

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 12/20/2024
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide the residents a safe, clean, comfortable, and homelike environment for 2 of 4 residents (Resident #3 and Resident #8) reviewed for the right of a homelike physical environment.</p> <p>The facility failed to ensure Resident #3 and Resident #8's bathrooms were free live cockroaches, and the air conditioner window unit filters were free of being clogged with lint.</p> <p>The failures placed residents at risk of an unsanitary and uncomfortable environment and a decrease in quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #3's Facesheet, dated 12/18/2024, revealed Resident #3 was an [AGE] year-old female, with an admitted into the facility on [DATE] and diagnoses included Cerebral infraction, unspecified (a condition where blood flow to the brain is interrupted, leading to damage to the brain tissue without a specific cause), Generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry and nervousness about a variety of everyday situations), Cellulitis (a bacterial infection that affects the skin tissue and can cause redness, pain, tenderness, and blisters), and Osteoarthritis of knee (a condition that occurs when the cartilage in the knee wears down, causing pain and stiffness).</p> <p>Record review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 08/21/2024, indicated Resident #3 had a BIMS score of 10, which indicated moderate impairment of cognitive response. Section GG - Functional Goals indicated Resident #3 was dependent on assistance for all bed mobility as Section GG 5A, 5B, 5C, 5D and 5F were coded 01, which signified Dependent - helper does all the effort.</p> <p>During an interview on 12/19/2024 at 12:17 p.m., a family member of Resident #3 said she had reported to the facility on multiple occasions that Resident #3's bathroom had roaches running around on the floor. The family member of Resident #3 said when she went to visit Resident #3 a few days prior, she would turned on the bathroom light and a large roach ran from under the trash can across the floor with several smaller roaches that scattered in several directions. The family member of Resident #3 said she had put moth balls in Resident #3's room to exterminate and prevent roaches because The family member of Resident #3 said the facility did not address her concerns.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/19/2024 at 1:01 p.m., Resident #3 said she had seen cock roaches in her bathroom, and she did not like the bugs to run across her floor.</p> <p>During an observation on 12/20/2024 at 10:50 a.m., entered the room of Resident #3 and opened the bathroom door. When the light was turned on, observed a large brown cock roach on the floor against the far wall. When the trash can was moved, three (3) small roaches ran out. Investigator removed the front cover of the AC unit, and observed a thick layer, approximately two (2) inches deep of thick dark grey lint, coated on the inside coils of the air conditioner unit.</p> <p>Record review of Resident #8's Facesheet, dated 12/18/2024, revealed Resident #8 was a [AGE] year-old male, with an admitted into the facility on [DATE] and diagnoses included Type 2 diabetes mellitus with hyperglycemia (a condition where a person has persistently high blood sugar levels), Acquired absence of right and left leg below knee (surgical amputation caused by injury, disease, or other medical condition, as opposed to being born without them), Generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry and nervousness about a variety of everyday situations), and Pressure ulcer of other site, stage 3 (indicates a full-thickness skin loss, where the wound extends through layers of skin into the subcutaneous fat tissue, exposing visible fat but not muscle, tendon, or bone).</p> <p>Record review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, dated 12/09/2024, indicated Resident #3 had a BIMS score of 15, which indicated intact cognitive response.</p> <p>During an observation and interview on 12/20/2024 at 8:35 a.m., Resident #8 said he had cock roaches in his bathroom. Resident #8 said at night he would turn on the light in the bathroom and roaches ran around everywhere. Resident #8 said he had fake legs that he placed inside a pair of jeans with shoes attached. Resident #8 said he kept the prosthetic legs in the bathroom where he could put on his pants after he went to the bathroom. Resident #8 said two days prior, he put on his pants, and a large cock roach came out at the bottom of his pants. Resident #8 said he, was grossed out and nearly fell backwards trying to kill it. Resident #8 said he had reported the presence of cock roaches to the CNAs, nurses, DON, and Administrator. Resident #8 said he had seen roaches that morning and reported them to LVN C. Resident #8 said his window air conditioner unit did not cool his room and pulled the front cover off. There was a thick gray layer of fine lint and brown dirt caked on the inside of the unit. The AC unit was taped to the window with wide, silver tape.</p> <p>During an observation on 12/20/2024 at 8:45 a.m., opened Resident #8's bathroom door and a large brown cock roach ran out from underneath the trash can into the corner of the bathroom floor. The cock roach ran toward Resident #8's pants that contained his prosthetic legs.</p> <p>During an observation and interview at 12/20/2024 at 9:05 a.m., the Administrator entered Resident #8's bedroom and witnessed the large roach in his bathroom. The Administrator said she was aware that Resident #8 had cock roaches in his bedroom.</p> <p>During an interview on 12/20/2024 at 11:01 a.m., LVN C said she saw cock roaches in Resident #8's room earlier and documented it in Pest Control Logbook.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/20/2024 at 11:08 p.m., the Maintenance Supervisor said he had been at the facility approximately one (1) year. The Maintenance Supervisor said he was aware of reports of cock roaches in the facility. The Maintenance Supervisor said the facility had a contract with a pest control company to prevent infestation and the company came monthly. The Maintenance Supervisor said the pest control would come as needed but the facility had not needed services recently.</p> <p>During an interview on 12/20/2024 at 12:09 p.m., the Administrator said she had been at the facility approximately two (2) years. She said she was familiar with Resident #8 and reports of cock roaches in his room. The Administrator said the facility attempted to address the roaches by use of professional pest control and staff documentation in the Pest Control Logbook. The Administrator said the issues was bigger when she first arrived at the facility, which was approximately two (2) year prior, and situation with cock roach infestation had improved. The Administrator said she would not live with roaches in her house. The Administrator said she did not want any resident to have an unclean and unsafe environment. The Administrator said staffing issues were an issue in other departments than nursing.</p> <p>Record review of the facility's Pest Control Logbook, revealed the current log sheet documentation log documented the presence of roaches since 02/10/2023 and were found in multiple areas of the facility, including Section 1 and Section 2 of the facility. The last entry was dated 12/20/2024 and indicated large roaches were seen in Resident #8's room and bathroom on the date of the on-site investigation.</p> <p>Record review of the facility's Pest Management Service Agreement, dated 01/23/2023, revealed the contractor would perform month pest control service. Emergency service visits would be provided at a separate charge unless negotiated otherwise with the client.</p> <p>Record review of the facility's Pest Control Invoice for service, dated 11/27/2024, revealed the exterminator came in and treated the facility for American Roaches as the target pest.</p> <p>Record review of the facility's Pest Control Invoice for service, dated 10/22/2024, revealed the exterminator came in and treated the facility for American Roaches as the target pest as an entry was made that review of the logbook indicated roaches were observed in the employee bathroom and nurses' station. Documentation revealed pest control services were performed monthly for roach issues.</p> <p>Record review of the facility's Maintenance Policy, dated 12/20/2024 by hand, revealed policy and procedures were related to maintenance, which was a safe and sanitary environment that ensured safety, afforded protection, and enhanced the well-being of the residents, public, and staff. Activities included: controlling or eliminating nuisances and pollutants within the immediate environment.</p> <p>Record review of the facility's policy, Resident Rights, dated 02/2021, revealed employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility to include: a dignified existence and have the facility respond to his or her grievances.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458</p> <p>Based on interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 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 the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law procedures for 1 of 5 residents (Resident #3) reviewed for reporting allegations of abuse, neglect, and exploitation.</p> <p>The facility failed to report an allegation of abuse to the state agency when a family member of Resident #3 alleged Resident #3 had been abused by CNA B within the required timeframe.</p> <p>The failure could place residents at risk of not having allegations of abuse, neglect, or exploitation reported.</p> <p>Findings include:</p> <p>Record review of Resident #3's Facesheet, dated 12/18/2024, revealed Resident #3 was an [AGE] year-old female, with an admitted into the facility on [DATE] and diagnoses included Cerebral infraction, unspecified (a condition where blood flow to the brain is interrupted, leading to damage to the brain tissue without a specific cause), Generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry and nervousness about a variety of everyday situations), Cellulitis (a bacterial infection that affects the skin tissue and can cause redness, pain, tenderness, and blisters), and Osteoarthritis of knee (a condition that occurs when the cartilage in the knee wears down, causing pain and stiffness).</p> <p>Record review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 08/21/2024, indicated Resident #3 had a BIMS score of 10, which indicated moderate impairment of cognitive response. Section GG - Functional Goals indicated Resident #3 was dependent on assistance for all bed mobility as Section GG 5A, 5B, 5C, 5D and 5F were coded 01, which signified Dependent - helper does all the effort.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/19/2024 at 12:17 p.m., a family member of Resident #3 said she had reported an allegation of abuse to the facility's social worker by text on or about 11/18/2024, which included a video. The family member of Resident #3 said she viewed the video on the camera that was set up in the Resident #3's room and was recorded on 11/16/2024 at 7:45 a.m. The family member of Resident #3 said in a video, she could see Resident #3 on camera as she laid on her bed. The family member of Resident #3 said Resident #3 had her call light in her right hand and CNA B entered the room and sat on the edge of the bed. The family member of Resident #3 said CNA B placed her left elbow on Resident #3's right thigh and rolled her elbow forward. The family member of Resident #3 said Resident #3 stated to get off her and The family member of Resident #3 said Resident #3 looked uncomfortable and distressed. The family member of Resident #3 said CNA B stated to Resident #3 to stop pushing the call light because the sound was heard all over the building. The family member of Resident #3 provided the video to the investigator.</p> <p>Review of the video, dated 11/11/16/2024 at 7:45 a.m., revealed CNA B enter Resident #3's room as Resident #3 laid on her bed. The view of the video was above the resident and faced down toward the end of the bed and captured Resident #3 as she laid on her back with the bottom of her feet pointed toward the camera. Review of video showed CNA B as she sat on the edge of Resident #'s bed by her right knee and face toward Resident #3. Viewed CNA B as she placed her left elbow on Resident #3's thigh and roll her elbow slightly forward. Resident #3 stated, get up off me. Audio of the video revealed CNA B as she told Resident #3 that the call light made a bussing sound and went all through the building.</p> <p>During an interview on 12/19/2024 at 3:41 p.m., the DON said she had been at the facility approximately nine (9) months. The DON said she was familiar with Resident #3 and the allegation that CNA B had allegedly placed her elbow on Resident #3 upper leg. The DON said she was notified by Resident #3's family member. The DON said the allegation was not reported because when Resident #3's family member was asked about the allegation, Resident #3's family member did not think the act was intentional and felt training was appropriate. The DON said Resident #3's family member agreed to switch CNAs and held a care plan meeting to address the incident.</p> <p>During an interview on 12/20/2024 at 11:45 a.m., the Social Worker said Resident #3's family member called her first and left a message and then texted her the video. The Social Worker said she was the first employee to have possession of the video and she turned the video over to the Administrator and DON. The Social Worker said she thought the DON should see the video first and evaluated to determine how the facility should proceed. The Social Worker said she did not return Resident #'s family member call or expand on the conversation. The Social Worker said she knew, based on the video, staff needed to be trained to not sit on the Residents' bed. The Social Worker said Resident #3's family member mentioned in the voice message she could tell it was uncomfortable for Resident #3. The Social Worker said when she viewed the video and saw CNA B lean on Resident #3's with her elbow, she thought the movement was inappropriate due to the poor condition of Resident #3's leg. The Social Worker said while the incident was addressed, the administration should have followed protocol and reported the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/20/2024 at 12:09 p.m., the Administrator said she was familiar with Resident #3 and had seen the video provided by Resident #3's family member. The Administrator said she received the video from the Social Worker, who reported Resident #3's family member had sent it to her by text. The Administrator said the Social Worker said Resident #3's family member was upset about the staff leaning on Resident #3's sore upper thigh. The Administrator said the alleged abuse was not reported because there was no intent by CNA B to abuse Resident #3. The Administrator said Resident #3's family member never used the word abused and the Administrator said she did not speak with Resident #3's family member until the care plan meeting on 10/21/2024. The Administrator said Resident #3 was not assessed after the video was reviewed.</p> <p>Record review of the facility's policy, Abuse Prevention, dated 01/09/2023, revealed the Administrator was responsible for the overall coordination and implementation of the Center's abuse prevention program policies. Our Center will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor and to the Abuse Prevention Coordinator immediately. All reports of resident abuse, neglect, exploitation shall be promptly reported to local, state, and federal agencies (as defined by current regulations). An alleged violation of abuse/neglect will be reported immediately.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458</p> <p>Based on interview, and record review the facility failed to have evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated and prevent further potential abuse or mistreatment while the investigation was in progress for 1 of 5 residents (Resident #3) reviewed for abuse.</p> <p>1. The Administrator failed to investigate an alleged allegation of abuse when a family member of Resident #3 alleged Resident #3 had been abused by CNA B.</p> <p>2. The facility failed to prevent further potential abuse or mistreatment by allowing CNA B to remain on duty after the facility became of aware of the alleged allegation of abuse.</p> <p>These failures could place residents at risk for abuse and neglect by not investigating and implementing preventive measures.</p> <p>Findings include:</p> <p>Record review of Resident #3's Facesheet, dated 12/18/2024, revealed Resident #3 was an [AGE] year-old female, with an admitted into the facility on [DATE] and diagnoses included Cerebral infraction, unspecified (a condition where blood flow to the brain is interrupted, leading to damage to the brain tissue without a specific cause), Generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry and nervousness about a variety of everyday situations), Cellulitis (a bacterial infection that affects the skin tissue and can cause redness, pain, tenderness, and blisters), and Osteoarthritis of knee (a condition that occurs when the cartilage in the knee wears down, causing pain and stiffness).</p> <p>Record review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 08/21/2024, indicated Resident #3 had a BIMS score of 10, which indicated moderate impairment of cognitive response. Section GG - Functional Goals indicated Resident #3 was dependent on assistance for all bed mobility as Section GG 5A, 5B, 5C, 5D and 5F were coded 01, which signified Dependent - helper does all the effort.</p> <p>During an interview on 12/19/2024 at 12:17 p.m., a family member of Resident #3 said she had reported an allegation of abuse to the facility's social worker by text on or about 11/18/2024, which included a video. The family member of Resident #3 said after she viewed a video that was recorded on 11/16/2024 at 7:45 a.m., she reported the CNA in the video had allegedly abused Resident #3. The family member of Resident #3 said the facility held an IDT meeting on 11/21/2024 to discuss a video the family had provided to the facility on [DATE]. The family member of Resident #3 said she attended the meeting because she had reported an allegation of abuse and the facility had not addressed the allegation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/19/2024 at 2:34 p.m., CNA B said she had been at the facility for approximately three (3) years. CNA B said she was familiar with Resident #3. CNA B said she was approached by the DON who let her know that it had been reported CNA B had placed her elbow on Resident #3's sore leg and a grievance had been filed. CNA B said the DON said the administration staff who viewed the video could not see CNA B's elbow touch Resident #3's leg. CNA B said she was not suspended but she traded Resident #3's room with another CNA. CNA B said had not been informed about the call light statement and CNA B said she had never told Resident #3 to not use her call light.</p> <p>During an interview on 12/19/2024 at 3:41 p.m., the DON said she had been at the facility approximately nine (9) months. The DON said she was familiar with Resident #3 and the allegation that CNA B had allegedly placed her elbow on Resident #3 upper leg. The DON said the facility assigned another CNA to provide care for Resident #3 and educated CNA B to bring a chair into the room and not sit on the bed. The DON said she as well as Resident #3's family member did not think the act was intentional and felt training was appropriate. The DON said Resident #3's family member agreed to switch CNAs and held a care plan meeting to address the incident.</p> <p>During an interview on 12/20/2024 at 11:45 a.m., the Social Worker said Resident #3's family member called her first and left a message and then texted her the video. The Social Worker said she was the first employee to have possession of the video and she turned the video over to the Administrator and DON. The Social Worker said she thought the DON should see the video first and evaluated to determine how the facility should proceed. The Social Worker said when she viewed the video and saw CNA B lean on Resident #3's with her elbow, she thought the movement was inappropriate due to the poor condition of Resident #3's leg. The Social Worker said while the incident was addressed, the administration should have followed protocol and investigated the allegation and suspended CNA B if needed.</p> <p>During an interview on 12/20/2024 at 12:09 p.m., the Administrator said she was familiar with Resident #3 and had seen the video provided by Resident #3's family member. The Administrator said she received the video from the Social Worker, who reported Resident #3's family member had sent it to her by text. The Administrator said the Social Worker said Resident #3's family member was upset about the staff leaning on Resident #3's sore upper thigh. The Administrator said at that point, she spoke with the DON and the facility reeducated CNA B to avoid sitting on the side of residents' beds and to be more careful with individuals. The Administrator said CNA B did not go into Resident #3's room to hurt her. The Administrator said the alleged abuse was not reported because there was no intent by CNA B to abuse Resident #3. The Administrator said she did not speak with Resident #3's family member until the care plan meeting on 10/21/2024. The Administrator said the incident was not investigated as an allegation of abuse and neglect. The Administrator said the Resident #3 was not interviewed.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45458</p> <p>Based observation, interview, and record review, the facility failed to maintain an effect pest control program to keep the facility free of roaches for two (2) common areas, and for 2 of 4 residents (Resident #3 and Resident #8) reviewed for pest control program.</p> <p>The facility failed to ensure the facility was free of roaches The facility failed to ensure Resident #3 and Resident #8's bathrooms were free live cockroaches</p> <p>This failure could affect residents by placing them at risk for potential spread of infection, cross-contamination, and decreased quality of life.</p> <p>Finding include:</p> <p>Record review of Resident #3's Facesheet, dated 12/18/2024, revealed Resident #3 was an [AGE] year-old female, with an admitted into the facility on [DATE] and diagnoses included Cerebral infraction, unspecified (a condition where blood flow to the brain is interrupted, leading to damage to the brain tissue without a specific cause), Generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry and nervousness about a variety of everyday situations), Cellulitis (a bacterial infection that affects the skin tissue and can cause redness, pain, tenderness, and blisters), and Osteoarthritis of knee (a condition that occurs when the cartilage in the knee wears down, causing pain and stiffness).</p> <p>Record review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 08/21/2024, indicated Resident #3 had a BIMS score of 10, which indicated moderate impairment of cognitive response. Section GG - Functional Goals indicated Resident #3 was dependent on assistance for all bed mobility as Section GG 5A, 5B, 5C, 5D and 5F were coded 01, which signified Dependent - helper does all the effort.</p> <p>During an interview on 12/19/2024 at 12:17 p.m., a family member of Resident #3 said she had reported to the facility on multiple occasions that Resident #3's bathroom had roaches running around on the floor. The family member of Resident #3 said when she went to visit Resident #3 a few days prior, she would turned on the bathroom light and a large roach ran from under the trash can across the floor with several smaller roaches that scattered in several directions. The family member of Resident #3 said she had put moth balls in Resident #3's room to exterminate and prevent roaches because The family member of Resident #3 said the facility did not address her concerns.</p> <p>During an observation on 12/19/2024 at 8:29 a.m., a large brown cock roach laid on the floor in the common area by a roll of tables of a unit hall in Section 2. The cock roach was large and had not been present on 12/18/2024 when investigator entered facility and used same room for investigation entrance conference.</p> <p>During an interview on 12/19/2024 at 1:01 p.m., Resident #3 said she had seen cock roaches in her bathroom, and she did not like the bugs to run across her floor.</p> <p>(continued on next page)</p>		

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 12/20/2024
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.			
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/20/2024 at 10:50 a.m., entered the room of Resident #3 and opened the bathroom door. When the light was turned on, observed a large brown cock roach on the floor against the far wall. When the trash can was moved, three (3) small roaches ran out.</p> <p>Record review of Resident #8's Facesheet, dated 12/18/2024, revealed Resident #8 was a [AGE] year-old male, with an admitted into the facility on [DATE] and diagnoses included Type 2 diabetes mellitus with hyperglycemia (a condition where a person has persistently high blood sugar levels), Acquired absence of right and left leg below knee (surgical amputation caused by injury, disease, or other medical condition, as opposed to being born without them), Generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry and nervousness about a variety of everyday situations), and Pressure ulcer of other site, stage 3 (indicates a full-thickness skin loss, where the wound extends through layers of skin into the subcutaneous fat tissue, exposing visible fat but not muscle, tendon, or bone).</p> <p>Record review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, dated 12/09/2024, indicated Resident #3 had a BIMS score of 15, which indicated intact cognitive response.</p> <p>During an observation and interview on 12/20/2024 at 8:35 a.m., Resident #8 said he had cock roaches in his bathroom. Resident #8 said at night he would turn on the light in the bathroom and roaches ran around everywhere. Resident #8 said he had fake legs that he placed inside a pair of jeans with shoes attached. Resident #8 said he kept the prosthetic legs in the bathroom where he could put on his pants after he went to the bathroom. Resident #8 said two days prior, he put on his pants, and a large cock roach came out at the bottom of his pants. Resident #8 said he, was grossed out and nearly fell backwards trying to kill it. Resident #8 said he had reported the presence of cock roaches to the CNAs, nurses, DON, and Administrator. Resident #8 said he had seen roaches that morning and reported them to LVN C.</p> <p>During an observation on 12/20/2024 at 8:45 a.m., opened Resident #8's bathroom door and a large brown cock roach ran out from underneath the trash can into the corner of the bathroom floor. The cock roach ran toward Resident #8's pants that contained his prosthetic legs.</p> <p>During an observation and interview at 12/20/2024 at 9:05 a.m., the Administrator entered Resident #8's bedroom and witnessed the large roach in his bathroom. The Administrator said she was aware that Resident #8 had cock roaches in his bedroom.</p> <p>During an observation on 12/20/2024 at 9:45 a.m., a large brown cock roach was on the floor in the doorway between the hall and the common area, crushed with the insides smeared on the floor.</p> <p>During an interview on 12/20/2024 at 11:01 a.m., LVN C said she saw cock roaches in Resident #8's room earlier and documented in Pest Control Logbook.</p> <p>(continued on next page)</p>		

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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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/20/2024 at 11:08 p.m., the Maintenance Supervisor said he had been at the facility approximately one (1) year. The Maintenance Supervisor said he was aware of reports of cock roaches in the facility. The Maintenance Supervisor said the facility had a contract with a pest control company to prevent infestation and the company came monthly. The Maintenance Supervisor said the pest control would come as needed but the facility had not needed services recently. The Maintenance Supervisor said the facility was an older building and had issues with cock roaches at times. The Maintenance Supervisor said his role with pest control was to check the Pest Control Logbook, monitor the pest control documentation to ensure staff documented when pest were sighted, and monitor the agency the facility contracted with to ensure the exterminators completed what they were supposed to. The Maintenance Supervisor said pest control called him when they arrived, and he spot checked for quality services.</p> <p>During an interview on 12/20/2024 at 11:19 a.m., the Housekeeper Supervisor said he had been at the facility approximately four (4) months. The Housekeeper Supervisor said his expectation of the housekeeping staff was if they saw roaches, to report by documenting the Pest Control Logbook. The Housekeeper Supervisor said he had verbally instructed the housekeeping staff to document in the green Pest Control Logbook and he monitored the documentation. The Housekeeper Supervisor said pest control was the responsibility of maintenance. The Housekeeper Supervisor said inadequate reporting of pest could result in the negative outcome of a bigger infestation and unsanitary conditions.</p> <p>During an interview on 12/20/2024 at 12:09 p.m., the Administrator said she had been at the facility approximately two (2) years. She said she was familiar with Resident #8 and reports of cock roaches in his room. The Administrator said the facility attempted to address the roaches by use of professional pest control and staff documentation in the Pest Control Logbook. The Administrator said the issues were bigger when she first arrived at the facility and situation had improved. The Administrator said she would not live with roaches in her house. The Administrator said she did not want any resident to have an unclean and unsafe environment. The Administrator said staffing issues were an issue in other departments than nursing.</p> <p>Record review of the facility's Pest Control Logbook, revealed the current log sheet documentation log documented the presence of roaches since 02/10/2023. The last entry was dated 12/20/2024 and indicated large roaches were seen in Resident #8's room and bathroom on the date of the on-site investigation.</p> <p>Record review of the facility's Pest Management Service Agreement, dated 01/23/2023, revealed the contractor would perform month pest control service. Emergency service visits would be provided at a separate charge unless negotiated otherwise with the client.</p> <p>Record review of the facility's Pest Control Invoice for service, dated 11/27/2024, revealed the exterminator came in and treated the facility for roaches.</p> <p>Record review of the facility's Maintenance Policy, dated 12/20/2024 by hand, revealed policy and procedures were related to maintenance, which was a safe and sanitary environment that ensured safety, afforded protection, and enhanced the well-being of the residents, public, and staff. Activities included: controlling or eliminating nuisances and pollutants within the immediate environment.</p>		