

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Coronado Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 observation, clinical record review, interviews, facility documentation, and policy, the facility failed to ensure wound care treatments were provided according to professional standards of practice and provider orders for one resident (#4) out of three sampled residents. The universe was 165. This deficient practice placed residents at risk for infection. Findings include: Resident #4 was admitted on [DATE], with diagnoses including third-degree burns of the left forearm and buttock, muscle weakness, and dysphagia. A Skin Check Assessment form dated July 9, 2026, revealed that skin issues were evaluated and locations were identified as follows: Left gluteus: Pressure ulcer measuring 3.4 cm (centimeters) length x 3.5 cm width x 0.1 cm depth. Dressings included antimicrobial and dry dressings with a treatment frequency of daily. Left inner forearm: Identified as other skin issue present on admission; however, there was no evidence of measurements or treatment provided. Right outer forearm: Identified skin issue (burn) measuring 28 cm length x 7.5 cm width x 0.1 cm depth. Treatment consisted of A&D ointment and Xeroform applied daily. A care plan dated July 10, 2026, revealed the following focus areas: Risk for infection related to wound care. Interventions included monitoring and documenting vital signs as ordered in the clinical chart. Presence of, or potential for, pressure ulcer development related to impaired cognition and burns of the left forearm, left wrist, and buttock. Interventions included administering treatments as ordered and monitoring for effectiveness. A skin check progress note dated July 10, 2026, indicated that the initial skin assessment was completed. Resident #4 had a pressure ulcer on the left gluteus measuring 3.4 cm length x 3.5 cm width x 0.1 cm depth, treated with antimicrobial and dry dressings. The assessment also identified a burn on the right outer forearm measuring 28 cm length x 7.5 cm width x 0.1 cm depth, with ordered treatment of A&D ointment and Xeroform. While the note documented a burn wound from the left forearm to the palm of the left hand with pink moist tissue and serous drainage, it failed to include wound measurements or specified treatments for the left arm/hand burn. A review of the current active physician orders revealed the following orders: Left buttock: Clean with wound cleanser, apply silver sulfadiazine, and cover with a dry dressing every day shift; start date July 11, 2026. Left forearm: Clean with wound cleanser, apply A&D ointment and Xeroform, and cover with a dry dressing every day shift; start date July 11, 2026. Further review of physician orders showed no evidence of treatment orders for the right outer forearm burn identified on the July 09, 2026, skin assessment. A review of the Treatment Administration Record (TAR) for July 2026 showed no evidence that the left buttock and left forearm received wound treatments as ordered on July 11, 2026 and July 14, 2026. Progress notes dated July 11, 2026 and July 14, 2026, contained no evidence that wound treatments were provided for the left buttock or left forearm as ordered. Clinical record review confirmed Resident #4 was present in the facility and had no outside appointments on July 11 or July 14, 2026. A Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE], (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 035132	Facility ID: 035132 If continuation sheet Page 1 of 2

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment noted the resident had third-degree skin burns, with interventions including nonsurgical dressings, ointments, and medications. During an interview conducted on July 17, 2026, at 11:08 a.m., a Licensed Practical Nurse (LPN, Staff #156) stated the facility's process for wound care requires a skin assessment upon admission, followed by provider notification and obtaining treatment orders. Upon reviewing the clinical record, the LPN confirmed the resident had active orders from July 11, 2026, for the left buttock (silver sulfadiazine) and left forearm (A&D/Xeroform). The LPN further acknowledged that the TAR for July 2026 showed no evidence that these treatments were provided on July 14, 2026, and stated that the failure to provide treatment increases the resident's risk for infection. During an interview conducted on July 17, 2026, at 11:53 a.m., a second Licensed Practical Nurse (LPN, Staff #78) stated the wound care process involved reviewing orders, gathering supplies, following infection control protocols, and documenting in the MAR/TAR post-treatment. The LPN reviewed Resident #4's clinical record and confirmed active orders existed for the left buttock and left forearm. The LPN stated there was no evidence the treatments were performed on July 14, 2026, could not explain the omission, and noted the risk of infection resulting from the failure to follow orders. During an interview conducted on July 17, 2026, at 2:08 p.m., the Director of Nursing (DON, Staff #228) stated that the facility process is to monitor, assess, and treat according to physician orders. The DON confirmed the resident's diagnoses and the active orders for the left buttock and forearm. After reviewing the July 2026 TAR, the DON stated that the treatments were not performed or documented on July 14, 2026. The DON further noted that the failure to perform treatments as ordered results in a risk of infection and that missing documentation constitutes a documentation error. A facility policy titled, Administration of Medications and Fluids, Intravenous, reviewed on August, 2025, revealed that medications must be administered in accordance with the written orders of the attending physician. The policy further revealed that all current drugs and dosage schedules must be recorded on the resident electronic medication administration record (eMAR).		