STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation or mistreatment were reported immediately but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (Resident #1) of 16 resident reviewed for abuse or neglect. The facility failed to report to the State Survey Agency allegations of Abuse and Neglect when learning of an elopement of Resident #1. This failure could affect residents by placing them at risk of not having incidents of abuse and neglect being reviewed and investigated in a timely manner by the facility and State Survey Agency. The findings included: Record review of Resident #1's face sheet dated 04/24/2024 revealed [AGE] year-old male admitted on [DATE]. Resident #1's diagnoses: Alzheimer's disease, type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), hypertension (high blood pressure), and Major Depressive Disorder. Record review of Resident #1's Quarterly MDS dated [DATE] revealed: Section C- Cognitive Patterns Resident #1 had a BIMS score of 7 meaning severe cognitive impairment; Section E- Behavior Resident #1 had not exhibited and wandering; Section GG- Functional Abilities and Goals Resident #1 required supervision or touching assistance for eating, hygiene, dressing, transferring and walking; Section M- Skin Conditions Resident #1 had no skin conditions; Record review of Resident #1's Care plan dated 04/18/2024 revealed: Problem Start Date 12/19/2023: Behavioral Symptoms Goal: Resident will have fewer episodes of Depression and wandering in unsafe places (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Approach: Start Date 12/19/2023 Approach Start Date: 12/19/2023 Always ask for help if resident becomes abusive/resistive; Start Date: 12/19/2023 Convey acceptance of resident during periods of inappropriate behavior; Start Date: 12/19/2023 Encourage diversional activities; Start Date: 12/19/2023 Keep environment calm and relaxed; Start Date: 12/19/2023 Redirect resident as needed; Start Date: 12/19/2023 Remove from public area when behavior is unacceptable Problem Start Date: 12/19/2023: Falls/Safety Risk/Elopement Risk Goal: Resident will remain free of injuries related to falls and will remain in a safe environment Approach: Start Date- 12/19/2023 Assess resident's footwear for proper fit and non skid soles; Start Date: 12/19/2023 Encourage use of call light; Start Date: 12/19/2023 Instruct resident on safety measures; Start Date: 12/19/2023 Keep call light in reach: Start Date: 12/19/2023 Orthostatic hypotension precautions; Start Date: 12/19/2023 PT referral; Problem Start Date: 12/19/2023: Delirium Goal: Resident will be as alert and oriented as possible. Approach: Start Date: 12/19/2023 Assess for constipation; Start Date: 12/19/2023 Assess for Pain; Start Date: 12/19/2023 Minimize distraction; Start Date: 12/19/2023 Orient PRN; Start Date: 12/19/2023 Rule out acute illnesses Problem Start Date: 12/19/2023 Category: Cognitive Loss/ Dementia Cognitive Loss-related Alzheimer disease. Goal: Resident will be as alert and oriented as possible Approach: Approach Start Date: 12/19/2023 Anticipate needs and observe for nonverbal cues; Start Date: 12/19/2023 Approach in calm manner; Start Date: 12/19/2023 Explain what you intend to do while providing care; Introduce self-Created; Start Date: 12/19/2023 Orient PRN to person, place and time. Record review of Resident #1's progress notes revealed: Date & Time: 04/18/2024 at 8:00 PM, Documented by LVN B [Recorded as Late Entry on 0411912024 12:36AM] nurse went into resident room to give him his medication. resident wasn't in his. nurse and staff went to all rooms and living area looking for him. nurse notified ADMN and DON that resident couldn't be found. administrator notified police. police came to facility and look in all rooms. nurse notified resident [this resident family member] to report resident left the facility without telling anyone. resident was found at salvation army and bring back to facility. resident was wearing shorts, gray shirt and black shoes and his glasses. resident stated he got upset and took off walking and went a crunch that took him to the salvation army. resident was taking to hospital for eval and treatment. resident [this resident family member] notified he has returned and sent to hospital to get check out and will be moved to room [ROOM NUMBER] in station 2 unit. nurse in unit aware of the transfer and has his medications. waiting for resident return. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date & Time: 04/19/2024 at 3:06 AM Documented by LVN U: Resident returned via facility transport staff to secured unit. Assessed resident upon return, no open wounds, lesions, or immediate bruising observed. Resident range of motion WNL. Hand grasps strong, able to push and pull with hands and feet. States nothing happened to him during his departure. Resident denies pain, weakness, or feelings of sickness. Does not appear to be in distress. Resident made comfortable in their new room and offered a tray of food. Resident states that he's going to rest. Plan of care continues. Record review of Resident #1's physician orders reviewed on 04/26/2024 revealed: start date 04/18/2024, Admit to secured unit due to high elopement risk and poor safety awareness. During an interview on 04/24/2024 at 12:20 PM LVN B stated she worked the night of 04/18/2024. LVN B stated when she starts her shift she will pass medications on Hall 2 and then will pass medications on Hall 1. LVN B stated she went into Resident # 1's room about 7:30 PM to give him his evening medications and discovered he was not in his room and he his meal tray had not been touched. LVN B stated she immediately went to search for Resident #1. LVN B stated she asked staff if they had seen Resident #1 and asked them to look for him. LVN B stated when he was not in his usual places, she then called a CODE PINK, which was the code for missing resident. LVN B stated she then contacted the DON and ADMN and contacted law enforcement. LVN B stated she was not aware of how long resident had been gone. During an interview on 04/24/2024 at 1:58 PM the SW stated the ADMN was the abuse/Neglect coordinator. The SW stated elopement was a reportable incident. The SW stated the ADMN was responsible for reporting the elopement. During an interview on 0/24/2024 at 2:25 PM, the DON stated elopement was an incident that should have been reported to the State Survey Agency. The DON stated the ADMN was the Abuse/Neglect coordinator and was responsible for reporting and investigating incidents of Abuse and Neglect to the State Survey Agency. The DON stated she thought that the ADMN had reported the incident. The DON stated that residents that required assistance with ADLs and/ or were incontinent were checked every 2-3 hours and it would have been documented. The DON stated residents who were ambulatory were observed when in their room or while sitting in common areas, but there were no set time frames to document the whereabout of ambulatory residents. During an interview on 04/24/2024 at 2:45 PM, the ADMN stated she was the Abuse/Neglect Coordinator. The ADMN stated it was her responsibility to investigate and report abuse and neglect. The ADMN stated she had reported the elopement of Resident #1 and that she would not fail to report an incident. The ADMN pulled out a folder and revealed her initial report and the completed PIR. The ADMN stated she knew she had sent the report in an email but was not able to find the email and stated she did not have an intake number. The ADMN stated what led to failure of not reporting the incident was she must have gotten distracted and forgot to send the email. The ADMN stated she had made several reports during that time frame. Record review of the facility's policy titled Emergency Procedure-Missing Resident, dated September 1, 2023, revealed: Resident elopement resulting in a missing resident is considered a center emergency . Administrator/Incident Commander Report eh incident to the State Licensing and Certification Agency according to regulation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Coronado Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1751 N 15th St Abilene, TX 79603	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy titled Abuse Prevention Program, dated 01/09/20223, revealed: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by Center Administrator, or his/her designee, to the following person or agencies as required: a. The State licensing/certification agency responsible for surveying/licensing the center . An alleged violation of abuse, neglect, exploitation, or mistreatment will be reported immediately, but not later than: 2 hours if the alleged violation involves abuse OR has resulted in serious bodily injury; Twenty- four(24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interview and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for 1 (Resident #2) of 3 residents reviewed for discharge requirements. 1. The facility failed to ensure Resident #2 was provided a discharge in writing 2. The facility failed to document a discharge summary. This failure placed residents at risk of not receiving necessary care and services. Findings included: Record review of Resident #2 electronic face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnosis Anxiety, Type II Diabetes Mellitus, Dysuria , Hypertension, Altered Mental Status, acquired absence of right leg below knee, Acquired absence of left leg below knee. Record review of Resident's #2 Discharge MDS assessment dated [DATE] revealed: Section C Cognitive Patterns #2's BIMS Score was 12 indicating moderate cognitive impairment. Section E Wandering behavior was not exhibited. Section GG Functional Abilities and Goals Resident #2 required supervision with Eating, Toileting and Dressing. Section M Skin Conditions Resident #2 had no skin conditions. Record review of Resident #2's progress notes dated 04/12/2024 at 1:53 PM documented by the SW revealed, Resident has been advised that he is to have alternate residence placement by 3:30 PM Record review of Resident #2's medical chart reviewed on 04/20/2024 revealed no evidence of discharge paperwork completed. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/21/2024 at 6:24 PM, Resident # 2 stated the facility had told him he had to leave because he tested positive for illegal substances . Resident # 2 stated honest truth I signed myself out and went to the convenience store and bout Delta- 8 . He stated it was legalized Marijuana. Resident #2 stated he did not do meth because that is what caused him to lose his legs. Resident #2 stated when he returned to facility that he was told he had to pee in a cup or he would be discharged . Resident #2 stated he did not feel like he had a choice to take the drug test. Resident #2 stated the facility had called the emergency medical services because he was unresponsive. Resident #2 stated his blood sugar had gotten too low. Resident stated he declined to go to the hospital with them. Resident # 2 stated that after the emergency medical services left he was told he had to leave the facility that day, and he only had a few hours to leave due to his positive drug test. Resident #2 stated the facility told him they were going to discharge him to a local homeless shelter. Resident #2 stated he did not want to go to the local homeless shelter because it was not a permanent place. He could only stay 3 nights , and he needed help with his medications. Resident #2 stated he did not how it was safe to kick him out after he had been unresponsive that morning. Resident # 2 stated he would have gone somewhere else but he would not have gone to the local homeless shelter. Resident # 2 stated the facility did not provide him any paperwork or give him his medications at the time. Resident # 2 stated he was not doing good and he had been to the emergency room 4 times because he had blacked out and did not have his medications. He stated that he went to the facility today and that he had gotten his medications but there are so many scripts he was not sure what he was supposed to take. During an interview on 04/29/2024 at 11:59 AM, the ADMN stated their policy had changed recently and that she had talked with Resident #2 prior to incident on 04/12/2024. The ADMN stated their new policy was that if you tested positive for an illegal substance, it was an immediate discharge. The ADMN stated that Resident # 2 had not signed any confirmation of the immediate discharge policy. The ADMN stated he was not given a written discharge, because he refused to go to the local homeless shelter. The ADMN stated herself, the SW and the DON were responsible to ensure that discharges were done correctly . The ADMN stated what led to the failure of giving Resident # 2 an immediate discharge was because she followed the corporate policy. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled , Transfer or Discharge Notice dated March 2021, revealed Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge . Residents are permitted to stay in the facility and not be transferred or discharged unless: the transfer is necessary for the resident' s welfare and the resident' s needs cannot be met in the facility. the transfer or discharge is appropriate because the resident' s health has improved sufficient! so the resident no longer needs the services provided by the facility. the resident has failed, after reasonable and appropriate notice, to pay for (or to have pai under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility will only charge a resident allowable charge under Medicaid. the facility ceases to operate. Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: The safety of individuals in the facility would be endangered; The health of individuals in the facility would be endangered; The resident' s health improves sufficiently to allow a more immediate transfer or discharge; An immediate transfer or discharge is required by the resident' s urgent medical needs; and/or The resident has not resided in the facility for thirty (30) days. The resident and representative are notified in writing of the following information: The specific reason for the transfer or discharge The effective date of the transfer or discharge; The location to which the resident is being transferred or discharged . Record review of facility policy titled, Resident Possession and Use of Illegal Substances, dated March 2024, revealed: Possession of illegal substances and/or being under the influence of illegal substances is grounds for immediate discharge.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722 Based on interviews and record reviews, the facility failed to develop a comprehensive person-centered care plan based on assessed needs with the ability to be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 13 residents reviewed for comprehensive person-centered care plans. The facility failed to ensure Resident #1's comprehensive care plan contained interventions that addressed his need for supervision for wandering. This failure could affect the residents by placing them at risk for not receiving care and services to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Findings included: Resident #1 Record review of Resident #1's face sheet dated 04/24/2024 revealed [AGE] year-old male admitted on [DATE] with diagnoses of Alzheimer's disease, type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), hypertension (high blood pressure), and Major Depressive Disorder. Record review of Resident #1's Quarterly MDS dated [DATE] revealed: Section C- Cognitive Patterns Resident #1 had a BIMS score of 7 meaning severe cognitive impairment; Section E- Behavior Resident #1 had not exhibited wandering behaviors during the lookback period; Section GG- Functional Abilities and Goals Resident #1 required supervision or touching assistance for eating, hygiene, dressing, transferring and walking; Section M- Skin Conditions Resident #1 had no skin conditions. Record review of Resident #1's Care plan dated 04/18/2024 revealed: Problem Start Date 12/19/2023: Behavioral Symptoms Goal: Resident will have fewer episodes of Depression and wandering in unsafe places Approach: Start Date 12/19/2023 Approach Start Date: 12/19/2023 Always ask for help if resident becomes abusive/resistive; Start Date: 12/19/2023 Convey acceptance of resident during periods of inappropriate behavior; Start Date: 12/19/2023 Encourage diversional activities; Start Date: 12/19/2023 Keep environment calm and relaxed; Start Date: 12/19/2023 Redirect resident as needed; Start Date: 12/19/2023 Remove from public area when behavior is unacceptable Problem Start Date: 12/19/2023: Falls/Safety Risk/Elopement Risk Goal: Resident will remain free of injuries related to falls and will remain in a safe environment (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Approach: Start Date- 12/19/2023 Assess resident's footwear for proper fit and non skid soles; Start Date: 12/19/2023 Encourage use of call light; Start Date: 12/19/2023 Instruct resident on safety measures; Start Date: 12/19/2023 Keep call light in reach: Start Date: 12/19/2023 Orthostatic hypotension precautions; Start Date: 12/19/2023 PT referral; Problem Start Date: 12/19/2023: Delirium. Goal: Resident will be as alert and oriented as possible. Approach: Start Date: 12/19/2023 Assess for constipation; Start Date: 12/19/2023 Assess for Pain; Start Date: 12/19/2023 Minimize distraction; Start Date: 12/19/2023 Orient PRN; Start Date: 12/19/2023 Rule out acute illnesses Problem Start Date: 12/19/2023 Category: Cognitive Loss/ Dementia Cognitive Loss-related Alzheimer disease. Goal: Resident will be as alert and oriented as possible Approach: Approach Start Date: 12/19/2023 Anticipate needs and observe for nonverbal cues; Start Date: 12/19/2023 Approach in calm manner; Start Date: 12/19/2023 Explain what you intend to do while providing care; Introduce self-Created; Start Date: 12/19/2023 Orient PRN to person, place, and time. Record review of Resident #1's physician orders reviewed on 04/23/2024 revealed: start date 04/18/2024, Admit to secured unit due to high elopement risk and poor safety awareness. During an interview on 04/26/2024 at 9:00 AM, the MDS Coordinator stated Resident #1's care plan addressed wandering based on history of wandering per Resident #1's family member. The MDS Coordinator stated the lack of supervision being addressed must have been. She stated in Section E-Behavior Resident #1 had not exhibited and wandering on MDS was coded with no wandering because wandering behavior did not occur during look back period. She stated wandering and elopement are two different things, and Resident #1 had not exhibited exit seeking behaviors. During an interview on 04/26/2024 at 9:15 AM, the DON stated she had only been at facility a few weeks and started reading over Care Plans to review them. The DON stated she had seen issues and was working on the care plans. She stated there were no care plans on supervision and she should have double checked to see that the care plans were completed. The DON stated that unsafe places meant other resident rooms or restrooms and would be based on the assessment of each resident. She stated the resident exhibited wandering issues but not elopement issues, with that being the reason elopement was not addressed prior to the recent elopement on 04/18/2024. During an interview on 04/26/2024 at 11:41 AM, the ADMIN stated her expectations for Care plans was for the care plans to be accurate and updated as needed. She stated she did not know why some residents did not have person centered interventions for supervision as an approach after being identified as someone who wanders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 04/29/2024 at 11:44 AM, the DON stated her expectations of care plans to be patient centered with the residents' likes and dislikes. So the care plans paint a picture of routine of residents so staff would know where the residents were and the resident's routine. She stated the effects on resident was it hindered staff to know the residents as well and unable to provide person centered care. She stated she does not know what caused this failure because she was not here, and she had tried to correct care plans as she discovered the care plan needed to be updated. Review of facility's policy titled Comprehensive Care Plans dated 1/26/2024 revealed: The Comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the residents highest practical, physical, mental and psychological well-being. Any services that would otherwise be furnished but are not provided to the residents, exercise of his or her right to refuse treatment. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated . The services provided or arranged by the facility, as outlined in the comprehensive care plan, will meet professional standards of quality, and will be provided by qualified persons in accordance with each resident's written plan of care.

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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 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44722

Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 12 (Resident #1) residents reviewed for elopement.

The facility failed to provide supervision for Resident #1, who was care planed for wandering in unsafe places, to prevent him from eloping from the facility on 04/18/2024. The facility was unaware Resident #1 had exited the facility, the last time he was seen by an employee was 2:00 PM, and as a result, the resident was missing for approximately 6 and half hours and was located by assistance from law enforcement.

An Immediate Jeopardy (IJ) was identified on 04/26/2024. While the IJ was lowered on 04/27/2024 at 3:30 PM, the facility remained out of compliance at a severity level of no actual harm with a scope of isolated, due to the facility's need to evaluate the effectiveness of their corrective actions.

This failure could affect residents who were identified as elopement risks and placed them at risk of serious bodily harm, physical impairment, or death.

Findings include:

Record review of Resident #1's face sheet dated 04/24/2024 revealed [AGE] year-old male admitted on [DATE] with diagnoses of Alzheimer's disease, type 2 diabetes mellitus (body does not make enough insulin or does not use insulin well), hypertension (high blood pressure), and Major Depressive Disorder.

Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed: Section C- Cognitive Patterns indicated Resident #1 had a BIMS score of 7 meaning severe cognitive impairment. Section E- Behavior revealed Resident #1 had not exhibited and wandering. Section GG- Functional Abilities and Goals revealed Resident #1 required supervision or touching assistance for eating, hygiene, dressing, transferring and walking. Section M- Skin Conditions revealed Resident #1 had no skin conditions.

Record review of Resident #1's Care plan dated 04/18/2024 revealed:

Problem Start Date 12/19/2023: Behavioral Symptoms

Goal: Resident will have fewer episodes of Depression and wandering in unsafe places

Approach: Start Date 12/19/2023 Approach Start Date: 12/19/2023 Always ask for help if resident becomes abusive/resistive; Start Date: 12/19/2023 Convey acceptance of resident during periods of inappropriate behavior; Start Date: 12/19/2023 Encourage diversional activities; Start Date: 12/19/2023 Keep environment calm and relaxed; Start Date: 12/19/2023 Redirect resident as needed; Start Date: 12/19/2023 Remove from public area when behavior is unacceptable

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER: Coronado Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1751 N 15th St Abilene, TX 79603	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Problem Start Date: 12/19/2023: Falls/Safety Risk/Elopement Risk Goal: Resident will remain free of injuries related to falls and will remain in a safe environment Approach: Start Date- 12/19/2023 Assess resident's footwear for proper fit and non skid soles; Start Date: 12/19/2023 Encourage use of call light; Start Date: 12/19/2023 Instruct resident on safety measures; Start Date: 12/19/2023 Keep call light in reach: Start Date: 12/19/2023 Orthostatic hypotension precautions; Start Date: 12/19/2023 PT referral; Problem Start Date: 12/19/2023: Delirium Goal: Resident will be as alert and oriented as possible. Approach: Start Date: 12/19/2023 Assess for constipation; Start Date: 12/19/2023 Assess for Pain; Start Date: 12/19/2023 Minimize distraction; Start Date: 12/19/2023 Orient PRN; Start Date: 12/19/2023 Rule out acute illnesses Problem Start Date: 12/19/2023 Category: Cognitive Loss/ Dementia Cognitive Loss-related Alzheimer disease. Goal: Resident will be as alert and oriented as possible Approach: Approach Start Date: 12/19/2023 Anticipate needs and observe for nonverbal cues; Start Date: 12/19/2023 Approach in calm manner; Start Date: 12/19/2023 Explain what you intend to do while providing care; Introduce self-Created; Start Date: 12/19/2023 Orient PRN to person, place and time. Record review of the facility's document titled Accidents/Incidents dated 04/23/2024 revealed Resident #1 had an elopement on 04/18/2024. During an interview on 04/25/2024 at 4:55 PM CNA F stated she remembered seeing Resident #1 in the dining area around 1:30 PM on 04/18/2024. During an interview on 04/25/2024 at 2:15 PM, OT L stated she had visited with Resident #1 on 04/18/2024 around 2:00 PM. She stated he had come into the therapy area and was happy and talkative. OT L stated she could not believe that Resident #1 left the building. During an interview on 04/25/2024 at 5:45 PM CNA I stated she was working Hall 1 and placed Resident #1's tray in his room approximately 4:45pm. CNA I stated she assumed he was in the dining room watching television, playing games or reading books. CNA I stated she got distracted with another resident and did not go look for Resident #1. CNA I stated she later went back into Resident #1's room and his tray had not been touched. CNA I stated she figured the resident was still reading or playing games, so she left his tray for it to be re-heated when he was ready to eat. CNA I stated she should have gone and looked for the resident, but she did not. Record review of Resident #1's progress notes revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Nursing Center	1751 N 15th St Abilene, TX 79603

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date & Time: 04/18/2024 at 8:00 PM, Documented by LVN B [Recorded as Late Entry on 0411912024 12:36AM] nurse went into resident room to give him his medication. resident wasn't in his. nurse and staff went to all rooms and living area looking for him. nurse notified ADMN and DON that resident couldn't be found. administrator notified police. police came to facility and look in all rooms. nurse notified resident [family member] to report resident left the facility without telling anyone. resident was found at salvation army and bring back to facility. resident was wearing shorts, gray shirt and black shoes and his glasses. resident stated he got upset and took off walking and went a crunch (sic) that took him to the [local homeless shelter] resident was taking to hospital for eval and treatment. resident [family member] notified he has returned and sent to hospital to get check out and will be moved to room [resident room] in station 2 unit. nurse in unit aware of the transfer and has his medications. waiting for resident return. Date & Time: 04/19/2024 at 3:06 AM Documented by LVN U: Resident returned via facility transport staff to secured unit. Assessed resident upon return, no open wounds, lesions, or immediate bruising observed. Resident range of motion WNL. Hand grasps strong, able to push and pull with hands and feet. States nothing happened to him during his departure. Resident denies pain, weakness, or feelings of sickness. Does not appear to be in distress. Resident made comfortable in their new room and offered a tray of food. Resident states that he's going to rest. Plan of care continues. During an interview on 04/24/2024 at 12:20 PM, LVN B stated she worked the night of 04/18/2024. LVN B stated when she started her shift at 6:00 PM and she would pass medications on Hall 2 and then would pass medications on Hall 1. LVN B stated she went into Resident # 1's room about 7:30 PM to give him his evening medications and discovered he was not in his room and his meal tray had not been touched. LVN B stated she immediately went to search for Resident #1. LVN B stated she asked staff if they had seen Resident #1 and asked them to look for him. LVN B stated when he was not in his usual places, she then called a CODE PINK, which was the code for missing resident. LVN B stated she then contacted the DON and ADMN around 8:00 PM and contacted law enforcement after speaking with DON. LVN B stated she was not aware of how long resident had been gone. During an interview on 04/24/2024 at 1:20 PM LVN D stated there were a handful of residents who were assessed as being safe to sign themselves out of the facility, and Resident #1 was not one of those residents. LVN D stated Resident #1 was not appropriate to be out of facility unsupervised. LVN D stated that Resident # 1 likes to wander around the building. LVN D stated the facility had two dining areas, but the facility was only using one dining area. LVN D stated Resident #1 called the dining area that was not being used his library and would go read books in there because it was quiet. LVN D stated if he was not in that dining area reading books, he would be in the other dining area playing video games. LVN D stated it was common for staff to leave Resident #1's meal trays in his room because he would come back to his room when he saw meals were being delivered. LVN D stated she had worked the day shift on 04/18/2024, she remembered seeing Resident #1 around lunch time but did not remembering him after that. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/24/2024 at 1:58 PM the SW stated some residents were able to sign themselves out of the facility on a pass, if deemed safe to be out of facility on their own. The SW stated nursing assessed residents on their fall risk, BIMS, and cognitive ability. The SW stated Resident #1 was not safe to be out of facility on his own. The SW stated she was not aware of how Resident #1 got out of the facility or the time frame he was gone. The SW stated Resident #1 should not have been able to exit the building because the staff at the nurse's station and the AD should have been monitoring the doors. The SW stated Resident #1 had sunburn on his nose related to the elopement. The SW stated resident could have fallen, gotten hurt or killed. During an interview on 04/24/2024 at 2:25 PM, the DON stated she was notified, around 8:30PM on 04/18/2024, that Resident #1 was missing and arrived at facility a little before 9:00 PM. The DON stated she helped with getting a head count to verify all residents were in building. The DON stated law enforcement officers were going from room to room conducting searches. The DON stated law enforcement located Resident #1 at the local homeless shelter about 9:00pm. The DON stated Resident #1 was sent to Emergency Department to be assessed. The DON stated she talked with the Medical Director, and he gave an order for Resident #1 to be admitted to the secure unit when he returned from the emergency room . The DON stated Resident # 1 returned from the Emergency Department around 2:30 AM and was placed in the secure unit for safety. The DON stated that no other interventions were attempted prior to placing him in the secure unit. The DON stated she had talked with Resident #1's family representative, and they were on board for placing Resident #1 in the secure unit. The DON stated they were not sure what time Resident #1 had exited the building. The DON stated OT L stated they had seen Resident #1 about 2:00 PM, and a resident stated they saw him walk out the front door with someone around 2:30 PM. The DON stated the effect on Resident #1 could have been an injury from being out of the building on his own. The DON stated she did not know if Resident #1 would be safe out of the facility on his own. The DON stated all staff were responsible for monitoring the doors to ensure residents were not getting out of the building. The DON stated what led to failure of Resident #1 getting out of the building was that he was sneakier than anticipated. During an observation and interview on 04/24/2024 at 3:30PM, Resident # 1 was sitting in his room on his bed in the secure unit. Resident #1 stated he was not sure how he got out of the building, or which door he walked out. Resident #1 stated he saw an open door and just walked out. Resident # 1 stated he did not remember if he walked out with anyone. During an interview on 04/24/2024 at 4:50 PM, the Medical Director stated Resident #1 was placed in secure unit due to concerns for his safety when he returned from the emergency department after his elopement. The Medical Director stated Resident #1 was not safe to be out of the facility without having supervision. Review of google maps https://www.google.com/maps, accessed on 04/25/2024, revealed the distance between the facility to the local homeless shelter was 3 to 4 miles (depend on route taken). The resident would have had to walk down highly traffic streets with speed limits of 35 to 55 mph, cross busy intersections, and cross railroad tracks. During an interview on 04/26/2024at 11:35 AM, Deputy Fire Chief stated there were eleven trains that traveled thru the city between the hours of 6:00 AM and 6 PM per day and there were ten trains that traveled thru the city between 6:00 PM and 6:00 AM per day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/26/2024 at 12:15 PM, the AD stated prior to Resident #1's elopement some residents and visitors had the door code. The AD stated that some of their residents appear to be visitors so they could walk out with vendors or visitors, and no one would know they were a resident. The AD stated prior to the elopement the facility did not have a process for monitoring the doors. Record review of the facility policy titled Wandering and Elopements, dated September 1, 2023, revealed: The facility will ensure that residents who exhibit wandering behavior and or/or are at risk for elopement received adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. Definitions 'Wandering' is random or repetitive locomotion that may be goal-directed (e.g., The person appears to be searching for something such as an exit or person), non-goal directed, or animals. 'Elopement' occurs when a resident leaves the premises or safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so . Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. Resident will be assessed by the IDT for risk of Elopement and unsafe wandering on admission, readmission, quarterly, and//or with a change of condition (e.g., increased agitation, changes in mobility, wandering). A person-centered care plan will be developed. Based on the risk factors that identified in the risk assessment. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, and minimize risk associated with hazards will be added to the residents' care planning. Appropriate staff. Provided to help prevent accidents or elements. Nursing staff. Response interventions, and document accordingly. Changes we made. Indicated changes of condition. Any changes are new interventions, so we communicated to relevant staff. Record review of the facility policy titled Emergency Procedure-Missing Resident, dated September 1, 2023, revealed: Resident elopement resulting in a missing resident is considered a center emergency. This was determined to be an Immediate Jeopardy (IJ) on 04/26/2024 at 1:45 PM. The Administration was informed of the IJ. The Administrator was provided with the IJ template on 04/26/2024 at 3:45 PM. Record review of Plan of Removal accepted on 04/27/2024 at 12:08 PM reflected the following: 689: Accidents, Hazards, Supervision & Devices The facility failed to ensure Resident #1 received adequate supervision to prevent resident elopement. Residents at risk for elopement can be affected by this deficiency. Immediate Action: Action: Resident #1 was sent to the hospital for evaluation when he arrived back to the nursing facility 4/18/2024, no new orders received. Resident was assessed upon returning from the hospital on 4/19/2024. Resident was reassessed for being an elopement risk on 4/18/2024 and placed in the secured unit for safety. Medical Director notified of the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Person(s) Responsible: Charge Nurse and Director of Nursing Date: 4/18/2024-4/19/2024 Action: Resident head count performed throughout the center to ensure no other residents were identified as missing. No other residents noted missing. Person(s) Responsible: Director of Nursing Date: 4/18/2024 Action: All doors verified in working order. No issues noted with the door functions. Additionally, 4/15/2024, 4/16/2024, & 4/17/2024 the doors were checked for functionality with no concerns. Gates checked for functionality: 4/26/2024; No concerns, all gates are functioning properly. Person(s) Responsible: Maintenance Director & Designee Date: 4/18/2024; 4/26/2024 Action: Mock elopement drills performed each shift in 24 hours. Person(s) Responsible: Director of Nursing Date: 4/19/2024, 4/21/2024, & 4/23/2024 Steps to Ensure Compliance: Action: Signage present on doors that state, Attention visitors please do not allow anyone to exit the building with you that did not come in with you, help us keep our residents safe, any questions please contact a staff member, thank you. Person(s) Responsible: Director of Nursing Date: 4/26/2024 Action: All residents in house received an updated elopement assessment. Ensured all care plans match the updated elopement assessment and are person-centered. Person(s) Responsible: Director of Nursing and/or Designee Date: 4/18/2024 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: All staff educated: Wandering & Elopement/Missing Resident Policy (to include adequate supervision to prevent accidents or elopements and when delivering meal trays in either dining area or in residents rooms staff should ensure residents are located and aware of meal. Any meal tray picked up that is not eaten staff need to verify resident is located and aware meal tray is ready. Charge nurse will be notified immediately if resident is not observed and informed. All staff educated prior to working their next shift. All new and temporary staff educated prior to working their first shift. Person(s) Responsible: Director of Nursing, Administrator, and/or Designee Date: 4/19/2024 Action: Certified Nurses Aides, Certified Medication Aides, and Charge Nurses educated on the resident profile to inform them of the level of supervision, elopement risk, and educated over accuracy of documentation. The type and frequency of resident supervision may vary among residents as determined by the residents' assessed needs and the identified hazards in the environment. All Certified Nurses Aides, Certified Medication Aides, and Charge Nurses will be educated prior to working their next shift. All new and temporary staff educated prior to working their first shift. Person(s) Responsible: Director of Nursing and/or Designee Date: 4/26/2024 Action: If resident is not observed during medication pass, meal times, and/or routine resident care rounds the charge nurse will be notified and the center will initiate a search for the resident immediately. The clinical staff will know to perform this action through education. All Certified Nurses Aides, Certified Medication Aides, and Charge Nurses will be educated prior to working their next shift. All new and temporary staff educated prior to working their first shift. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: 4/26/2024 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Action items in the above plan of removal will be monitored for effectiveness daily, x7 days a week, for 1 month and until deemed by QAPI committee that the facility is in substantial compliance. If any changes are needed, they will be brought to the QAPI committee and discussed for a plan action. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: 4/27/2024 Action: Ad hoc QAPI performed with Medical Director to review the Immediate Jeopardy template and the facility's plan to lower the Immediate Jeopardy. Person(s) Responsible: Administrator Date: 4/26/20 Surveyors monitored the facility's Plan of Removal ad confirmed it was sufficient to remove the IJ through observations, interviews, and record reviews from 04/27/2024 at 12:08 PM. to 04/27/2024 at 3:18 PM as follows: Action: Resident #1 was sent to hospital on 04/18/2024 -Record review of Resident #1's progress note dated 04/18/24 at 8:00 pm signed by LVN B revealed 'resident was taking to [a local] hospital for eval and treatment. resident [family member] notified he has returned and sent to hospital to get check out and will be moved to room [ROOM NUMBER] in station 2 unit. -Reviewed Discharge Instruction from hospital dated 04/18/2024 at 10:17 pm Action: Resident #1 elopement risk assessment on 04/18/2024 -Record review of elopement risk assessment completed on 04/18/2024 at 09:40 am indicating resident was an elopement risk. Action: Resident #1 placed in secured unit on 04/18/2024 oRecord review of Orders- 04/18/2024 order stating admit to secure unit due to high elopement risk and poor safety awareness. oObservation- 04/27/24 at 1:10 pm observed resident #1 resting in bed on the secure unit with no issue noted. Action: doors in working orders on oRecord review on 04/15/2024- verified check off sheets for all doors and gates checked my maintenance man. 04/27/24 at 1:30 pm. Interview with Maintenance stated he had performed the checks daily since 04/15/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	oRecord review of random sample of residents at risk for elopement that care plans were person-centered (specifically residents not in locked unit) 12 outside secure unit and 17 inside total of 29 residents who are elopement risk; 10 of those 12 residents not on the locked were, previously, no elopement risk Review: oRecord review of Resident #16- verified elopement risk assessment completed 04/19/24 and care plan was initiated 04/24/2024 o Record review of Resident #17- verified elopement risk assessment completed 04/19/24 and care plan was already in place. oRecord review of Resident #18- verified elopement risk assessment completed 04/19/24 and care plan was initiated 04/19/2024 Copy of inservice & signature sheet oRecord review of Wandering & Elopement/Missing Resident Policy oRecord review Resident profiles regarding level of supervision, Type/frequency of supervision, elopement risk, accuracy of documentation, Types of identified hazards in the environment, Verify inservice o1 nurse on each station & on each shift = total of 4 nurses oDuring an interview on 4/27/24 at 1:30 pm via phone interview LVN M confirmed he had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. LVN works night shift on station 1 oDuring an interview on 04/27/24 at 1:35 pm via phone interview LVN N confirmed he had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. LVN works night shift on station 2 oDuring an interview on 04/27/24 at 2:00 pm LVN P demonstrated how to pull up a resident's profile and identified if a resident was an elopement risk. LVN confirmed she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. LVN works day shift on station 2 oDuring an interview on 04/27/24 at 2:40 pm LVN E demonstrated how to pull up a resident's profile and identified if a resident is an elopement risk. LVN confirmed she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. LVN works day shift on station 1 o2 nurse aides on each station & on each shift Total of 8 aides if 12H shift (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	oDuring an interview on 04/27/24 at 12:20 pm CNA R demonstrated how to pull up a resident's profile and identified if a resident is an elopement risk. CNA confirmed she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. CNA works day shift on station 1 oDuring an interview on 04/27/24 at 12:25 pm CNA C demonstrated how to pull up a resident's profile and identified if a resident is an elopement risk. CNA confirmed she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. CNA works day shift on station 1 oDuring an interview on 04/27/24 at 1:00 pm CNA H demonstrated how to pull up a resident's profile and identified if a resident is an elopement risk. CNA confirmed she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. CNA works day shift on station 2 oDuring an interview on 04/27/24 at 1:10 pm CNA T confirmed she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. CNA works night shift on station 2 oDuring an interview on 04/27/24 at 2:45 pm CNA S confirmed during a phone interview that she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. CNA works night shift on station 1 oDuring an interview on 04/27/24 at 2:50 pm A CNA confirmed during a phone interview that she had received in-services on Wandering & Elopement/Missing Resident Policy and Resident profiles. CNA works night shift on station 1 Interview charge nurses if any residents not observed during Medication pass, Mealtimes, Routine resident care rounds, and Ask what these are & how to document the rounds oDuring an interview on 04/27/24 at 1:30 pm via phone interview LVN M confirmed he understands what to do If resident is not observed during medication pass, mealtimes, and/or routine resident care rounds. LVN works night shift on station 1 oDuring an interview on 04/27/24 at 1:35 pm via phone interview LVN N confirmed she understands what to do If resident is not observed during medication pass, mealtimes, and/or routine resident care rounds. LVN works night shift on station 2 oDuring an interview on 04/27/24 at 2:00 pm LVN P confirmed she understands what to do If resident is not observed during medication pass, mealtimes, and/or routine resident care rounds. LVN works day shift on station 2 oDuring an interview on 04/27/24 at 2:40 pm LVN E confirmed she understands what to do If resident is not observed during medication pass, mealtimes, and/or routine resident care rounds. LVN works night shift on station 1 Action: adhoc QAPI & Medical Director notified of IJ oRecord reviewed sign is QAPI sheet where medical Director was informed o04/27/24 at 12:26 observed Administrator give in-service to dietary staff regarding Wandering & Elopement/Missing Resident Policy and Abuse and Neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER: Coronado Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1751 N 15th St Abilene, TX 79603	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was removed on 04/27/2024 at 3:30 PM, the facility remained out of compliance at a level of no actual harm and a scope of isolated, due to the facility monitoring the effectiveness of their Plan of Removal. The ADMN was informed of this at 3:30PM.