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	03/26/2024

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 - 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** 49319 Based on clinical record review and review of facility documentation, policy and procedure, the facility failed to protect the residents' rights (#49, #216 and #175) to be free from abuse by another resident (#161 and #216) and by a visitor. The deficient practice could result in further resident abuse. Findings include: Regarding resident #49 and resident #161 -Resident #49 (alleged victim) was admitted to facility on June 16, 2019 with diagnoses of history of psychotic disturbance, mood disturbance, anxiety, anoxic brain damage, adult failure to thrive and depression. Review of the clinical record revealed that resident #49 had a BIMS (Brief Interview for Mental Status) score of 3 indicating the resident had severe cognitive impairment; and that, the resident had wandering behaviors. -Resident #161 (alleged perpetrator) was admitted to the facility on [DATE] with diagnoses of history of encephalopathy, type II diabetes, homelessness and muscle weakness. Review of the clinical record revealed that resident #161 had a BIMS score of 3 indicating the resident had severe cognitive impairment. Both residents #49 and #161 reside in the secured behavioral unit. The facility report dated May 25, 2023 included that on May 18, 2023 that resident #161 made contact with resident #49. Per the documentation, on the evening of May 18, 2023, a certified nurse assistant (CNA/staff #165) saw resident #49 was in the hallway with another resident's (#161) wheelchair; and, had a small amount of blood on her face. It also included that the CNA did not witness any contact between the residents; and that, resident #49 entered the room and used the wheelchair of resident #161. (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Continued review of the facility report revealed that resident #161 was seen by the nurse to be scooting on the floor yelling, she took my wheelchair. Per the documentation, resident #161 reported that she made contact with the nose of resident #49 because resident #49 took his chair. Further, the facility report included that this was an isolated event; and that, this incident resulted in a facial bruise for resident #49. An interview with a licensed practical nurse (LPN/staff #201) was conducted on March 25, 2024 at 3:08 p.m. The LPN stated that during common area times, staff give activities such as games or playing cards to and continuously monitored the residents. The LPN said that there were 25 residents in the unit; and that, resident #49 can get very loud and resident #161 can get very intrusive. The LPN said that at the time of the incident, she recalled that residents #49 and #161 were separated from each other. The LPN said that the kinds of abuse included physical, emotional, neglect, financial and sexual; and that, when a resident to resident altercation occurs, the involved residents are separated from each other, assessed for injuries, the incident is reported to the Administrator and DON (director of nursing) immediately and investigated. Further, the LPN stated that residents are then placed on one on one monitoring, the physician and psychiatric physician; and that, the psychiatric physician may come in for an as needed evaluation of the residents involved. Regarding resident #175 and a visitor Resident #175 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), type II diabetes, unspecified psychosis and anxiety disorder. A progress note dated October 12, 2022 at 11:28 a.m. revealed that a staff witnessed the resident's visitor was hitting the back of the head of resident #175; and that, resident #175 sustained a small opening on the back of his head. Another progress note dated October 12, 2022 at 12:13 p.m. included that a CNA reported that the resident was having an argument in his room with his visitor. Per the documentation, the social services manager was requested to help deescalate the situation and ask visitor to leave; and that, when the social services manager entered the resident's room, the visitor was standing in the doorway and was demanding for her purse back from the resident. The documentation also included that the CNA reported that the visitor used her large black purse to hit the back of the head of resident #175 who then took purse away from the visitor and was holding onto it until support arrived. The documentation also included that resident #175 had blood on the back of his head; and that, the resident reported that the visitor does this all the time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility 5-day report dated October 19, 2022 included that in the morning of October 12, 2022, resident #175 and his visitor was having a discussion as the visitor was exiting the facility. The operation manager overheard the visitor say I will not as the visitor was leaving; and resident #175 was walking a distance away behind the visitor. Per the documentation, the visitor came back a short time later; and resident #175 and the visitor were having a verbal discussion in the resident's room. The CNA overheard the discussion being louder in volume and as the CNA was entering the resident room, the CNA saw the visitor swing her purse at the resident. The documentation also included that the CNA asked assistance from the licensed practical nurse (LPN who positioned herself between the resident and the visitor; and that, the social services director also entered the room and spoke with resident #175 who returned the purse of the visitor who then left the facility and was told that she would not be permitted to return to the facility. Further review of the report revealed that the resident sustained a cut on the back of his head due to this incident. The facility concluded that this was an isolated event between resident #175 and his visitor, no pattern identified and the facility acted promptly. Regarding resident #216 and resident #223 -Resident #223 (alleged victim) was admitted on [DATE] with diagnoses of Huntington's disease, dementia, traumatic brain injury and major depressive disorder. The clinical record revealed resident had a BIMS score of 8 indicating the resident had moderate cognitive impairment. -Resident #216 (alleged perpetrator) was admitted to the facility on [DATE] with diagoses of alcohol polyneuropathy, schizoaffective disorder, bipolar disorder and traumatic brain injury. The clinical record revealed resident had a BIMS score of 13 indicating the resident had intact cognition. The facility report dated April 26, 2022 revealed that in the morning of April 20, 2022, a CNA saw resident #216 had a closed hand contact with the back of resident #223. Per the documentation, the CNA immediately gave verbal direction to stop and move away from each other; and that, the CNA was able to place herself in between residents #216 and #223. The documentation included that resident #116 reported that he asked for a cigarette while on the smoking patio from resident #223 who threw the box of cigarettes in the direction of resident #216. It also included that resident #216 reported that resident #223 was swinging his arms around which made resident #216 feel threatened. The documentation also included that resident #216 stated he went to leave the patio and was pushing the wheelchair of resident #223 from behind while resident #223 was swinging his arms around. Further, the documentation included that resident #216 reported that he made contact with Resident #223; and, resident #223 reported that resident #216 hit him but did not elaborate or provide any details. Continued review of the facility report revealed that this was an isolated event between residents #216 and #223. In an interview with a CNA (staff #161) conducted on March 14, 2024 at 2:43 a.m., the CNA stated that abuse can be physical, verbal, financial and emotional; and that, if abuse happens, she will immediately report the incident to the administrator who will then suspend the staff involved in the allegation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview with another LPN (staff #110) was conducted on March 21, 2024 at 3:26 p.m. The LPN stated that when a resident report that a staff abused them, she will contact the abuse coordinator within two hour and the administrator may decide to send the staff home. The LPN also stated that if a resident to resident altercation occurs, staff will separate and re-direct residents involved and staff will then call and report the incident to the administrator. Further, the LPN said that staff also do room changes and check residents regularly to avoid altercations. During an interview with another LPN (staff #81) conducted on March 21, 2024 at 3:34 p.m., the LPN stated that abuse happens between residents, staff will separate both residents from each other. The LPN also said that when a staff is accused of abuse, the involved staff will be taken off shift pending the facility's investigation. Further, the LPN said that abuse allegations are reported to the Administrator immediately. Review of facility's policy on Abuse included that it is their policy that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation; and that, abuse is willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting in physical harm, pain or mental anguish. Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F 0689 Level of Harm - Minimal harm or potential for 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** 49319 Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure adequate supervision was provided to one resident (#184) to prevent elopement. The deficient practice could result in injury or harm to the resident. Findings include: Resident #184 was admitted to the facility on [DATE] with diagnoses of meningitis, sepsis, subperiosteal abscess of mastoid in left ear, pneumonia due to pseudomonas, chronic viral hepatitis C and transient ischemic attack. The initial admission record dated June 10, 2022 included the resident was alert but was not oriented to time, place and person; and, was not able to follow simple commands. The documentation also included that the resident was ambulatory and had no wandering behaviors The care plan dated June 10, 2022 included the resident was at risk for impaired cognitive function/dementia or impaired thought process related to dementia. Interventions included to give step by step instructions one at a time as needed to support cognitive function, keep routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion. Another care plan dated June 10, 2022 revealed that per the resident's public fiduciary, the resident will remain in the facility with LTC (long term care) services. Interventions included to establish a pre-discharge plan with the resident, family/caregivers, evaluate progress and revise plan as needed. The care plan dated June 23, 2022 included the resident was at risk for a communication problem. Intervention included to anticipate and meet the resident needs. The MDS (Minimum Data Set) note dated September 8, 2022 revealed the resident was alert and oriented x2, was able to make needs known, was independent with transfers and ADLs (activities of daily living) and required set up assistance. The elopement evaluation dated September 10, 2022 included that the resident had a score of 3 indicating low risk for elopement. Per the documentation, the resident was alert and oriented, had no history of elopement in the last 6 months, was not making statements about a desire to leave the facility and had no wandering behavior. The nursing progress note dated November 27, 2022 included that the front door alarm was set off around 7:00 p.m.; and that, a head count was completed and resident #184 was not in his room. Per the documentation, the smoking patio on Palm and South unit was checked; and, a nurse on south unit reported she saw a person walking down 19th Avenue that fit the description of resident #184. Further, the documentation included that an incident report was made. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry social services note dated November 28, 2022 included that social services received a voicemail message from the local police department regarding the resident's missing person report. The social services note dated November 29, 2022 revealed that staff spoke with the resident's public fiduciary regarding resident's choice to leave AMA (against medical advice). An interview was conducted on March 14, 2024 at 1:49 p.m. with the Director of Nursing (DON/staff #159) who stated that when a resident is not found, the protocol was to search the building, until the resident was found. The DON stated that if staff could not find the resident, the facility will call the police and place a missing person report. In another interview with the DON conducted on March 14, 2024 at 2:14 p.m., the DON stated that there was no self-report with investigative documentation and witness statements for this incident. During a telephone interview with the resident's public fiduciary conducted on March 14, 2024 at 2:18 p.m., the public fiduciary stated she had full guardianship on resident #184 on August 8, 2022; and that, she did not allow the resident or gave consent for the resident to leave the facility. The public fiduciary further stated that the facility called her to let her know that resident #184 exited through the fire exit door; and that, staff followed the resident but could not catch up to him. Further, the public fiduciary stated that the resident refused to come back. An attempt to conduct a phone interview with the social services staff (#229) was conducted on March 14, 2024 at 2:27 p.m. but was unsuccessful as staff #229 did not answer or return the call.