into bed. During an interview on 09/15/2022 at approximately 9:15 p.m., the DON stated Resident #9 was going to be sent out to the Emergency Department for further evaluation for pain and the redness to her right foot. The DON stated she thought Resident #9 was still receiving antibiotics for the cellulitis to her right lower extremity but after reviewing her records, the records indicated she had finished her course of antibiotics on 09/10/2022 and her foot was still showing signs of infection. Record review of Resident #9's hospital emergency room records dated 09/15/2022 revealed the following: . Emergency Department note .Triage Chief Complaint Cellulitis right foot brought in from [nursing facility]home by ambulance. [Facility Name] called due to cellulitis on right foot XXX[AGE] year-old female presented to emergency department by ambulance from [Facility Name] for evaluation of right foot cellulitis. Upon exam patient has foot, notice there was a piece of metal shaving in patient's plantar/ball aspect of the right foot. Piece of metal shaving was approximately 5mm in depth. Which was removed here in the ER. Dorsal aspect (on top of) of the right foot notice redness and swelling . Further review of emergency department records revealed Resident #9 had received intra venous antibiotics for the cellulitis in her right foot, a tetanus shot, was discharged back to the nursing facility with a prescription for oral antibiotics and to follow up with her primary care physician for further evaluation regarding the cellulitis in her right foot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #9's nursing progress notes revealed the following: .09/13/2022 at 4:49pm .Skin assessment for Resident .left forearm with dried small cut about an inch in length with steri-strips in place . Bruise on right bicep, bruise on right forearm, left lower leg skin tear .bruise on left shin .cut on right shin with dressing in place .Resident tolerated skin assessment and was calm. No yelling during assessment .*(no documentation regarding right lower extremity or wound on second right toe) .09/15/2022 at 10:00pm .This nurse was notified by DON that resident was going to be sent out to the ER d/T RLE swelling and uncontrolled pain. electronically signed LVN D. 09/16/2022 at 1:00am .[Local Hospital] called and stated that resident was ready to return to facility, X-ray 3 views of right knee and 3 views of right foot was done with no fractures .medications given were Ceftriaxone (an antibiotic) IVPB (intravenous piggy back) .Diagnosis Cellulitis of right foot and foreign body in the right foot was removed and will be returning with prescription for Keflex (an antibiotic) 500mg QID x 10 days Record review of Resident #9's Medication Administration Record for September 2022 revealed on 09/15/2022, the MAR revealed a new order for Cephalexin 500mg, amount to administer 1, oral; Frequency Four Times a Day, Diagnosis Cellulitis of Right lower limb, Start Date 09/16/2022-09/20/2022 .Resident #9 received this medication four times a day with 2 missed doses on 09/19/2022 and on 09/20/2022, the medication was discontinued. In an interview on 09/16/2022 at 2:30pm, LVN A said that she had performed the treatment to Resident #9's right second toe yesterday on 09/15/2022 after Resident #9 came out of the shower room and she recalled her foot was red, her skin was peeling, the wound itself looked wet, looked like slough (the yellow/white material in the wound bed) was around it. It was absolutely not resolved; cannot recall what the order was but I think it was to clean and cover with just a basic order, normal saline; it did occur to me that it might need a more thorough order from [Physician C], but at the time I was doing the treatment, I was just trying to get so many things done at one time. LVN A said she was in the middle of her medication pass and it was impossible to try and be all these different places at once; LVN A said she did not have time to contact Physician C about Resident #9's right foot still showing signs of infection. LVN A said she recalled Resident #9 being treated with antibiotics for a foot infection the last time I worked the secure unit, cannot recall exact date and honestly still thought she was receiving antibiotics . In an observation and interview on 09/19/2022 at 3:44 p.m., LVN F performed wound care to Resident #9's right toe and foot. The observation revealed Resident #9's right foot to be improved showing little signs of redness and swelling on the dorsal (top part of foot). LVN F said there was no warmth to the foot and observation of the wound bed to the right second toe no longer had the yellow slough present and there was a healthy pink wound bed noted. Resident #9 said her foot felt much better and her pain had improved. In an interview on 09/19/2022 at 2:17pm, RN B said she did not notify Physician C when she worked on 09/13/22 and 09/14/2022 regarding Resident #9's right foot still having signs of infection. RN B said she performed a skin assessment on 09/13/2022 and recalled the whole toe was red on Resident #9's right foot. RN B said signs of infection are redness, swelling and warmth and thought it was getting better , so it didn't alert me to contact the doctor. RN B said she felt it was still in the healing process and just needed more time but said that Physician C would look at it on his next visit at the facility. RN B said she was unsure when that date would be. RN B said Physician C usually was in the facility on Thursday or Fridays. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0684 Level of Harm - Actual harm Residents Affected - Few	Record review on 09/19/2022 of a photograph from 09/03/2022, taken and provided by RN B revealed Resident #9's right foot and second toe to have redness and an open area on the second joint of the right second toe. The opening was noted to have a small amount of yellow substance present in the wound bed and there was peeling skin noted to the base of the right second toe. The dorsal (top of foot) area had minimal redness to it. In an interview on 09/20/2022 at 3:58pm, Physician C recalled being initially notified of Resident #9 having a possible infection in her right foot on 09/03/2022, he gave a telephone order for antibiotics and Physician C said he had not been contacted regarding the continued redness, warmth and swelling in Resident #9's right foot until Thursday evening on 09/15/2022, when he was contacted by the DON and a FaceTime video call was performed to evaluate Resident #9's right foot. Physician C said that his expectation would be that if a foot continued with redness and warmth after completing a course of antibiotics, he would expect to be notified to ensure additional orders were not necessary. In an interview on 09/21/2022 at 5:10pm, the DON said that her expectation for staff if a skin assessment reveals warmth, redness or swelling her expectation is for the physician to be notified and to chart it in a progress note. The DON said continued redness and warmth indicate that there is still inflammation and the doctor needs to be notified. The DON said, If not addressed, the condition could worsen. In an interview at exit, on 09/26/2022 at 1:30 p.m., the [NAME] President of Operations indicated that the facility did not have a specific policy regarding quality of care. Record review of the facility policy entitled Resident Examination and assessment dated 2001, revised February 2014 revealed the following: .The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan .2. Notify the physician of any abnormalities such as, but not limited to: .e. wounds or rashes on the resident's skin; and f. worsening pain, as reported by the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on observations, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 2 of 25 residents (Resident #4 and Resident #25) reviewed for accidents and supervision. The facility failed to: A. Take reasonable precautions and provide adequate supervision and interventions to prevent Resident #4 from being physically harmed by Resident #24, when Resident #24 had increasing behaviors of anxiousness, agitation, and threatening behaviors over a period of approximately three weeks, which resulted in Resident #24 hitting Resident #4 in the face requiring emergency medical attention at a local hospital for Resident #4 on 09/16/22. B. Take reasonable precautions and provide adequate supervision and interventions when Resident #21 was witnessed by staff to be experiencing escalated behaviors of both physical and verbal aggression directed towards Resident #25 on 09/02/2022 and 09/09/2022 and on 09/14/2022 Resident #21 hit Resident #25 in the face . Resident #21 sustained a small red scratch across bridge of nose and a light purple discoloration under and by the nose on both sides. These failures could place residents at risk for resident-to-resident altercations that could result in serious physical and psychosocial harm and require emergency treatment and/or hospitalization . Findings include: In an interview on 09/16/2022 at 10:00am, the DON said that on 08/16/2022 the facility merged an all-female secure unit with an all-male secure unit. Resident #4 Record review of Resident #4's electronic face sheet, dated 09/22/2022 revealed that she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include, .Major depressive disorder, Alzheimer's disease with early onset, Cognitive Communication Deficit, Seizures . Record review of Resident #4's most recent quarterly MDS dated [DATE] indicated she had unclear speech and rarely/never made herself understood. Section C indicated Resident #4 was Severely cognitively impaired. Section E indicated Resident #4 had no known behaviors. Section G indicated Resident #4 required supervision and setup help only for locomotion on the unit and did not require any mobility devices. Section I included the following diagnoses of Alzheimer's disease, depression, and a Seizure Disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #4's care plan with a last care Conference date of 08/10/2022, revealed the following: .Problem: Start Date: 09/09/2022 Behavioral Symptoms-I pace up and down the halls frequently with no regards to others in my path. 8/1/22 I walked up behind another resident and got hit in the stomach. 8/17/2022 I pushed another resident in the hallway while I was pacing up and down the hall. 08/26/2022 I hit another resident in the face while walking in the hallway. Goal: I will have less than 3 episodes of physical aggression with other people in my path over the next 90 days .Approach: .I become stressed at times with loud noises such as others yelling and or loud televisions .I will be redirected to a quiet area when behavior is unacceptable .Problem Start Date: 09/09/2022 .I have behavior symptoms as evidenced by my wandering related to Alzheimer's disease. I reside in a secure unit. I wander into other resident's rooms and take their belongings. Edited: 09/15/2022 .Goal: My dignity will be maintained and I will wander about the secure unit without occurrence of significant injury over the next 90 days .Edited 09/12/2022 .Approach: Assist me in reorientation to room and secure unit with verbal cues .Observe my location with visual checks at least every 2 hours .Problem Start Date: 09/19/2022 .I have a laceration to my left eyebrow area r/t I was hit in the face by another resident when I went into his room uninvited. Goal: My laceration will heal with no redness swelling, drainage within the next 2 weeks .Approach: I will have my laceration monitored for redness, swelling or drainage . Record review of Resident #4's Event Report dated 09/16/2022 at 6:56pm, revealed the following: .Event Report: [Resident #4] .Event Date: 09/16/2022 at 6:55pm, Completed by LVN N .Description: Hit in face by another resident .Event Details: .CNA saw resident walking down the hallway. She then heard another resident say I'm going to hit you again if you don't get out of my room CNA said resident was hanging onto doorknob .Event was not witnessed .Describe Injury Laceration to left eyebrow area .Treatment Call 9-1-1, First Aid, Assessment and Physician Order/Treatment .New intervention immediately implemented to prevent reoccurrence: Increased monitoring for aggressor. ON called social worker and local mental health facility . Record review of Resident #4's nursing progress notes revealed the following entries: .09/16/2022 at 6:02pm The resident was transferred via ambulance from facility to [Local Hospital] due to altercation with another resident that occurred on the day shift .Electronically Signed LVN O .09/16/2022 7:03pm (late entry) CNA saw resident walking down the hallway. She then heard another resident say, I'm going to hit you again if you don't get out of my room. CNA N said resident was hanging onto doorknob of that resident's room. She immediately removed resident from his room and called me. Resident has approx. 2cm laceration to left eyebrow with moderate bleeding. Area cleaned with NS; pressure applied to stop bleeding. Dressing applied. ADMIN and DON notified. 911 called. Resident continued ambulating throughout unit. No other injuries noted. Resident left facility at 6:20pm on stretcher with EMS. [family member] notified, [Physician C] notified . electronically signed by LVN M .09/16/2022 at 9:45pm .This nurse called [Local Hospital] spoke with [Hospital RN] the resident is ready to come back to the facility. She received four sutures to the wound on her forehead/eyebrow area this nurse gave condition report on the resident to the facility administrator . Resident #24 Record review of Resident #24's electronic face sheet, dated 09/22/2022 revealed that he was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses to include, .Paranoid Schizophrenia, Patient's noncompliance with other medical treatment and regimen, Alcohol dependence, in remission, Unspecified dementia without behavioral disturbance . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #24's most recent quarterly MDS dated [DATE] indicated he had clear speech, was able to make self-understood, and had the ability to understand others. Section C indicated Resident #24 was moderately cognitively impaired with a BIMS score of 10. Section E indicated Resident #24 had verbal behaviors directed toward others (e.g., threatening others, screaming at others, cursing at others) and section E0800 did not indicate Resident #24 had rejected care or wandered. Section G indicated Resident #24 required supervision and setup help only for locomotion on the unit and did not require any mobility devices. Section N revealed Resident #24 had received an antipsychotic and antianxiety medication during a 7 day look back. Record review of Resident #24's care plan with a last care Conference date of 06/29/2022, revealed the following: .Problem: Start Date: 03/27/2022 Behavioral Symptoms-I have behavioral Symptoms of wandering . Goal: I will have fewer episodes of wandering .Approach: Redirect resident as needed .Remove from public area when behaviors is unacceptable 03/27/2022 .Problem Start Date 03/27/2022 Psychotropic Drug Use . Edited 06/29/2022 .Goal: Benefit without side effects .Monitor target behaviors per psychotropic flowsheets . Problem: Mood State Edited 07/21/2022 .Goal I will express/exhibit satisfaction .Approach: .Meds as ordered Record review of Resident #24's electronic physician orders dated 08/22/2022 thru 09/22/2022, unsigned revealed the following: .Start Date: 03/25/2022- Open Ended .Senior Psychiatric and Psychological Services to Evaluate and Treat as Needed .Start Date: Risperdal Consta (risperidone microspheres) suspension . 25mg/2mL; amt: 25mg; Intramuscular .DX: Paranoid Schizophrenia .Once a day on Every Wednesday 2 weeks; Bedtime .ordered by [PNP M] .Start Date: 03/25/2022 Olanzapine tablet; 15mg; amt: 1 oral DX: Paranoid Schizophrenia .Twice a day .Ordered by: [Physician C] .Carbamazepine tablet extended release 12 hr; 100mg; amt: 1 tablet; oral DX: Paranoid Schizophrenia .Ordered by: [PNP M] . Start date: Clonazepam .; 0.5mg; amt: 1 oral DX: paranoid schizophrenia three times a day .Ordered By: [PNP M] . According to the National Alliance on Mental Illness, .Risperdal Consta Extended-release injectable suspension: 25 mg .Generic Name: risperidone, is a medication that works in the brain to treat schizophrenia .Risperidone rebalances dopamine and serotonin to improve thinking, mood, and behavior . One of the long-acting injectable forms, known as Risperdal Consta(R), should be received every 2 weeks as ordered by your healthcare provider . Missing doses of risperidone may increase your risk for a relapse in your symptoms . Risperdal Consta(R) (risperidone long-acting injection) should be received every 2 weeks. It should be administered by your health care professional through an injection into your upper arm or buttocks area. The medication effects last for approximately 2 weeks . Accessed on 10/03/2022 https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Risperidone-(Risperdal). According to the National Alliance on Mental Illness, .Olanzapine (Zyprexa) .is a medication that works in the brain to treat schizophrenia .Olanzapine rebalances dopamine and serotonin to improve thinking, mood, and behavior .symptoms of schizophrenia include .hallucinations, delusions, disorganized thinking, little desire to be around other people . Missing doses of olanzapine may increase your risk for a relapse in your symptoms. Do not stop taking olanzapine or change your dose without talking with your healthcare provider first. For olanzapine to work properly, it should be taken every day as ordered by your healthcare provider . Accessed on 10/03/2022 https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Olanzapine-(Zyprexa) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	According to the National Alliance on Mental Illness, .Carbamazepine (Tegretol) .is a mood stabilizer medication that works in the brain. It is approved for the treatment of bipolar 1 disorder (also known as manic depression) .Symptoms of depression include .psychomotor agitation (nervous energy) .symptoms of mania include: Feeling irritable or high . Missing doses of carbamazepine may increase your risk for a relapse in your mood symptoms . Accessed on 10/03/2022 https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Carbamazepine-(Tegretol). According to the National Alliance on Mental Illness, .Clonazepam is a benzodiazepine. It is approved for the treatment of panic disorder .also commonly used to treat difficulty sleeping and alcohol withdrawal . Benzodiazepines, such as clonazepam, are often used for short periods of time only. They may produce emotional and/or physical dependence (addiction) even when used as recommended. With input from you, your health care provider will assess how long you will need to take the medicine. Do not stop taking clonazepam without talking to your healthcare provider first. Stopping clonazepam abruptly may result in one or more of the following withdrawal symptoms: irritability, nausea, tremor, dizziness, blood pressure changes, rapid heart rate, and seizures. Withdrawal reactions may occur when dosage reduction occurs for any reason .Accessed on 10/03/2022 https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Clonazepam-(Klonopin) Record review of Resident #24's August MAR revealed Resident #24 had an order for Abilify 400mg; amount to administer 400mg; intramuscular .Once a day every 28 days .Start 04/11/2022 End Date 08/18/2022 . 08/01/2022 revealed Resident #24 did not receive this medication due to Not administered: Drug Item Unavailable, Called Pharmacy Waiting on prior authorization .[LVN N] .On 08/18/2022, an order was placed on MAR for Risperdal Consta 25mg/2mL; administer 25mg intramuscular once a day on Friday, every two weeks; review of the MAR for 08/19/2022 revealed there was no administration record for this medication and this order was discontinued on 08/24/2022 and reentered to reflect the same order Risperdal Consta 25mg/2mL; administer 25mg intramuscular once a day on Wednesday, every two weeks and review of the MAR for 08/24/2022,revealed there was no administration of this medication and no reason/comment charted. Review of Resident #24's medications for Olanzapine, Clonazepam and Carbamazepine did not reflect any missed doses or refusals. According to the National Alliance of Mental Illness, .Abilify (Aripiprazole) is a medication that works in the brain to treat schizophrenia .It is a second-generation antipsychotic .aripiprazole rebalances dopamine and serotonin to improve thinking, mood and behavior . Accessed on 10/03/2022. https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Aripiprazole-(Abilify) Record review of Resident #24's September MAR revealed Resident #24 had the following refusal of medications or there was no documentation to show the medication had been administered: Carbamazepine 100mg 6 doses: 09/01, 09/03, 09/04, 09/07, 09/08, 09/12. Clonazepam 0.5mg 11 doses: 09/01 nighttime dose, 09/03 morning and afternoon dose, 09/04 morning and afternoon dose, 09/07 nighttime dose, 09/08 morning dose, 09/09 afternoon dose, 09/12 nighttime dose, 09/13 afternoon dose, 09/14 afternoon dose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	Olanzapine 15mg 6 doses: 09/01 evening dose, 09/03 morning dose, 09/04 morning dose, 09/07 evening dose, 09/08 morning dose, 09/12 evening dose. Risperdal Consta 25mg IM 1 dose on 09/07/2022 Record review of Resident #24's Point of Care History from dates 08/16/2022 thru 09/17/2022, revealed the following behaviors were charted for Resident #24: Screaming at others: 08/27/2022 08/28/2022 09/17/2022 Threatening Others: 08/19/2022 The resident was very upset just walking next to hospitality aid or even looking at the hospitality aid and attacked the aid a few times and would lift his left fist to the aid to threaten to hit the aid. I would get in between the two and redirect the resident as the aid walked the other direction to get the resident back to his room . [agency CNA 2] . 08/26/2022 Cursing at others: 09/12/2022 (yelled for several hour) [Agency CNA] Pacing: 09/12/2022 09/14/2022 Making Disruptive Sounds: 09/14/2022 Hitting Others: 09/16/2022 hit a resident in the face once [TNA E] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #24's psychiatric evaluation/management visits by [PNP M] revealed the following: 8/12/2022: (*Prior to merge of units) Patient reports to 'just fine' Staff report no behavioral problems .He is pleasant and says he has been doing well. He says he has been sleeping well. He denies any needs. No acute emotional distress noted .Diagnosis: Paranoid Schizophrenia, generalized anxiety disorder .patient has shown mild improvement in response to treatment. 08/18/2022 .Patient is very agitated today. He is sitting in the common area. He is yelling and not easily redirected. Staff says he has been agitated since they moved residents from the female unit in and has escalated today. He calms some after he eats but then begins yelling again in the shower. Order given for Zyprexa (Olanzapine) 10mg now .One time order for Zyprexa IM given now for extreme agitation and aggression. Patient is generally non-compliant with medications .Behavior was uncooperative, hostile and agitation .Mood was angry and anxious .Diagnosis: Paranoid Schizophrenia, Generalized Anxiety Disorder . Comments: Yelling and aggressive with self, staff, and other residents. Record review of Resident #24's event report revealed the following: . Event Date 09/16/2022 at 6:36pm . Completed by: [LVN N] .Description: hit another resident in the face . Event Details: aggressive/combative behavior .Was resident or others injures during the behavioral episode? Yes .other resident had laceration to left eyebrow . Does resident exhibit or complain of any of the following? Anger .Behavioral Symptoms . Physical Behavior directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing .): not exhibited in last 7 days .Verbal Behavioral Symptoms (e.g., threatening others, screaming at others, cursing at others) directed towards others: Behavior not exhibited in last 7 days (*refer to nursing note on 09/14/2022). Other behavior symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, throwing food, verbal/vocal symptoms like screaming, disruptive sounds) .Behavior not exhibited in last 7 days . Behavior Symptoms put others at risk for injury Did any of the identified symptoms(s) put others at significant risk for physical injury? Yes .Rejection of Care Presence and Frequency Did the resident reject evaluation or care (e.g., .taking medications .) Behavior not exhibited . Further review of the event report indicated that Resident #24 had received daily for seven days his antipsychotic, antianxiety and antidepressant medications for seven days (refer to September MAR for evidence there was only 5 days for his antipsychotic and 3 days of administration for the anti-anxiety) .Notes: .CNA heard resident say 'I am going to hit you again if you don't get out of my room. CNA said another resident was hanging onto doorknob of the resident's room, bleeding from her head. She immediately removed resident from his room and called me. Resident immediately went to his bed and laid down. DON, Administrator notified. [Physician C] and [PNP M] notified. Resident is no under increased level of supervision. Social worker on scene. Electronically signed [LVN N] . Record review of Resident #24's nursing progress notes revealed the following entries: 8/20/2022 6:15am Late Entry; .Reported by staff that when supper tray was brought to resident in his room resident knocked tray in air yelling 'get that out it's poison!' Unable to redirect. Electronically signed [LVN L]. 09/01/2022 10:00pm, .The resident refused all scheduled night medications, past several attempts to administer them . electronically signed [LVN O] .10:10pm notified [PNP M] of refusal of HS meds. No new orders . Electronically signed [LVN O]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	09/02/2022 at 6:00pm Mood is Anxious Electronically signed [LVN O] 09/07/2022 at 10:00pm .He REFUSED his night medications past several attempts to administer them. Notified [Physician C] and [PNP M]. No complains of pain, no behaviors/emotional distress noted. He is asleep in bed . Electronically signed [LVN O]. 09/11/2022 at 12:00am .Mood: Anxious, Irritable, Angry .Behavior Guarded, agitated, paranoid . electronically signed [LVN O]. 09/13/2022 at 12:00am .Behavior Guarded, agitated . Electronically Signed [LVN O] 09/14/2022 at 5:33pm .Resident threatened Administrator. No physical touch noted. Electronically Signed [RN B] 09/16/2022 at 7:09pm .CNA heard resident say, 'I am going to hit you again if you don't get out of my room'. CNA said another resident was hanging onto doorknob of the resident's room, bleeding from her head. She immediately removed resident from his room and called me. Resident immediately went to his bed and laid down. DON, Administrator notified. [Physician C] and [PNP M] notified. Resident is not under increased level of supervision. Social worker on scene. Electronically signed [LVN N] 09/16/2022 at 7:11pm .SW informed by nursing staff and Administrator; resident hit a female resident who wandered in his room [Local Law Enforcement] present to visit with resident regarding incident with assault. Resident adamantly stating she walked in my room to police .Per staff, resident had been having delusions of someone harming him and seemed to be in a vigilant and attack mode off and on throughout the week. Resident typically self-isolates and very rarely leaves his room. It is difficult for SW and staff to assess and have a rapport with resident due to resident refusal to talk with staff. Resident mood typically antisocial, irritable, exhibiting self-isolating behavior . Electronically signed [SW]. Observation on 09/19/2022 at 10:18am revealed Resident #4 continued with pacing and wandering up and down secure unit #1. Resident #4 was noted to have sutures to her left eyebrow and purple/greenish discoloration to her left eye and orbit. In an interview on 09/14/2022 at 11:20am, CNA R said that she always works Unit 1. CNA R said that there had been a big change since the facility had merged the females in with the males a few weeks ago. CNA R said yesterday 09/13/2022, Resident #24 was pacing and he started getting agitated at [Resident #9] for screaming and [Resident #25] for pacing/wandering and started screaming Shut up, shut up, Shut up! CNA R said that the facility removed [Resident #9] from the secured unit due to her screaming and yelling on 09/13/2022, but there were still residents that were triggers for Resident #24 and Resident #21, to become verbally and physically aggressive towards. In an interview on 09/14/2022 at 12:00pm, TNA S said that yesterday [Resident #24] became very upset on the unit and had verbal aggression towards two staff members and kept yelling shut up, shut up, which is usually a warning he gives you before he snaps. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 09/19/2022 at 9:00am, the Administrator reported that Resident #24 had hit Resident #4 in the face on Friday evening 09/16/2022, which sent Resident #4 to the hospital where she received four sutures to her left eyebrow and Resident #24 was placed on line-of-sight monitoring until 09/17/2022, whe n he was sent to a local psychiatric hospital. The Administrator indicated that the police were notified. The Administrator said that there were two staff members on the unit at the time of the incident and that the CNAs did not see Resident #4 wander into Resident #24's room until TNA E overheard Resident #24 threatening to hit Resident #4 again if she did not leave his room. In an interview on 09/19/2022 at 4:30pm, LVN N said that she was working when the resident-to-resident altercation occurred with Resident #4 and Resident #24. LVN N said that TNA E had come to her and informed her that there had been an incident. TNA E said she was walking down the hall and heard Get out of my room or I am gonna hit you again if you don't get out of my room. LVN N said that TNA E found Resident #4 in Resident #24's room and removed her from Resident #24's room. LVN N said TNA E reported that Resident #4 was bleeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 09/19/2022 at 12:33pm, CNA R said that she always works secure unit 1 and had worked at the facility for three and half years. CNA R said that she had worked last Wednesday on 09/14/2022 and noted that Resident #24 was pacing up and down the hallways and that Resident #4 would wander into Resident #24's room often. CNA R said that Resident #4 is easily redirected when found wandering but unless staff are looking down the hallway and not distracted by other residents it is hard to see her go into other rooms. CNA R said that Resident #24 will usually give verbal warnings and will yell for residents that wander to get out his room and that is the staff's cue to get in there and see what is going on. CNA R said that since the facility combined the females and the male secure units in mid-August it has been a lot, especially for [Resident #24]. CNA R said that Resident #24 prefers a calm, quiet atmosphere and does not like his space invaded. CNA R said that Resident #9 had a known behavior of screaming and yelling; Resident #4 was very prone to wander into other rooms and would require redirection multiple times throughout the day. CNA R said she had notified both the Administrator and the DON when behaviors had started increasing on unit 1 since the females and males had been combined in mid-August and was told to redirect. CNA R said she had expressed concern last week to the DON about the increased behaviors with Resident #24 and the facility finally removed Resident #9 from the secure unit. CNA R said that had helped but there were still other residents that were triggers, specifically residents that had a behavior of wandering. CNA R said that she had worked last Saturday when Resident #24 was transferred to the local psychiatric hospital and that Resident #24 voiced to her I shouldn't have hit her, I shouldn't have hit her referring to Resident #4. CNA R said Resident #24 was sent to the local psychiatric hospital by a police escort due to the facility feeling it was unsafe to have a staff member transport Resident #24. CNA R felt that due to the increased behaviors with the females, specifically residents that were prone to wandering, it was difficult to supervise the hallway at all times with other tasks needing to be done. CNA R said it would be easy for wandering residents to go into another resident's room without staff seeing it unless they strictly monitor the hallways at all times. CNA R said that initially when the units were combined, they were staffing 3-4 aides, but indicated that there had been a dispute between two staff members soon after the merge and one of those staff members was taken off the unit, which left 3 and then eventually it has dwindled down to 2 staff on the unit. CNA R said only if staff call and tell the DON or Administrator to let them know it is getting out of hand will they send an additional person, which often times had been the Administrator. CNA R said that she had reported multiple times via her phone to the DON regarding the increased behaviors that residents were experiencing since the merge of the two units and was just told to report it to your nurse and redirect. CNA R said in addition she had verbalized to both the Administrator and to the DON multiple times on the phone and in person that this was getting out of hand and it was too much to handle. It was unfair to women and men, they (males) were not used to the stimulation from the females; I have requested the mesh stop signs and they said they would see what they could do and I have been asking for black tape to put on the floor so residents would walk around it thinking it was a hole in the floor. I mentioned it definitely more than once and was just told 'we will look into it; we will see what we can do'. CNA R said that neglect was not doing something that you know should be doing and it could be harmful or hurtful to a resident. CNA R said that she charts on behaviors each shift and reports to her charge nurse every day. CNA R said that she feels that Resident #24 and Resident #4's incident could have been prevented when Resident #24 was showing signs of increased agitation and verbally yelling to other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 09/19/2022 at 2:17pm, RN B said that she knew Resident #24 was agitated last week because a lot of the women wander and walk into other resident's rooms; we are often redirecting. RN B said that there are always two CNAs on the secure unit and that if she is not busy, she will go onto the unit and help as well. RN B said that she has seen Resident #24 agitated and knew that sometimes when she offered his clonazepam, he would refuse it. RN B said that clonazepam is to help him with his anxiety. RN B said that sometimes she charts the refusal and sometimes she doesn't but anytime medications are refused, the physician should be notified . RN B said she has seen Resident #4 go up and get really close to other residents in the secure unit and said she cannot make sense with her speech. RN B said staff attempt to redirect her and I would explain to Resident #24 that [Resident #4] is unaware of the wandering and doesn't understand what she is doing and he would not comment but would just go back to reading his bible. RN B said that if he is left alone, Resident #24 is okay but when people just keep going into his room, he becomes very aggravated. RN B said he is a big man and I do feel that he could hurt someone. RN B said yes, I was scared of him. RN B said that interventions for Resident #4 and Resident #24 were just to continually watch and supervise. RN B said she was aware that Resident #24 had a history of being physically aggressive but was not aware it was with other residents. RN B said that she had heard him verbalize to resident's that had wandered into his room get out of my room and said Resident #24 often verbalized things that did not make sense. RN B said she recalled Resident #24 refusing some of his psychiatric medications and that the implications to his medication refusal were symptoms coming back and indicated psychotic symptoms. RN B said that I think he would be really calm if he kept a routine regimen . (referencing Resident #24's medications) RN B said that she had not notified Physician C when Resident #24 refused his medications and said she was not aware that was facility protocol. RN B said that it happens a lot with him, so she wasn't sure. RN B said that Resident #24 would stay in his room but would get upset when someone entered his room. RN B said that it would upset Resident #24 because it violated his territory and said that she had witnessed Resident #24 last week, threaten the Administrator with his fist and said she charted it but did not think she quoted what Resident #24 said but mentioned he threatened he would hit him [the Administrator]. In an interview on 09/19/2022 at 4:00pm, CNA T said that she works at the facility through an agency and works regularly at the facility, specifically on the secure units. CNA T said that since the facility combined the females with the males on secure unit 1 it has been more difficult to supervise the unit due to the increased number of behaviors and residents requiring supervision on the unit. CNA T said that the women roam a lot and it was difficult to keep them out of the men's rooms. CNA T said that lately the men, specifically Resident #24 had been getting agitated and aggressive verbally with yelling at residents to get out of his room or get away from him. CNA T said that when Resident #24 comes out of his room and sits in a chair in the common area, he will yell at the female residents get away from me, get out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 09/19/2022 at 4:30pm, LVN N said that TNA E reported to her Friday evening (9/16/2022) that there had been an incident. LVN N said that TNA E reported she was walking down the hall and heard Resident #24 say get out of my room or I am gonna hit you again if you don't get out of my room. LVN N said TNA E reported that she removed Resident #4 from Resident #24's room and reported to me. LVN N said she cleaned her forehead and stopped the bleeding; the DON came onto the unit at that time and we decided to send Resident #4 out and Resident #24 was on his bed resting. LVN N said that the facility had implemented line of sight after the incident and that the police showed up, the DON, the social worker, and the Administrator so she personally did not interview Resident #24 about what had happened and indicated that he seemed like he did not want to be approached. LVN N said that Resident #4 is unable to verbalize what had happened due to having unclear speech. LVN N said that she had seen Resident #24 previously that day and he seemed fine to her and indicated that he just doesn't like people going in his room. LVN N said that since the units were combined wi [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff for 2 residents (Resident #9 and Resident #10) of 25 reviewed for nursing staff and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to: Ensure staff were assigned and were providing care for three residents on Hall 5 for a minimum of three hours after the DON learned of a no call no show and failed to assign staff to provide supervision and ADL assistance to Resident #9 and Resident #10. This failure by the facility placed the residents at risk of not receiving supervision, timely care, and services they may need. Findings Include: Resident #9 Record review of Resident #9's electronic face sheet, dated 09/22/2022 revealed she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include, .Chronic Pain, Cellulitis of Right Lower Limb, Dementia with behavioral disturbances, anxiety disorder, Major Depressive Disorder According to the Centers for Disease Control and Prevention, (CDC), Cellulitis is .Cellulitis is a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin. If untreated, it can spread and cause serious health problems.Cellulitis is treated with antibiotics. Most cellulitis infections can be treated with oral antibiotics (taken by mouth). More serious infections may need to be treated in the hospital with intravenous (IV) antibiotics, which are given directly into a vein . Record review of Resident #9's admission MDS dated [DATE] indicated a BIMS score of 13, which indicated no cognitive impairment. Section E did not indicate Resident #9 had exhibited any behaviors. Section G indicated Resident #9 required limited assistance by one staff member for transfers, extensive assistance for dressing by two persons, extensive assistance by one staff member for toileting, extensive assistance of two persons for personal hygiene and supervision by one staff for eating. Section H indicated she was frequently incontinent of bladder and occasionally incontinent of bowel. Section J indicated that she received scheduled pain medication and indicated no fall history. Section M revealed resident was at risk for developing a pressure injury. Section N revealed Resident #9 received antipsychotics, and an antidepressant. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's care plan dated 03/16/22 with a most recent care plan review date of 07/28/2022, revealed the following: .Problem 07/27/2022 Category Falls: Resident is at risk for falls due to history of falls .Goal I will have less than 3 actual falls over the next 90 days .Approach: I will have a low bed and fall mat next to my bed due to my behavior of crawling out on to the floor from my bed .09/04/2022 . Problem: 09/20/2022 Category Falls: I am at likely risk for falls as I do not notify staff via call light or verbally before I attempt to get out of bed or my wheelchair .Goal: I will not, to the extent practicable, experience more than 3 falls in 90 days .Approach: Keep bed in lowest position with brakes locked .Teach resident safety measures such as call light use and or verbal notification before attempting to exit bed or wheelchair Resident #10 Record review of Resident #10's electronic face sheet, dated 09/22/2022 revealed that she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include, .Fracture of right neck of femur , schizoaffective disorder, bipolar type, dementia in other diseases classified with behavioral disturbances, Type 2 diabetes mellitus Record review of Resident #10's quarterly MDS dated [DATE] indicated a BIMS score of 00, which indicated severe cognitive impairment. Section E indicated Resident #10 had exhibited rejection of care for 1-3 days during a 7 day look back. Section G indicated Resident #10 required extensive assistance by two staff members for transfers, dressing, and locomotion off unit only occurred once or twice and required one person for assistance, one person with setup help for eating, and limited assistance by two staff for toilet use, and extensive assistance by one person for personal hygiene assistance. Section G revealed resident was dependent up on staff for physical help in part of bathing and required one staff for assistance. Section G indicated Resident #10 required a wheelchair for mobility. Record review of Resident #10's care plan dated 09/06/2022, revealed the following: .Problem 09/06/2022 Problem: ADL Functional/Rehabilitation Potential .Goal: I will achieve maximum functional mobility . Approach: ambulation transfers x 1 .bathing/hygiene amount of assist x 1 .toileting amount of assist x 1 . Problem: hip Fracture: I have a fracture to my right hip/femur .Goal: I will have maximum functional mobility . Approach: .weight bearing status as tolerated .Problem: Falls I am at risk for falls related to lower extremity weakness .Goal: I will have less than 3 falls over the next 90 days .Approach: Encourage use of call light, keep call light within reach In a combined interview with both the Administrator and the DON on 09/20/2022 at 10:00 a.m., the DON said the staffing for Station 2 was for there to be two nurses, 2 CNAs on Secure Unit 1, 2 CNAs on Secure Unit 2, one aide for Hall 3, and one aide for Hall 4, She stated the aides for Hall 3 and 4 were to split and rotated to take care of three residents that resided on Hall 5 and that there was another resident on Hall 5, but she had one on one supervision in place. The DON said Hall 6 was currently empty. Observation on Hall 5, on 09/21/2022 at 9:45 a.m. revealed Resident #9 was lying in her bed, eyes closed. Observation on Hall 5, on 09/21/2022 at 11:39 a.m. revealed Resident #10 was calling out Can somebody help me get up?, there were no staff visible on the hall or at the nurse's station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on Hall 5, on 09/21/2022 at 11:39 a.m. revealed the Surveyor heard a faint cry behind a closed door and when opened, Resident #9 was noted to be off of her main bed that was in a low position, having fallen with her face down towards the metal bed frame and her fall mattress was pushed out away from her body, her call light was not in reach. Resident #9 had oxygen tubing that was pulled tight around her face. The Surveyor alerted LVN A to provide assistance to Resident #9 and LVN A immediately came into the room and turned Resident #9 over onto the fall mattress that was on the floor. Resident #9 had a scant amount of blood coming from her nares . Resident #9 was assessed by LVN A with no significant injuries noted but was found to be in a heavily urine-soaked brief that had leaked onto her clothing. Observation and interview on 09/21/2022 at 11:45 a.m. revealed Resident #10 was observed to be sitting on the edge of her bed, her brief was off of her body entirely and was heavily saturated with a strong odor of urine. Resident #10's breakfast tray was sitting on her bedside tray table and was untouched. Resident #10's wheelchair was positioned across the room and out of reach from the resident. Resident #10's call light was in reach behind her bed and Resident #10 verbalized, it does no good to use it, they do not come. Resident #10 was sitting on the edge of the bed and said that she needed assistance to go to the bathroom and had been hollering for a long time. Resident #10 stated no one had been in her room this morning to provide assistance to her other than dropping her breakfast tray off. Resident #10 said she had removed her soiled brief herself because it was so saturated, and she needed to go to the bathroom but was unable to reach her wheelchair to get to the bathroom. Observation and record review on 09/21/2022 at 11:41 a.m. of the staffing schedule posted on Hall 400 close to the nurse's station revealed there was not a staff member assigned for Hall 5, where Resident #9 and Resident #10 resided. Hall 3 indicated CNA G, Hall 400 indicated CNA H and CNA I was the float. In an interview on 09/21/2022 at 11:45 a.m., CNA H and CNA G verbalized they had not been assigned to Hall 500, they had not performed any care or checked on any residents that morning as well. They said no one in the facility had asked them to provide coverage on Hall 500. CNA G said she had provided relief for another aide that was performing one on one supervision so that she could take a break. CNA G said there should be a float covering that hall and named CNA I. In an interview on 09/21/2022 at 11:48 a.m., LVN A said she had not seen CNA I this morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/21/2022 at 11:55 a.m., the DON said that CNA J had stayed over this morning to work Hall 500 and was here until 8:30 a.m. The DON said CNA I had been a no call/no show and that she was made aware around 9:00 a.m. but that she had still been trying to reach her but had not communicated with the other staff to cover Hall 500 . The DON said she did not realize CNA H was not covering on Hall 500. The DON said the outcome of not having staff assigned to Hall 5 was that care and assistance with ADLs had not been provided. The DON said the incontinent care was not documented but that it was expected to be performed every two to three hours and there was not any specific documentation to show it had been done. The DON said that Resident #9 was dependent on staff for most all ADLs, specifically transfers and toileting and indicated she was incontinent . The DON said Resident #10 was incontinent as well and had been able to self-transfer to her wheelchair on her own, however if her wheelchair was out of reach she would need staff to assist her. The DON said Resident #10 did not use her call light and would holler out for assistance. The DON said the unsampled resident was mostly independent and required little assistance from staff to assist him, however he should have had any spills on his bedside tray table cleaned by staff and his linens should have been changed if they were obviously soiled . In an interview on 09/21/2022 at 12:01 p.m., the Regional [NAME] President of Operations said the facility had a staffing call at 8 a.m . this morning and that there were no staffing issues identified. The RVPO said there was nothing reported to her regarding a no call no show employee and understood there was 3 CNAs to cover Halls 3, 4 and 5. In an interview on 09/21/2022 at 12:23 p.m., CNA K said she had arrived at the facility around 7:40 a.m. this morning and relieved CNA J, who was providing one on one care for a resident. CNA K said that she left her one on one assignment and went to work on secure unit 1 at 9:00 a.m CNA K said she did not provide any ADL assistance for any residents other than the resident she was supervising that was on one-on-one supervision. Record review of the facility's policy Staffing revised July 2021 revealed: Policy Statement: Our center provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the center assessment. Policy Interpretation and Implementation: 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on observation, interview and record review the facility failed to ensure psychotropic medications were not given unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for one of twenty-five residents (Resident #9) reviewed for unnecessary medications. The facility failed to ensure: A. Resident #9 had an approved diagnosis to receive an antipsychotic medication, Risperidone (used to treat Schizophrenia); Resident #9 was receiving this medication for a diagnosis of anxiety. B. Monitor Resident #9, who received an antipsychotic medication, Risperidone for side effects and targeted behaviors. This failure could put residents at increased risk of receiving unnecessary psychotropic medication. Findings : Record review of Resident #9's electronic face sheet, dated 09/22/2022 revealed that she was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses to include, .Chronic Pain, Cellulitis of Right Lower Limb, Dementia with behavioral disturbances, anxiety disorder, Major Depressive Disorder According to the Centers for Disease Control and Prevention, (CDC), Cellulitis is .Cellulitis is a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin. If untreated, it can spread and cause serious health problems.Cellulitis is treated with antibiotics. Most cellulitis infections can be treated with oral antibiotics (taken by mouth). More serious infections may need to be treated in the hospital with intravenous (IV) antibiotics, which are given directly into a vein . Record review of Resident #9's admission MDS dated [DATE] indicated a BIMS score of 13, which indicated no cognitive impairment. Section E did not indicate Resident #9 had exhibited any behaviors. Section N revealed Resident #9 received antipsychotics, and an antidepressant. Record review of Resident #9's care plan dated 03/16/22 with a most recent care plan review date of 07/28/2022, revealed the following: . Problem start Date 08/05/2022 Category Psychotropic Drug Use I have a history of Dementia in other diseases classified elsewhere with behavioral disturbance and anxiety disorder due to known physiological condition and have been prescribed Psychotropic medications. Edited 09/04/2022 .Goal: Short Term Goal Target Date: 10/27/2022 I will show no adverse reactions over the next 90 days .Approach: Monitor for side effects per psychotropic flowsheet, monitor target behaviors per psychotropic flowsheets, refer to social services if needed .08/05/2022 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #9's Electronic Physician's Order dated 09/13/22, revealed the following: .Start Date: 09/13/2022, End Date: Open Ended .Order Description: Risperidone Tablet 1mg; amt; 1 tab; oral . Frequency: Three Times a Day .Diagnosis: Anxiety disorder due to known physiological condition, ordered by: [PNP M] and electronically signed on 09/13/2022 [PNP M]. Record review of Resident #9's Medication Administration Record for August and September 2022 revealed the following: -Risperidone 0.25 mg amount to administer: 3 oral twice a day Diagnosis: [blank]. Start/End Date 07/27/2022- Discontinued on 08/23/2022. Documentation on the MAR confirmed Resident #9 had received this medication twice a day from 07/27/22 thru 08/23/22 except for 08/15/2022, 08/16/2022 and the morning dose on 08/17/2022. -Risperidone 1 mg amount to administer: 1 tab oral twice a day Diagnosis: Anxiety disorder due to known physiological condition. Start/End Date 08/23/2022-Discontinued on 09/13/2022.Documentation on the MAR confirmed that Resident #9 had received this medication twice a day from 08/23/2022 thru 09/13/2022 except for one evening dose on 09/06/2022. -Risperidone tablet; 1mg; amount to administer: 1 tab oral three times a day, Diagnosis: Anxiety disorder due to known physiological condition. Start /End Date: 09/13/2022-Open ended . Documentation on the MAR confirmed that Resident #9 had received this medication twice a day from 08/23/2022 thru 09/13/2022 except for three doses, midday doses on 09/17/2022 and 09/19/2022, and an evening dose on 09/19/2022. According to MedlinePlus.gov, accessed on 09/29/22 at https://medlineplus.gov/druginfo/meds/a694015.html indicated. Risperidone is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers [AGE] years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children [AGE] years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain .IMPORTANT WARNING: .Risperidone is not approved by the Food and Drug Administration (FDA) for the treatment of behavior problems in older adults with dementia. Talk to the doctor who prescribed this medication if you, a family member, or someone you care for has dementia and is taking risperidone . Some side effects can be serious .fever, muscle stiffness, falling, sweating, unusual movements of your face or body that you cannot control .faintness, seizures, slow movements or shuffling walk (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to FDA Label for Risperdal, accessed on 09/26/22 at https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/020272s056,020588s044,021346s033,021444s03lbl.pdf indicated .Black Box Warning: Increased mortality in elderly patients with dementia-related psychosis .Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperdal is not approved for use in patients with dementia-related psychosis . Indications for usage . treatment of schizophrenia in adults and adolescents . Adverse reactions . The most common adverse reactions in clinical trials were somnolence, appetite increased, fatigue, rhinitis, upper respiratory tract infection, vomiting, coughing, urinary incontinence, saliva increased, constipation, fever, Parkinsonism, dystonia, abdominal pain, anxiety, nausea, dizziness, dry mouth, tremor, rash, akathisia, and dyspepsia Record review of Resident #9's nursing progress notes revealed the following: .09/13/2022 at 7:15pm .Order received from [Psychiatric Nurse Practitioner] for Risperdal (Risperidone) 1mg TID. Initial dose given without adverse reaction .Resident continues to yell and scream without reason. Not easily redirected. electronically signed LVN L. Record review of Resident #9's Medication Administration Record, Treatment Administration Record and nursing progress notes from 08/01/2022 thru 09/22/2022, revealed no monitoring of any kind for adverse side effects for receiving the medication Risperidone. In an interview on 09/14/2022 at 3:00 p.m., Resident #9's responsible party said she had been contacted by the facility and had given consent for Resident #9 to receive Risperidone for her anxiety. Multiple observations on the following dates and times revealed Resident #9 did not present with any significant side effects such as involuntary movements or appeared heavily sedated: -09/14/2022 at 12:09p.m. :Resident #9 was awake, alert and sitting in wheelchair at nurse's station. -09/15/2022 at 11:48 a.m.: Resident #9 was awake, alert, and lying in bed. -09/16/2022 at 1:15 p.m.: Resident #9 was awake and sitting in the activity room with Administrator and Activity Director, drinking a soda and eating some chocolate candy. -09/19/2022 at 3:44 p.m.: Resident #9 was awake, received wound care from LVN F, awake and alert. -09/23/2022 at 8:00 a.m., Resident #9 was awake, alert, and sitting up in wheelchair receiving assistance eating breakfast from one staff member. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/2022 at 3:01 p.m., PNP M said she had overseen Resident #9 for psychiatric services since her admission into the facility. PNP M said that when Resident #9 admitted to the facility 07/27/2022, she had been receiving the medication Risperidone. PNP M said that since her admission she had adjusted her dosage a couple of times with the most recent increase being on 09/13/2022. PNP M said Resident #9 was receiving the medication Risperidone for anxiety and depression. PNP M said anxiety and depression was not an approved indication for the administration of Risperidone and it was typically only ordered for diagnoses of Schizophrenia and Huntington's Disease. PNP M said she had recently increased Resident #9's dosage of Risperidone to 1mg three times a day due to increased screaming out and anxiety, specific to her not wanting to be in a nursing home. PNP M said the Risperidone was indicated so she could become more comfortable so she is less anxious. PNP M said the action Risperidone had was to work on the dopamine and serotonin receptors in the brain, which could, if a dose was too high, make a resident sleepy. PNP M said Resident #9 was not a good historian, and it was unclear, and it was hard to figure out if she has a history of a psychiatric diagnosis. PNP M said she felt the Risperidone was validated due to seeing her with behaviors of yelling, screaming and having emotional levels of distress. PNP M said that aside from the guidelines for nursing homes set forth by Medicare, you have to do what is best for the patient and not what is best for Medicare. PNP M said that to her knowledge Resident #9 had tried anti-depressants and natural remedies to reduce her anxiety but over time her anxiety and depression had increased. PNP M said she was uncertain who had initially ordered the Risperidone for Resident #9, it was thought to be a psychiatric hospital and said, I guess it had shown some improvement for her. Record review of Resident #9's psychiatric evaluation and management visits for the following dates: 07/29/2022 and 08/26/2022, revealed Resident #9 was being seen for agitation, anxiety, depression/sadness, delusions and dementia. Review of the evaluation and management notes performed by PNP M indicated diagnoses of adjustment disorder with mixed disturbance of emotions and conduct and dementia in other diseases classified elsewhere with behavioral disturbance. In an interview on 09/20/22 at 3:58 p.m., Physician C said anxiety and depression were not approved diagnoses for Risperidone but said [Resident #9] does have the approved psychiatric diagnosis and indicated she had schizoaffective disorder. When asked how a resident was diagnosed with schizoaffective disorder Physician C said that it is a personality diagnosis and is diagnosed over a time period of six months or greater and go through a series of evaluation and the resident would have to have a series of psychosis of 30 days or less. Physician C said someone would have to go through a series of psychosis, which is 30 days or less, but that he would defer the diagnosis and management for her psychiatric needs to the facility's psychiatric provider. Physician C said he had only been Resident #9's primary care physician since her admission on 07/27/22. Physician C said monitoring for side effects was necessary when a resident received the medication Risperidone, and indicated it was important to monitor specifically for dystonia (repetitive muscle contractions, abnormal fixed postures), tardive dyskinesia (involuntary, repetitive body movements such as grimacing, sticking out the tongue and lip smacking) and said the true thing that happens, if they don't need it and they zonk out, they go lethargic and sleep more. Record review of Resident #9's History and Physical dated 07/31/2022, electronically signed by Physician C on 08/09/2022 and a physician progress note dated 08/19/2022, electronically signed by Physician C on 08/22/2022, revealed Resident #9 had a diagnosis of Major Depressive Disorder with no evidence of being evaluated for schizophrenia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/20/2022 at 5:10 p.m., the DON said anxiety was not an approved diagnosis for the administration of Risperidone and that she was unaware that Resident #9 was receiving Risperidone for anxiety. The DON said the facility's psychiatric service provider should be aware that anxiety was not an approved indication for Risperidone and she was not sure why it had been prescribed for that. The DON could not recall the last time she had reviewed antipsychotics to ensure there was a clinical indication for them . The DON said side effect and behavior monitoring should be done anytime a resident received an antipsychotic and was not sure why it was not being done for Resident #9 . Record review of the facility's policy entitled, Medication Management, dated January 2022, revealed the following: .Medication Management, Policy . Each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs. This includes any drug .without adequate monitoring , without adequate indications for its use .Medication management is based on the care process and includes recognition or identification of the problem/need, assessment, diagnosis/cause identification, management/treatment, monitoring, and revising interventions, as warranted as well as documenting medication management steps .When selecting medications and non-pharmacological approaches, members of the IDT, including the resident, his or her family, and/or representative(s), participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's need and changes in condition. The facility's medication management supports and promotes: .Selection and use of medications in doses and for the duration appropriate to each resident's clinical conditions, age, and underlying causes of symptoms and based on assessing relative benefit and risks to, and preferences and goals of, the individual resident; .The monitoring of medications for efficacy and adverse consequences .Additional specific guidelines are applied to Psychotropic drugs which are defined as any drug that affects brain activities associated with mental processes and behavior. This includes, but are not limited to antipsychotics .Based on a comprehensive assessment of a resident, the facility must insure: Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record .Monitoring of Psychotropic Medications: When monitoring a resident receiving psychotropic medications, the facility must evaluate the effectiveness of the medications as well as look for potential adverse consequences. After initiating or increasing the dose of a psychotropic medication, the behavioral symptoms must be reevaluated periodically (at least during quarterly care plan review, if not more often) to determine the potential for reducing or discontinuing the dose based on therapeutic goals and any adverse effects or functional impairment .Potential adverse consequences: The facility assures that residents are being adequately monitored for adverse consequences such as: General .excessive sedation . neurologic agitation, distress, extra pyramidal side effects, neuroleptic malignant syndrome, parkinsonism, tardive dyskinesia, cerebrovascular event .Indication for use must be thoroughly documented in the medical record. While antipsychotic medication may be prescribed for expressions or indications of distress, the IDT must first identify and address any medical, physical, psychological causes, and or social/environmental triggers .Diagnoses alone do not necessarily warrant the use of an antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37012 Based on observation, interview and record review, the facility failed to follow menus for 3 of 9 menu items observed for meal accuracy. The facility failed to: A. Ensure menu items were available and prepared according to the planned menu, for lunch on 09/15/2022 and 09/19/2022, for residents that received a regular diet. specifically, the recipe for Caesar Salad was not followed on 09/15/2022 lunch meal and the sweet potatoes and collard green recipes were not followed for the lunch meal on 09/19/2022. These failures could place residents at risk for dissatisfaction, poor intake, altered nutritional status, choking, and/or unintended weight loss. Findings Include: Record review of the facility's Week-at-a-glance menu revealed the lunch menu on 09/15/2022 included the following menu items: Cheese Lasagna 1 square, Caesar Salad 1 cup, Garlic Bread 1 each, Double Chocolate Brownie. Observation on 09/15/2022 at 12:15 p.m. revealed Resident #12 was served lunch in her room. Observation of the lunch tray revealed the following: cheese lasagna, tossed salad, no salad dressing observed on the tray, one piece of thin sliced white bread with a buttered substance on it and a small chocolate brownie square and a small glass of tea. In an interview on 09/15/2022 at 12:15 p.m., Resident #12 said that the food could be a lot better and that she preferred to have salad dressing on her salad instead of eating it dry. Observation, interview, and test tray sampled on 09/15/2022 at 12:45 p.m. with the Dietary Manager, the Administrator, the RVPO and the DON was performed. The temperature was appropriate. The facility staff that sampled the test tray all agreed as well that the salad was not a Caesar salad and indicated that a Caesar salad was made with a certain type of lettuce, had parmesan cheese as well as a special Caesar dressing with it and that the salad that was sampled and served was a regular salad and ranch dressing. The Administrator stated if the menu called for a Caesar salad, then the facility should have ensured a Caesar salad was served and the menu followed. The Dietary Manager said she did not have the ingredients to serve the Caesar salad, nor did she have the specific dressing for a Caesar salad. The Dietary Manager was not sure why she did not have the ingredients to adhere to the menu but stated the menu should have been followed. Record review of the menus provided for the Caesar Salad revealed the following: .Salad, Shredded Lettuce with Caesar Dressing (iceberg) (Bulk dressing) .Ingredients: Lettuce, Iceberg, Fresh, Head Cheese, Parmesan Grated Salad Dressing, Caesar, Bulk, Spice Pepper, Black Ground (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/19/2022 at 10:50 a.m. revealed the menu on the wall , which was posted as Honey Glazed Ham; Whipped Sweet Potatoes; Garlic Spinach; Dinner Rolls; Pineapple [NAME]. [Substitution for Garlic Spinach was Collard Greens.] In an interview on 09/19/2022 at 11:20 a.m., Cook A said she was the staff who was responsible for cooking the lunch meal for today (09/19/2022). Cook A said she followed and used the recipes that the Dietary Manager had printed out for her. Cook A said she used the recipes to cook the sweet potatoes, collard greens, which was a substitution for the spinach, and the ham. In an interview on 09/19/2022 at 11:25 a.m., the Dietary Manager said staff followed the recipes to cook the dishes according to the menu. The Dietary Manager said she printed the recipes out before each meal and provided copies to the cooks. Observation and tasting of a sample food tray with the Dietary Manager on 09/19/2022at 12:30 p.m. revealed the plate consisted of a piece of ham, one serving of sweet potatoes, and a serving of spinach. The food items were tasted and revealed the ham was bland , the sweet potatoes were bland and could not taste nutmeg, cinnamon, or brown sugar as indicated by the recipe that was reviewed, the collard greens were bland, unsalted, and did not contain bacon as indicated in the recipe. The Dietary Manager stated the sweet potatoes did not look like they had seasoning in them. The Dietary Manager tasted the sweet potatoes and said they did not taste sweet enough and could use more sugar and cinnamon. The Dietary Manager said she could tell there was no seasoning or bacon added to the collard greens as well. Record review of the facility menu provided by the Dietary Manager revealed the following recipes: .Sweet potatoes, whipped (can) .Ingredient Potato, sweet, Yam, Cut, Canned Margarine, Solids, Sugar, Brown, Light, Granulated, Bulk, Spice, Cinnamon, Ground, Spice, Nutmeg, Ground . Greens, Collard Country Style . Ingredient Greens, Collard or Turnip, Frozen, Water, Margarine Solids, Salt Granulated, Bacon, Pork, Raw, Sliced, 18-22 .4. Chop up bacon into small pieces. Mix into greens with margarine Record review of the facility's policy entitled, Food and Nutrition Services dated 2001, revised September 2021 revealed the following: . Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident .Policy Interpretation and Implementation .6. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.