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 01/30/2026
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 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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(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	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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(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	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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interim DON (Director of Nursing/Staff #122), who stated that the facility is expected to follow the physician's orders as written by the provider. Staff #122 also stated that care plans are to be updated quarterly and as needed to provide patient-specific care. Staff #122 also stated that documentation of the completion of orders and care plan interventions should be done according to the facility's system in place to ensure that staff are able to paint a picture of the care a resident is to receive. Staff #122 also stated that should a resident refuse care and services, staff is expected to document the refusal of the care, update the resident's care plan regarding the refusal of treatment, and ensure the providers are aware of the refusal for necessary changes to care. Regarding Resident #56, Staff #212 reviewed the care plan for Resident #56 and stated that there had been a note within the care plan that stated that Resident #56 refused to utilize their care plan. However, the reviewed care plan retrieved from Resident #56's electronic health record on January 28, 2026, did not include the note that the resident refused to utilize the helmet. Both care plans were reviewed side by side by Staff #212, and she stated that she was unsure what had happened with the documentation discrepancy. Staff #212 stated that the floor staff had access to view and review Resident #56's electronic health record and care plan regarding the usage of the helmet out of bed. Staff #212 also stated that the documentation of the helmet should have been determined by the facility, and, to include the refusal of the usage of the helmet, so that the provider is aware of the refusal. Staff #212 also stated that if a sign were in place in the resident room, the expectation of staff would have been to educate and encourage Resident #56 with cues to wear the helmet and to document any refusals. A policy titled 'Comprehensive Person-Centered Care Planning', last revised in April of 2024, revealed that in the event a resident refused certain services posing a risk to the resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks; and the interdisciplinary team's efforts to educate the resident and the resident representative and any alternate means to address the risks. A policy titled 'Documenting and Charting', last reviewed in July of 2024, revealed that 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. The policy also revealed that it is the policy of the facility to provide the facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility documentation, staff and resident interviews, and the facility policy and procedures, the facility failed to provide an ongoing program of activities designed to meet the interest and the physical, mental, and psychological well-being of one resident (Resident #15). The sample was three residents and the universe is 191 residents. The deficient practice could result in a decline in physical, mental, and social skills. Findings include: Resident #15 was admitted to the facility on [DATE] with diagnoses that include, Chronic Obstructive Pulmonary Disorder (COPD), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, bipolar disorder, and anxiety. Review of the comprehensive care plan initiated on August 5, 2021 revealed a focus indicating Resident #15 participates in activities with assistance such as bingo and ice cream social. Interventions include invite to scheduled activities, provide activities calendar monthly, and establish and record a prior level of activity involvement and interests by talking with resident, caregivers, and family on admission and as needed. Further review of the care plan revealed a focus for elopement risk/wanderer related to impaired safety awareness, dementia, and anxiety. Interventions include providing structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Further review of the care plan revealed a focus for psychotropic medications use related to bipolar disorder with psychotic features. Interventions include, non-pharmalogical interventions (NPI) done: back rub, redirection, speak to/approach in a calm manner, reposition, provide a quiet environment, and take to activities. Review of the most recent quarterly minimum data set (MDS) dated [DATE] revealed Resident #15 had a brief interview for mental status (BIMS) score of 9, indicating a moderate cognitive impairment. Additionally, Resident #15 had a score of 13 on the Resident Mood Interview indicating Resident #15 was moderately depressed and reported sometimes feeling socially isolated. Further review of the MDS revealed Resident #15 required maximum assistance with toileting, bathing, and transfers to and from the wheelchair. Further review of the MDS revealed Resident #15 to be taking scheduled antipsychotic and psychotropic medications with clinical indication. Review of the social activity task log for the dates of December 29, 2025 through January 29, 2026 which included activities such as; bingo, games, T.V., snack socials, story time, exercise, and smoking, revealed two days out of thirty days marked for activity participation. An observation was conducted on January 28, 2026 at 10:08am of Resident #15 located outside of his room in the hallway with no observed staff nearby. Resident #15 was observed to be in his wheelchair at this time. Residents were observed in the common area of the secured unit with one staff present. The television was playing a movie at a loud volume and several residents were staring at the wall. An observation was conducted on January 28, 2026 at 2:35pm. Resident #15 was not observed to be in the common area of the secured unit where the scheduled ice cream social was to be held. At the observed time, no activities were being held. An observation was conducted on January 29, 2026 at 9:42am. Eight residents were observed in the common area while two staff members were observed in the secluded nursing desk conversing with each other. The television was on however, no staff interaction, structured activities, or resident socialization were observed. On January 29, 2026 at 10:32 am., Resident #15 was observed in bed with covers drawn, and lights off. An interview was conducted on January 30, 2026, at 9:58 a.m. with the Activity Director (Staff #279). Staff #279 stated that she currently only has one staff member, a Certified Nursing Assistant (CNA) who is on light duty, working on Mondays, Tuesdays, and Wednesdays. Staff #279 further stated that there is no activities staff on the weekends and that CNAs are expected to hold activities on the weekends. Staff #279 stated that she brings over residents from the (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	secured unit whom she knows will not try to elope or wander, and that CNAs on the secured unit will play games with residents who cannot attend scheduled activities. Staff #279 stated that the CNAs will set up games for residents on the secured unit and will sometimes stay through their lunch to assist. When asked, Staff #279 stated that she does not have enough staff to hold the activities she wants to do. She further stated that if she had a full-time assistant, she could prioritize providing one-on-one activities and indicated that residents' social skills and behaviors would improve greatly. Staff #279 also stated that the few minutes she is able to sit with residents is not enough. Staff #279 stated that activity participation is documented in Point of Care (POC) and that she was recently told by a previous Director of Nursing that she must also keep paper documentation of participation. Staff #279 stated that she did not document, and was not trained to document, when a resident refused, was out of the building, or when activities were not applicable.Review of the paper activity participation logs for December 2025 and January 2026 which were provided by Staff #279 revealed Resident #15 was not documented to be in attendance for the month of January 2026. Resident #15 activity participation was documented once for the month of December 2025.Review of the December 2025 and January 2026 activity calendars for both the secured unit and non-secured unit revealed the only activities scheduled are a mix of bingo, coffee social, woodworking, table games, and open activities. Activity calendars for both the secured and non-secured units revealed that the scheduled activities were identical for both units and did not reflect individualized or unit specific programming for residents on the secured unit. An observation was made on January 30, 2026, at 10:57 am in the secured unit common area. Two CNAs entered the room at 11:17 a.m. and did not interact with any residents. They sat in the small area designated for nursing staff. One resident was observed sitting in the corner of the room yelling, and the television was on however, no residents were observed engaging with the television or participating in any activity.An interview was conducted on January 30, 2026, at 11:20 am with two CNAs (Staff #114 and Staff #28). Staff #114 stated that there is no set time for activities in the secured unit and that CNAs provide activities if they have time. Staff #28 stated that they still have their own work to do, which is providing resident care. Staff #114 stated that they do not document the activities they do and that they do them on their own time so the residents have something to do.Review of the policy titled Delivery of Activity Services last revised in July 2007 and last reviewed in February 2024 revealed, should a resident be considered medically or mentally incompetent, or physically unable to participate in such programs, an entry will be made in the resident's medical record (chart) stating fully the reason(s) for the restriction(s). Such an entry will be signed and dated by the person recording such data. Further review of the policy revealed, It is the policy of this facility to ensure that residents have the right to choose the types of activities and social events in which they wish to participate.

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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 a review of the clinical record, staff interviews, and a review of policies and procedures, the facility failed to ensure that the physician's orders were implemented per professional standards for one resident (Resident #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 include:Resident #56 was admitted on [DATE], with the diagnosis that included epilepsy, unspecified, not intractable, without status epilepticus; traumatic brain compression with herniation, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; anxiety disorder, unspecified; unspecified mood [affective] disorder and major depressive disorder.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 indicated 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 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 their 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 they would need to be careful with their 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 them with the application of the helmet when needed.On January 29, 2026, at 10:31 AM, Resident #56 is observed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walking out of the dining room without a helmet applied to his head.Review of medical record lacked evidence that the physician-order to wear helmet when out of bed was implemented, and lacked documentation of resident refusal.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 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 discontinued 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 usage of the helmet had been discontinued. Staff #9 stated that the risk of not applying an ordered helmet and not documenting any usage, refusals, or discharges can put a resident (continued on next page)

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 01/30/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviewed the orders of Resident #56 and stated that the order states to wear the helmet out of bed, which indicates that if the resident's head is not supported, such as out of bed, or sitting at the side of his bed, the helmet should be on. Staff #213 also stated that it's the responsibility of the nursing staff to ensure this is being done, and that it should be documented on the MAR/TAR, expressed uncertainty of reach administration record that staff are to utilize, as that is the responsibility of the nursing staff. 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 interim DON (Director of Nursing/Staff #122), who stated that the facility is expected to follow the physician's orders as written by the provider. Staff #122 also stated that care plans are to be updated quarterly and as needed to provide patient-specific care. Staff #122 also stated that documentation of the completion of orders and care plan interventions should be done according to the facility's system in place to ensure that staff are able to paint a picture of the care a resident is to receive. Staff #122 also stated that should a resident refuse care and services, staff is expected to document the refusal of the care, update the resident's care plan regarding the refusal of treatment, and ensure the providers are aware of the refusal for necessary changes to care. Regarding Resident #56, Staff #212 reviewed the medical records and confirmed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #56 had an active order to utilize his helmet out of bed, and had also stated that the order had not been discontinued, indicating that the order is active, and if there had been a discussion for a discontinuance. Staff #212 stated that the expectation was to have the order discontinued on the resident's electronic health record if that had been the discussion to do so. Staff #212 then stated that whether or not the Resident #56 is wearing the helmet or not wearing the helmet, the lack of an accurate order in place did not depict if an order should be in place or not, and the overall care of the resident is being completed. Staff #212 also stated that the documentation of the helmet should have been determined by the facility, and, to include the refusal of the usage of the helmet, so that the provider is aware of the refusal. Staff #212 also stated that if a sign were in place in the resident room, the expectation of staff would have been to educate and encourage Resident #56 with cues to wear the helmet and to document any refusals.A policy titled ‘Documenting and Charting', last reviewed in July of 2024, revealed that 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. The policy also revealed that it is the policy of the facility to provide the facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident.A policy titled ‘Physicians Orders', last reviewed in August of 2025, revealed that it is the policy of the facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. The policy also revealed that medication, treatment or related procedure orders are transcribed in the eMAR and eTAR accordingly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, observations, and review of facility policies and procedures ,the facility failed to ensure food was stored within appropriate guidelines. The deficient practice could increase the risk for foodborne illness. The facility census was 191 and the survey sample size was thirty-five.During the initial kitchen observation conducted on January 27, 2026 at 8:21am, food debris was noted in the dry storage area, under the bottom shelf. It appeared to dry, crumblike items. The dietary manager #42 also observed the debris and stated that it could possibly draw vermin to the area. He also stated that their procedure is that dishwashing staff are responsible for sweeping and mopping all floors after every meal, including this dry storage area.During this same initial tour, the refrigerator was observed and the following items noted: one individual plastic cup of applesauce with a loosened snap-on type lid that was open approximately 1/4 inch, exposing it to air. Three sheet cakes were found in the back of the refrigerator on separate shelves. These cakes were uncovered, exposed to air, and undated. Also observed were undated tubes of ground beef in their original packaging, and one open block of cheese, exposed to air and undated.In this initial observation, three sheet trays of uncovered burger patties were seen in the freezer. There were a total of ninety patties in single layers with a sheet of wax paper between trays, all exposed to air. The dietary manager #42 stated they were being removed from the freezer for resident lunches on this date. One opened and undated bag of frozen egg rolls were also seen exposed to air. Staff #42 stated that these practices could allow foodborne illness potential.When the door of the ice machine was lifted, debris particles were seen on the rubber rims. These particles appeared gray and wet. The dietary manager #42 stated this area need cleaning.During a second kitchen observation on January 28, 2026 at 9:10am, the unit refrigerators were examined. On the 500 wing, spilled liquid appearing similar to yogurt was noted on the bottom shelf. Staff #42 also observed the spill and stated that his staff come daily at 2pm to clean all unit refrigerators.After observing the tray line on January 28, 2026, the last unit tray cart was followed. The test tray temperatures were measured by staff #42. The chicken [NAME] measured 120 degrees. the mixed vegetables read 115 degrees, but an accurate reading was not achieved on this food item as it was impossible to maintain a discrete pile for the thermometer to enter. the baked bread pudding measured 120 degrees.On January 29, 2026 at 1:20pm, dietary manager #42 stated that sweeping and mopping are done after lunch and at night (the kitchen closes at 8pm). They do not clean after breakfast due to how busy they are at that time. Staff #42 also stated that he is responsible for overseeing that these tasks are completed.The facility's Resident/Personal Food Storage policy was reviewed and stated: Food storage areas shall be clean at all times.