STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035132	A. Building B. Wing	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Healthcare Center	11411 North 19th Ave Phoenix, AZ 85029

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on clinical record review, staff interviews, and review of the facility policy and procedures, the facility failed to ensure one resident (#465) was free from abuse of another. The deficient practice could result on resident being physically and psychosocially harmed by other residents. Finding includes: Resident #465 was admitted to the facility on [DATE] with diagnosis included metabolic encephalopathy, acute respiratory failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD), protein-calorie malnutrition, dysphagia, benign prostatic hyperplasia without lower urinary tract symptoms, Hypertension (HTN). Resident #465 is alert and oriented with BIMS score of 13. Resident #464 was admitted to the facility on [DATE] with diagnosis included rhabdomyolysis, unspecified convulsions, heart failure, chronic viral hepatitis C, adjustment disorder with mixed anxiety and depressed mood, mood disorder, insomnia, other stimulant abuse, opioid abuse. Resident #464 is alert and oriented with BIMS score of 14. Review of an 5 Day Report revealed that Resident #465 was interviewed by the Operations Manager (staff # 177) and he stated that Resident #464 became upset with Resident #465 being in his room. Resident #465 further stated that Resident #464 kicked at him, contacting his right forearm causing a skin tear. Resident #465 was moved from room [ROOM NUMBER] A and relocated to 507 B, and full body check was completed. Review of the 5 Day Report revealed that Resident #464 stated to a Licensed Practical Nurse (LPN, staff# 205) that I told Resident #465 that I was going to kick his ass. When asked why he was upset, Resident #464 did not provide a reason. Facility further reached out to the crisis response team due to Resident #464 behaviors. Review of Resident #465 in a progress note on November 8, 2021 by the Behavioral staff revealed that Resident was just lying in his bed when Resident #464 came over to his bed and started kicking him then he hit him on his arm causing it to bleed. Review of Resident #464 in a progress note on November 7, 2021 from the Behavioral staff revealed that resident confirmed to staff that Yes, I told Resident #465 that I was going to kick his ass so I went up to him and hit and kicked him. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Coronado Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11411 North 19th Ave Phoenix, AZ 85029	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interview was conducted with Certified Nursing Assistant (CNA, staff # 156) on November 7, 2021 she stated that she heard a commotion from room [ROOM NUMBER] and responded immediately. She noted Resident #464 by Resident #465 bed and he was informed by Resident #465 that Resident #464 kicked him. During an interview conducted on December 20, 2023 at 11:05 AM with the Operations Manager (staff #177), she stated that she does not remember about the incident. She further stated that if criteria is present then it should be substantiated. During an interview conducted with Director of Nursing (DON, staff #11) on December 21, 2023 at 2:35 PM, she stated that facility will file a report within 2 hours whether the injury is serious or non-serious to the State Agency. Review of the facility policy Abuse Prevention of and Prohibition Against revised 11/2017 stated that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325 Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure that one resident (# 613) had a reconciliation of post-discharge medications according to professional standards. The deficient practice could result in unsafe discharges for residents. Findings include: Resident # 613 was admitted into the facility on [DATE] with diagnoses that included rhabdomyolysis, dementia, acute respiratory failure with hypoxia, and chronic obstructive pulmonary artery disease. A discharge Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident was moderately cognitively impaired. Clinical record review revealed that resident # 613 had a planned discharge on May 21, 2021. Discharge documentation electronically signed by staff # 203 on May 21, 2021 revealed that the resident had improved sufficiently, and no longer needed the services of the facility. Discharge progress notes electronically signed by staff # 203 revealed resident required assistance with activities of daily living, and supervision - oversight, encouragement or cueing. Clinical record review revealed that resident # 613 was to be discharged with all her current medications on hand. The following physician medication orders were actively being administered and were listed on the discharge report: - Zoloft tablet, 25 milligrams by mouth, one time a day for depression - Amlodipine besylate tablet, 5 milligrams, 1 tablet by mouth one time a day for hypertension - Docusate sodium tablet 100 milligrams, 1 tablet by mouth one time a day for bowel care - Acetaminophen tablet 650 milligrams, 1 tablet by mouth every 6 hours as needed for pain - Calcium carbonate tablet chewable 500 milligrams, 1 chewable tablet by mouth every 6 hours as needed for dyspepsia The May 2021 medication administration record (MAR) report revealed staff # 203 administered the Zoloft, Amlodipine, and Docusate on the day of discharge. Photographs of nine medication blister packs, taken by daughter May 2021, revealed resident # 613 was discharged with blister pack of Amlodipine 5 milligram, however was also given eight other medication blister packs belonging to three different residents # 614, # 615, # 616. The photographs revealed that three out of eight medication blister packs were not empty; including 2 blister packs of Diltiazem 360 milligram extended release containing at least 8 and 5 capsules each, and 1 pack of Atorvastatin 40 milligram containing at least 8 tablets. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 614 was admitted into the facility on [DATE] and discharged on [DATE]. Review of the May 2021 MAR revealed actively administered to resident # 614: - Cardizem long acting tablet extended release, 24 hour 360 milligrams (Diltiazem hydrochloride extended release coated beads) give 1 tablet by mouth one time a day for hypertension, hold for heart rate below 60 - Clonidine hydrochloride tablet 0.2 milligram, give 1 tablet by mouth one time a day for hypertension - Levetiracetam tablet 1000 milligrams, give 1 tablet by mouth two times a day for seizures - Lisinopril tablet 40 milligrams, give 1 tablet by mouth one time a day for hypertension - Atorvastatin calcium tablet 20 milligrams, give 1 tablet by mouth at bedtime for hyperlipidemia Staff # 203 administered Cardizem, Clonidine, Levetiracetam, and Lisinopril to resident # 614 on May 21, 2021. Staff # 205 administered Atorvastatin to resident # 614 on May 21, 2021. Resident # 615 was admitted into the facility on [DATE] and discharged on [DATE]. Review of the May 2021 MAR revealed actively administered to resident # 615: Atorvastatin calcium tablet 40 milligrams, give 1 tablet by mouth at bedtime for hyperlipidemia. Staff # 206 administered Atorvastatin to resident # 615 on May 21, 2021. Resident # 616 was admitted into the facility on [DATE] and discharged on [DATE]. Review of the May 2021 MAR revealed actively administered to resident # 616: Apixaban tablet 5 milligrams, give 5 milligrams by mouth every 12 hours for atrial fibrillation. Staff # 203 administered Apixaban to resident # 616 on May 21, 2021. During an interview via phone on December 19, 2023 at 03:00 PM with the daughter of resident # 613 reaffirmed that resident # 613 had been discharged with medications that were not for her mother stating that medication blister packages were labeled with other resident's names. The medication blister packs that were given to resident # 613: 1. Amlodipine besylate tablet, 5 milligrams, 1 tablet by mouth one time a day for hypertension 2. Cardizem long acting tablet extended release, 24 hour 360 milligrams (Diltiazem hydrochloride extended release coated beads) give 1 tablet by mouth one time a day for hypertension, hold for heart rate below 60 - containing at least 8 capsules 3. Cardizem long acting tablet extended release, 24 hour 360 milligrams (Diltiazem hydrochloride extended release coated beads) give 1 tablet by mouth one time a day for hypertension, hold for heart rate below 60 - containing at least 5 capsules (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Clonidine hydrochloride tablet 0.2 milligram, give 1 tablet by mouth one time a day for hypertension 5. Levetiracetam tablet 1000 milligrams, give 1 tablet by mouth two times a day for seizures 6. Lisinopril tablet 40 milligrams, give 1 tablet by mouth one time a day for hypertension 7. Atorvastatin calcium tablet 20 milligrams, give 1 tablet by mouth at bedtime for hyperlipidemia 8. Atorvastatin calcium tablet 40 milligrams, give 1 tablet by mouth at bedtime for hyperlipidemia 9. Apixaban tablet 5 milligrams, give 5 milligrams by mouth every 12 hours for atrial fibrillation An interview was conducted on December 19, 2023 at 1:22 PM with Registered Nurse (RN/Staff # 45) who stated that they learn which residents will be discharged from their case managers. Staff # 45 stated the process for residents who are able to take their medications home involves physically printing out a medication sheet which they can use to grab the medications that are given to the residents. Staff # 45 states that the discharge nurse is the one responsible to verify that the medications handed to the resident or family match the discharge summary. Staff # 45 stated that if a resident is given Cardizem and does not require it can cause the heart rate to drop. An interview was conducted on December 20, 2023 at 8:29 AM with the Operations Manager (Staff # 177) who stated that nurses handle the actual discharge and provide documents regarding any records. Staff # 177 stated that medication reconciliation is done by the nurses which go through the reconciliation list, however interdisciplinary team will complete individualized section of the discharge form. An interview was conducted on December 20, 2023 at 8:40 AM with the Director of Nursing (DON/Staff # 11). The DON stated that as member of the interdisciplinary team he works with other staff during the discharge process. DON stated there is always a potential risk that a resident could be discharged with inappropriate medication because it is a full manual process. DON stated that the floor nurses don't really document anything, they print-out the orders and go with resident to sign-off on discharge paperwork. At 10:00 AM DON stated that the facility was notified that a resident had been discharged with medications belonging to other residents days after. DON stated the facility had implemented an education on this stating, I will find documents to find reports we did about this occurrence. At approximately 12:16 PM DON provided a written letter and dated May 25, 2021 by DON which revealed the following: The facility was notified that a resident was discharged to a group home with another residents' medications. Facility will implement and establish a system to evaluate medications on discharge to ensure right medication go with the discharging resident. Licensed nurses will in-serviced by DNS or designee about discharge process, ensuring right medications are prepared and given to residents on discharge as well as reviewing discharge paperwork with residents with proper documentation. DON stated that discharging a resident with other resident's medications did not meet his expectations. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Nursing Services Policy and Procedure titled, Admission, Transfer and Discharge Rights: Discharge Summary (revised 11/2016) revealed that, When the facility anticipates a resident's discharge, the discharge summary shall include, but not limited to, the following: b. A final summary of the resident's status to include a description of the resident's: xiv. Medications. Additionally, A reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).