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	01/30/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, staff interviews, and a review of policies and procedures, the facility failed to update and revise care plans for two residents (Residents #21 and #56). The deficient practice can result in inaccurate monitoring of a resident's medical conditions and care, which are necessary to achieve the resident's health and well-being goals. The universe was 180. Findings Includes: Regarding Resident #21: Resident #21 was admitted to the facility on [DATE], with diagnoses of multiple sclerosis, bipolar disorder, anxiety disorder, and cognitive communication deficit. The Minimum Data Set (MDS) dated [DATE], revealed the resident had limited range of motion in the lower extremities and was dependent on staff for toileting hygiene, bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. On September 16, 2024, a complaint was filed with the State Agency (SA) regarding Resident #21. The complainant stated the resident had telephoned 911 and requested a brief change, and noted the resident had a history of this. However, review of the care plan dated January 5, 2022, with revisions, did not include the resident behavior of calling 911 for brief change. An interview was conducted on January 28, 2026, at 12:46 PM with Certified Nursing Assistant (CNA, staff #159). She stated resident #21 experiences anxiety and sundowning every evening. When the resident requires assistance, she thinks she has pressed her call button but has actually pressed the remote for the bed controls. So, in a panic she dials 911. The CNA stated this is a behavior that the Resident had and that brief changes are completed frequently. An interview was conducted on January 28, 2026, at 1:51 PM with the acting Director of Nursing (DON, staff #105). She stated residents exhibiting behaviors are always documented in the care plan. Otherwise, clinical staff would not know what the behaviors are. An interview was conducted on January 28, 2026, at 2:42 PM with CNA (staff #250). She stated resident #21 has a behavior of calling 911 for brief changes, however because of the resident's confusion (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she forgets the staff were just in the room and completed a brief change. When the resident does call 911, the operator will call the facility and check with the clinical staff to ensure if the resident requires emergency services. Regarding Resident #56: Resident #56 was admitted on [DATE], with the diagnosis that included epilepsy, unspecified, not intractable, without status epilepticus; traumatic brain compression with herniation, subsequent encounter, alcohol abuse, in remission; alcoholic cirrhosis of liver without ascites; thrombocytopenia, unspecified, essential (primary) hypertension; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; anxiety disorder, unspecified; unspecified mood [affective] disorder; major depressive disorder, single episode, moderate; anddepression, unspecified. A care plan focus with the initiation date of June 3, 2023, revealed that Resident #56 had an activities of daily living self-care performance deficit related to activity intolerance, fatigue, confusion, and TBI (traumatic brain injury), and to wear a helmet out of bed. There was no evidence in Resident #56's care plan that indicate that Resident #56 refused to utilize the helmet, or that the usage of the helmet was to be discontinued. An active order entry dated June 6, 2023, revealed that Resident #56 was to wear a helmet when out of bed; the entry further revealed that the type of order was a standard treatment (TAR). A physician's progress note dated January 9, 2026, revealed that Resident #56 is to utilize a helmet out of bed. A quarterly therapy screen progress note dated January 13, 2026, revealed no indication of Resident #56's refusal to apply the helmet out of bed, or the discontinuance of the utilization of the helmet out of bed. A quarterly MDS (minimum data set) assessment dated [DATE], revealed that Resident #56 had a BIMS (brief interview of mental status) score of 10, indicating moderate cognitive impairment and a higher likelihood of requiring assistance with daily activities. The assessment also revealed that, within the last 7 days before the completion of the assessment, Resident #56 did not exhibit behaviors of rejection of care that are necessary to achieve the resident's goals for health and well-being. A physician's progress note dated January 19, 2025, revealed that Resident #56 is to utilize a helmet out of bed, and that Resident #56 refuses to. There is no evidence that the helmet usage for Resident #56 had been discontinued. On January 27, 2026, at 9:00 AM, an observation of Resident #56 was made during the initial interview conducted on survey day one, where Resident #56 had been standing in their room, out of bed, without a helmet on. A helmet had been located on a night stand located against the wall of the head of the bed. The same wall had also been observed with a sign that stated 'HELMET ON AT ALL TIMES OUT OF BED'. During this observation, Resident #56 stated that the staff had helped him put the helmet on in the past. Following this interview and initial observation, a nurse walked into Resident #56's room to administer medications at approximately 9:31 AM. It was observed that this nurse did not assist the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident with the application of the helmet. At 9:38 AM, Resident #56 was observed walking out of his room without a helmet applied to his head. On January 28, 2026, at 10:21 AM, Resident #56 is observed in the activities room with no helmet applied to his head. Another observation on January 28, 2026, at 12:07 PM, where Resident #56 is observed getting up from his seat in the dining room following the completion of their meal, to walk around the room, and then walked out of the dining room. Following this observation, an interview was conducted with Resident #56. During this interview, Resident #56 shared the extent of their traumatic brain injury and stated that he would need to be careful with his ambulation due to the possibility of re-injury. Resident #56 stated that he was aware of the signage on the wall located at the end of their bed, and that he had staff assist him with the application of the helmet when he need it. On January 29, 2026, at 10:31 AM, Resident #56 is observed walking out of the dining room without a helmet applied to his head. An interview was conducted on January 29, 2026, at 10:31 AM, with an LPN (licensed practical nurse/Staff #203), who stated that they have provided care to Resident #56, and stated that Resident #56 has a history of seizures, that he has seizure medications been administered, and that he has had seizures while at the facility. Staff #203 reviewed the medical record of Resident #56, and stated that they had been unsure as to why Resident #56 required helmet usage when out of bed, and had not seen Resident #56 wear the helmet during her time working on the hall Resident #56 resided on. Staff #203 stated that with Resident #56's history of seizures and TBI, Resident #56 had the risk of re-injury if he did not wear his helmet as ordered. At this time of the interview, an observation was made of Resident #56's room with Staff #203, which identified the signage to wear the helmet when out of bed, located on the wall at the end of Resident #56's bed, and the helmet located on the nightstand under the signage, against the wall that the signage is located on. Staff #203 stated that they would need to review the chart of Resident #56 for further assessment of helmet usage. An interview was conducted on January 29, 2026, at 10:57 AM, with a CNA (certified nursing assistant/Staff # 9), who stated that they have provided care to Resident #56 before, and, that Resident #56 used to wear it more frequently when they first arrived to the facility, however, was unable to determine why Resident #56 stopped wearing it, and why the resident should have been wearing it. A secondary interview with Staff #203 was conducted at 1:40 PM, with an additional staff member (charge nurse/Staff #121) during an observation of Resident #56's room, where the signage located on the wall at the end of the bed of Resident #56 was no longer located. Staff #121 stated that they were unsure why the signage was taken down and that if helmet usage were to be discontinued, that would be at the discretion of therapy, and then the signage would be removed. Following the observation of Resident #56's room, Staff #203 once again stated that they were unsure that Resident #56 had a helmet to be worn and that the Resident's risk of not wearing an ordered helmet would be further head injury and seizures. Staff #203 also stated that if a resident should refuse treatment, such as a helmet, that is to be documented on the MAR/TAR (medication administration record/treatment administration record), and to ensure the charge nurse is aware of the refusal. Staff #203 stated that the facility expects to ensure documentation of refusals is documented in a resident's chart, and that residents do have the right to refusal of treatment, and to provide re-education on the treatment intervention and the risk of not completing the ordered treatment. Regarding Resident #56, Staff #203 could not locate the treatment on the MAR/TAR and stated that the appliance, such as a helmet, would be a (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment that would be documented on a MAR/TAR. Staff #203 also stated that they were unaware of the signage located in Resident #56's room, and that Resident #203 had been ordered to utilize a helmet out of bed. Staff #203 stated that if the documentation regarding the refusal of treatment is not accurate and documented within the health records, it poses the risk that the care plan team would not be able to adequately update Resident #56's care plan as necessary to achieve the resident's goals for health and well-being. A secondary interview was conducted with Staff #9 at 1:56 PM, who stated that they were aware of the signage in Resident #56's room, but had expressed uncertainty regarding when the signage had been originally put up on the wall in Resident #56's room. Staff #9 also stated that she had assumed that therapy discharged the order due to the resident no longer wearing the helmet. Staff #9 also stated that they had not been informed of the helmet usage, and had not been informed if the helmet usage had been discontinued. Staff #9 also stated that they have never assisted Resident #56 with putting on the helmet or with further education on why he should wear the helmet, due to not being told to do so. Staff #9 stated that the risk of not applying an ordered helmet and not documenting any usage, refusals, or if it had been discontinued can put a resident at further risk for additional injuries, the possibility of an inadequate healing process, the lack of protection to the resident's head, and the lack of communication of a resident's care. An interview was conducted on January 30, 2026, at 11:41 AM, with the director of rehabilitation services (Staff #213), who stated that the facility's expectations regarding physical appliances, including helmets, is that the facility's therapy services are trained individuals to assess, and provide additional training to the residents and the floor staff regarding the usage of the physical appliances. Staff #213 stated that each resident undergoes an assessment for proper and adequate usage of appliances, and ensures the appliances can be put on and taken off. Staff #213 also stated that any caretaker can apply on a helmet for a resident, and receives training from therapy services when a helmet has been ordered for a resident. Regarding Resident #56, Staff #213 stated that therapy services did work with the resident at some point during their stay. Staff #213 reviewed the medical records of Resident #56 and stated that Resident #56 underwent assessment and education regarding his helmet during his occupational therapy session. Staff #213 stated that Resident #56 underwent therapy for active range of motion of the right shoulder, full shower routine, strength, fine motor skills, and upper extremities. Staff #213 also stated that a part of his occupational therapy services included being able to put on and take off a helmet, and stated that there had been modifications to his ordered helmet to allow easier accessibility to put on and take off. Staff #213 stated that Resident #56 had been discharged from therapy services, with the expectation to continue the usage of the helmet out of bed, and to have floor staff queue Resident #56 to get ready for the day, and to utilize the helmet. Staff #213 also stated that Resident #56 had been in a unit that required constant supervision, and the ability to cue the resident for helmet usage should not have been an issue. Staff #213 also stated that floor staff would have been able to apply the helmet back on for the resident if observed off. Staff #213 had also stated that should a physical appliance be discontinued from a resident's care, it would be documented in a resident's chart, and if the helmet had been discontinued from Resident #56's care and services, it was not evident in Resident #56's charts. Staff #213 further stated that the risk of not utilizing an ordered helmet can put a resident at risk for further injury, as well as worsening medical conditions. Staff #213 also stated that the risk of inadequate documentation of a resident's treatment implementation, or documentation of a discontinued physical appliance such as a helmet, can provide inaccurate documentation of the current status of a resident's care, and inaccurate care planning. An interview was conducted on January 30, 2026, at 12:20 PM, with the (continued on next page)

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