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	06/04/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of records, and review of facility policy and procedure, the facility failed to ensure one resident's (#30) rights were honored with notification of changes of condition to the resident's legal guardian. The deficient practice could result in a legal guardian not being aware of a resident's condition, and unable to participate in medical decision-making on behalf of the resident. -Findings include: Resident #30 was re-admitted to the facility on [DATE], with diagnoses that included acute on chronic congestive heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic kidney disease, unspecified dementia, and dysphagia. A Letter and Acceptance of Permanent Guardianship, provided to the State Agency, dated April 25, 2024, revealed Resident #30 was appointed a permanent legal guardian by the court. An Advance Directive Statement dated June 25, 2024, revealed verbal consent from the resident's Public Fiduciary for the resident's care directives. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition. A patient profile banner in the resident's electronic medical record revealed Resident #30 has a legal guardian, with a phone contact. A care plan dated June 25, 2024, revealed the resident is at risk for impaired cognitive function / dementia or impaired thought processes. There was no evidence of any intervention to include communication with the resident's legal guardian. A Case Manager note dated June 26, 2024, revealed case management followed up with a call to the resident's emergency contact, and they informed the name of the Public Fiduciary. An additional Case Manager note dated June 26, 2024, revealed the Public Fiduciary called back and the resident lives at a memory care unit. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An eMAR-Medication Administration Note dated June 28, 2024, revealed a change of condition for elevated INR, hold coumadin for 48 hours, and repeat INR. The note stated Provider notified. Responsible party notified: Resident #30, does not want anyone else notified. There was no evidence of notification to the resident's legal guardian. A Nursing note dated June 29, 2024, revealed the resident's blood glucose was uncontrolled and noted to be 560 at 3:00 PM. The provider was notified of concerns, and new order was noted. There was no evidence of notification to the resident's legal guardian. An eMAR-Medication Administration Note dated June 30, 2024, revealed a change of condition for dose increase of Glargine for uncontrolled blood glucose. The note stated Provider notified. Responsible party notified: Resident #30. There was no evidence of notification to the resident's legal guardian. A Social Service Summary, dated July 3, 2024, revealed Resident #30 admitted from the hospital and was there for skilled services. The note state There is no discharge date at this time. Case manager will follow up with the resident regarding discharge plans. There was no evidence of notification to the resident's legal guardian. An eMAR-Medication Administration Note dated July 4, 2024, revealed a change of condition for chest x-ray for diagnosis of congestive heart failure. The note stated Provider notified. Responsible party notified was Resident #30. There was no evidence of notification to the resident's legal guardian. An additional eMAR-Medication Administration Note dated July 4, 2024, revealed a change of condition for increased dose of Lasix for edema. The note stated Provider notified. Responsible party notified: Resident #30. There was no evidence of notification to the resident's legal guardian. A Nursing note dated July 5, 2025, revealed a new verbal order received from the provider to schedule paracentesis for diagnosis of ascites. There was no evidence of notification to the resident's legal guardian. A Care Conference note dated July 10, 2024, revealed the Interdisciplinary Team (IDT) held a Care Conference for Resident #30 on Juy 9, 2024. There was no evidence of communication to the resident's legal guardian. A Case Manager note dated July 10, 2024, revealed case management spoke with the resident's Public Fiduciary, letting her know Notice of Medical Non-Coverage (NOMNC) was issued, and the resident will return back to the memory care unit. An interview was conducted with a registered nurse (RN / Staff #16) on June 4, 2025, at 11:19 AM, who stated if a resident has a legal guardian, nursing communication occurs with both the legal guardian and the resident, and nurses obtain a resident's legal consents with the legal guardian. Staff #16 stated if a resident has a change of condition, the legal guardian would be notified. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted with a licensed practical nurse (LPN / Staff #28) on June 4, 2025, at 11:28 AM. Staff #28 stated if there is a change of condition with a resident, the nurse would call the legal guardian to let them know about changes with the resident. Staff #28 stated that even if the resident requested that the nurse not contact anyone, the nurse would still contact the legal guardian anyway. An interview was conducted with the Social Services Supervisor (Staff #91) on June 4, 2024, at 11:42 AM. Staff #91 stated that a legal guardian, is an individual appointed by court, that is responsible for a resident, and they would make decisions for the resident. Staff #91 stated that nursing staff would communicate with both the resident and the legal guardian regarding medical changes of condition and decision-making. Staff #91 stated that even if a resident did not want their legal guardian notified, the guardian is appointed by the court, so staff would be obligated to communicate with the guardian, and that they have to be informed of what is going on with the resident. An interview was conducted with the Director of Nursing (DON / Staff #35) on June 4, 2025, at 12:58 PM. The DON stated that there are different levels of legal guardianship, so he would have to see documentation to see what the specific guardianship entails. The DON stated that sometimes the facility does not know if a resident has a legal guardian. Additionally, the DON stated that if the facility was aware that the resident has a court appointed legal guardian, then communication and consent for treatment should occur with the legal guardian, and that if the resident has a change of condition, then both the resident and legal guardian should be notified. Review of the facility policy titled Resident Rights, reviewed May 2022, revealed it is the policy of this facility that all resident rights be followed per state and federal guidelines. The Resident has the right to be fully informed in advance about care and treatment, and, unless adjudicated incompetent or otherwise found incapacitated under state law, participate in planning medical treatment, to be fully informed in a language he or she understands of his or her medical condition, to refuse medical treatment, to Nursing Center compliance with the terms of a written directive concerning medical care signed by Resident (i.e. Durable Power of Attorney for Health Care, Living Will, etc.) that complies with applicable state law, and to be informed of any significant change in the Resident's condition, or need to alter treatment significantly. Review of the policy titled Advance Directive Documentation, revised November 2016, revealed a conservator the person appointed by a court with the legal power and duty of taking care of and managing the property and/or personal affairs of another person who is considered incapable of administering his/her own affairs. Decision-making capacity is the ability to make choices that reflect an understanding and appreciation of the nature and consequences of one's actions. A person is presumed to have a capacity to make health care decisions unless the attending physician determines that the person is incapacitated or a court rules that the person is incompetent. A surrogate decision-maker is an individual who participates in health care decision-making on behalf of an incapacitated person. This individual may be formally appointed by the Durable Power of Attorney for Health Care or by a court in a conservatorship or guardianship proceeding. The admission Coordinator, or Social Service Director, shall provide the resident or responsible agent information regarding the right to formulate an advance directive, inquire whether he/she has completed an Advance Directive, and document in the resident's health record. If a resident is not capable of independent decision making inform the surrogate decision maker to document his/her desire to initiate an advance directive and his/her knowledge that this decision is in the resident's best interest or is to comply with resident's known desires, when this need arises.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of records, and review of facility policy and procedure, the facility failed to ensure one resident (#10) was provided care regarding wound care treatments. -Findings include: Resident #10 was re-admitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia, methicillin resistant staphylococcus aureus infection, bacteremia, acute and subacute infective endocarditis, type 2 diabetes mellitus with foot ulcer, and congestive heart failure. A significant change minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section M revealed the resident had 4 unstageable pressure ulcers present on admission or reentry, and additionally diabetic foot ulcer(s) present. The assessment revealed the resident was receiving pressure ulcer/injury care and application of dressings to the feet. A care plan dated April 8, 2025, revealed the resident has actual impairment in skin integrity / pressure injury development: pressure injury (PI) right heel, PI left distal heel, PI left proximal heel, and PI sacrum. Interventions included to administer treatments as ordered and monitor for effectiveness, educate resident, family / caregivers as to causes of skin breakdown; including: transfer / positioning requirements; importance of taking care during ambulating / mobility, good nutrition and frequent repositioning, and weekly head to toe skin at risk assessment. A physician order dated April 9, 2025, indicated to cleanse sacrum with wound cleanser, apply Silver Sulfadiazine Cream 1 % to sacrum topically, and cover with dry dressing, every day shift. A physician order dated April 9, 2025, indicated to apply betadine topically to right 3rd toe, every day shift. Four physician orders dated April 9, 2025, and discontinued April 15, 2025, indicated to apply betadine moist gauze and cover with dry dressing, every day shift, to 4 wound locations: left lateral mid foot, left distal heel, left proximal heel, and right lateral mid foot. Five physician orders dated April 16, 2025, indicated to apply MeSalt and cover with dry dressing, every day shift, to 5 wound locations: left lateral mid foot, left distal heel, left proximal heel, right lateral mid foot, and right lateral heel. A Skin Evaluation- PRN/Weekly assessment dated [DATE], revealed Resident #10 had sacral ulceration, and open ulceration to the left lateral mid foot, left distal heel, left proximal heel, right lateral heel, right lateral foot, and a missing toe nail to the right 3rd toe with dry crusted blood. A Skin Pressure Ulcer Weekly assessment dated [DATE], revealed the following unstageable pressure ulcers: 1.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Right heel, lateral (length x width): 6.8 x 5.0 centimeters (cm), depth: unable to determine (UTD) 2.) Left heel, distal: 2.0 x 2.0, depth: UTD 3.) Left heel, proximal: 1.0 x 1.0, depth: UTD 4.) Sacrum: 2.5 x 4.0, depth: UTD A Skin Ulcer Non-Pressure Weekly assessment dated [DATE], revealed the following wounds: 1.) Diabetic ulcer, left lateral mid foot: 0.5 x 0.4, depth: UTD 2.) Diabetic ulcer, right lateral mid foot: 1.0 x 2.0, depth: UTD 3.) Right 3rd toe, toe nail came off for unknown reason: 0.8 x 0.8, depth: UTD A Skin Pressure Ulcer Weekly assessment dated [DATE], revealed the following unstageable pressure ulcers: 1.) Right heel, lateral: 1.2 x 1.0, depth: UTD 2.) Left heel, distal: 2.0 x 2.0, depth: UTD 3.) Left heel, proximal: 3.0 x 2.5, depth: UTD 4.) Sacrum: 2.6 x 4.0, depth: UTD A Skin Ulcer Non-Pressure Weekly assessment dated [DATE], revealed the following wounds: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) Diabetic ulcer, left lateral mid foot: 2.5 x 1.5, depth: UTD 2.) Diabetic ulcer, right lateral mid foot: 1.0 x 2.0, depth: UTD 3.) Right 3rd toe, toe nail came off for unknown reason: 0.8 x 0.8, depth: UTD An Interdisciplinary Team Skin Review - Weekly Update, dated April 16, 2025, revealed the following interventions are monitored to maximize resident outcomes to further enhance the wound healing process: treatment per physician orders, medication / mineral / vitamin supplements, and pressure redistributing devices. The resident's response to treatment plan revealed the resident readmits with ongoing pressure injuries to bilateral heels and returns with new pressure injury to the sacrum, low air loss mattress put in place, utilizing heel protectors when in bed, and utilizing a waffle cushion to the wheelchair. There was no evidence of addressing the resident's missed wound care treatments. An Interdisciplinary Team Skin Review - Weekly Update, dated April 22, 2025, revealed the same response to treatment: readmits with ongoing pressure injuries to bilateral heels and returns with new pressure injury to the sacrum, low air loss mattress put in place, utilizing heel protectors when in bed, and utilizing a waffle cushion to the wheelchair. There was no evidence of addressing the resident's missed wound care treatments. The Medication and Treatment Administration Record (MAR / TAR) for April 2025, revealed no evidence that Resident #10 received any wound care treatments on April 10, 2025. Additionally, the MAR / TAR revealed 2; Hold/See Nurse Notes for all wound care orders for the following dates in April 2024: 11, 13, 14, 16, 17, 19, 21, 23, 24, 26. Review of the clinical record revealed the following nurse notes regarding the wound treatments that were not administered: -April 11: resident not in room or surrounding area -April 13: not in room, several attempt between 11:00 and 2:00 -April 14: not in room or on unit, unable to change dressing -April 16: refused dressing change -April 17: not in room or on unit, unable to change dressing -April 19: refused at this time -April 21: attempted to see resident x 2, not in room or surrounding (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-April 23: not in room or on unit -April 24: refused treatment, wanting to sleep -April 26: no evidence of a note Additionally, there was no evidence of follow-through to re-attempt treatment at a later time, or to coordinate with the resident an alternate time, or to communicate to the following shift to attempt to provide wound care. An interview was conducted with a registered nurse (RN / Staff #16) on June 4, 2025, at 11:19 AM, who stated if a resident is unavailable for treatment, staff would find the resident see where they are at. If the resident was not in their room, or anywhere else that staff looked, the nurse would then notify managers and determine the last time the resident was seen, and that would be urgent to locate a missing resident. Staff #16 stated if the resident were at dialysis, staff would give the treatment when the resident returns. Additionally, Staff #16 stated if a resident were in their wheelchair, smoking, or visiting with family, and preferred the treatment not at that particular time, then staff would return to see if it is a better time later. Staff #16 stated if a nurse did not return later to give an ordered wound treatment, the result could be infection or worsening of symptoms, because of the missed treatment. Staff #16 stated her understanding of neglect is residents not getting their needs met. An interview was conducted with a licensed practical nurse (LPN / Staff #28) on June 4, 2025, at 11:28 AM. Staff #28 stated if a nurse noticed a resident were not in their room and they had a treatment due, the nurse would check in common areas and all other places such as activities, the bathroom, patios, other resident rooms, and therapy gym. If the resident could not be located, that would be an urgent situation, and then the nurse would announce the resident as missing, and staff would search until that resident were located. Staff #28 stated if a resident were due a wound care treatment, and the resident was busy doing something they wanted to do, and the resident stated not right now, then the nurse would come back later and reschedule it with the resident. Staff #28 stated that if a resident were not given ordered medication or treatment over time, that would be neglect. An interview was conducted with the Director of Nursing (DON / Staff #35) on June 4, 2024, at 12:28 PM. The DON stated that neglect could be withholding services and care, locking a resident in a room, or not allowing the resident things they need. The DON stated the expectation for nurses is to follow physician orders, and if there is a change, to notify the physician for guidance. The DON stated if a resident is unavailable for treatment, the nurse would hold the treatment and wait for resident and/or find the resident. The DON stated if the resident was up in their wheelchair or smoking or visiting with family and the resident said not right now for a treatment, the nurse should then ask when a better time would be, and try to follow up at least one more time. If a resident were due a treatment and could not be located, the DON stated the nurse would look for the resident, and have other staff assist in looking for the resident, and that the facility has an elopement procedure if residents are missing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interview with the DON continued, and the clinical record was reviewed for Resident #10. The DON stated that the 2 coded on the MAR / TAR indicates to see the nurse's notes. The DON stated that no wound care treatment was provided on April 10, 2025, and no notes specifying the reason. The DON stated that there was no evidence that the wound care treatments were followed-up to attempt later on April 11, 13, 14, 16, 17, 19, 21, 23, or 24, 2025. The DON stated that there was no evidence of the nurse following-up or to educate the resident, and that he would expect that the nurse would follow-up on what the determination was and then have the follow-through. The DON stated that esident #10 was choosing to make himself unavailable for wound treatments that the nurses were trying to provide. The DON also stated that he was not aware of a scheduled time that the resident should have been in his room for wound treatments. Review of the policy titled Abuse: Prevention of and Prohibition Against, revised October 2023, revealed it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Neglect is the failure of the facility, its employees, or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the facility policy titled Wound Management, revised February 2021, revealed it is the policy of this facility that a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. Once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's order. All wound or skin treatments should be documented in the resident's clinical record at the time they are administered. In order to prevent the development of skin breakdown or prevent existing pressure ulcers from worsening, nursing staff shall monitor impact of interventions and modify interventions as appropriate based on any identified changes in condition and review and / or re-evaluate existing treatment regimen in connection with the resident's clinical presentation, to include current interventions and care plan considerations, if any wound is non-healing or not showing signs of improvement after a given time or any time a wound is worsening. Review of the policy titled Physician Orders, revised May 2021, revealed it is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. Medication, treatment, or related procedure orders are transcribed in the medical record accordingly. Review of the policy titled Documentation and Charting, reviewed July 2022, revealed it is the policy of the facility to provide a complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care, guidance to the physician in prescribing appropriate medications and treatments, the facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident, nursing service personnel with a record of the physical and mental status of the resident, the elements of quality medical nursing care, and a legal record that protects the resident, physician, nurse and the facility.