STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675746	A. Building B. Wing	07/10/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and describes the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 6 of 6 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6) reviewed for comprehensive person-centered care plans. 1. The facility failed to develop a care plan based on assessed needs with measurable objectives in the areas of Hospice, Encephalopathy, Seborrheic dermatitis, Anxiety Disorder, Trisomy 21, Hepatitis B, Hyperlipidemia, Gastro-esophageal reflux disease, without esophagitis, Fatty Live, and Unspecified Convulsions, Dementia for Resident #1. 2. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of malnutrition, Schizoaffective Disorder, Cerebral infarction, Seizure Disorder, Hyperlipidemia, GERD, Pruritus, and Generalized Anxiety Disorder for Resident # 3. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Traumatic brain injury, Urinary incontinence, Depression, Anxiety, Post-traumatic Stress Disorder, Schizoaffective disorder, Pruritus, Alcohol dependence, Cannabis dependence, Dementia, Insomnia, Dysphagia, Aphasia, Dysphagia, Cognitive communication deficit and Wernicke's encephalopathy for Resident #3. 4. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Bipolar disorder, atrial fibrillation, ADL deficits, Fracture of unspecified metatarsal bones, Unspecified open wound of left great toe without damage to nail, Mixed hyperlipidemia, Nicotine dependence, Anxiety disorder, Essential (primary) hypertension, Heart Failure, and Unspecified sequelae of unspecified cerebrovascular disease for Resident #4. 5. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Alzheimer's Disease, ADL deficits, Major Depressive Disorder, Nutritional status, Delirium, Cognitive communication deficit, Dysphagia, Cardiac murmur, Essential (primary) hypertension, Type 2 diabetes mellitus, and Hyperlipidemia for Resident #5. 6. The facility failed to develop a care plan based on assessed needs with measured objectives in the areas of Drug Dependency, Generalized anxiety disorder, GERD, Insomnia, Hyperlipidemia, and Essential (primary) hypertension for Resident #6. These failures could place residents at risk for not receiving care and services to meet their needs.The findings include: 1. Record review of Resident #1's Facesheet, dated 07/09/2025, revealed a [AGE] year-old male, with an admission date into the facility of 05/08/2025. Resident #1 had diagnoses which included Encephalopathy (a broad range of conditions that cause brain dysfunction, leading to altered consciousness, cognitive impairment, and neurological symptoms), unspecified, Seborrheic dermatitis (common, long-term skin condition that causes scaly patches, inflamed skin, and dandruff), Anxiety Disorder (mental health condition characterized by excessive, uncontrollable, and often irrational worry about everyday events or activities), Polyosteoarthritis, unspecified (arthritis affecting multiple joints, but without further detail about the specific joints involved), Trisomy 21 (a genetic disorder where a person has three [3] copies of chromosome 21 instead of the usual two [2], Alzheimer's Disease (most common form, where a person experienced the effects of more than one type of dementia), unspecified, Hepatitis B (a viral infection that affects the liver, causing inflammation and potential long-term damage), Hyperlipidemia (condition where there are elevated levels of lipids, including cholesterol and triglycerides, in the blood), Gastro-esophageal reflux disease, without esophagitis (occurs when stomach acid flows back into the esophagus but does not cause inflammation or damage [esophagitis], Fatty Liver (condition where there's an excessive buildup of fat in the liver), and Unspecified Convulsions (sudden, involuntary muscle contractions or spasms where the specific cause or type was no identified). Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1's BIMS score was not calculated. Section C0100, Should Brief Interview for Mental Status (C0200 - C0500) be Conducted was coded 0 for No - resident was rarely/never understood; therefore, BIMS score was not determined. Section I - Active Diagnoses revealed Resident #1 had medically complex conditions, with diagnoses which include GERD, Hyperlipidemia, Arthritis, Non-Alzheimer's Dementia, Seizure Disorder, Encephalopathy, Viral Hepatitis B, and Trisomy 21. Record review of Resident #1's Care Plan, with recent review of 05/14/2025, revealed objectives that lacked the ability to be evaluated, quantified, and verified were: death with dignity (Hospice); [Resident #1] will maintain

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan was prepared by an interdisciplinary team, that included but not limited to a nurse aide with the responsibility for the resident for 6 of 6 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6) reviewed for care plans. The facility failed to ensure the nurse aides with responsibility for the residents were invited and attended the resident care plan conferences. This failure could place residents at risk for not receiving the care and services to meet their needs.The findings include: 1. Record review of Resident #1's Facesheet, dated 07/09/2025, revealed a [AGE] year-old male, with an admission date into the facility of 05/08/2025. Resident #1 had a diagnosis which included Encephalopathy (a broad range of conditions that cause brain dysfunction, leading to altered consciousness, cognitive impairment, and neurological symptoms), unspecified. Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1's BIMS score was not calculated. Section C0100, Should Brief Interview for Mental Status (C0200 - C0500) be Conducted was coded 0 for No - resident was rarely/never understood; therefore, BIMS score was not determined. 2. Record review of Resident #2's Facesheet, dated 07/09/2025, revealed a [AGE] year-old male, with an admission date into the facility of 10/12/2020. Resident #2 had diagnosis which included Vascular Dementia (a decline in thinking and reasoning skills caused by conditions that damage blood vessels in the brain, reducing blood flow and oxygen supply to the brain cells). Record review of Resident #2's Annual MDS, dated [DATE], revealed Resident #2's BIMS score was 10, which indicated moderate impairment. 3. Record review of Resident #3's Facesheet, dated 07/09/2025, revealed a [AGE] year-old male, with an admission date into the facility of 05/05/2022. Resident #3 had a diagnosis which included Wernicke's Encephalopathy (a serious brain disorder caused by thiamine [vitamin B1] deficiency, often linked to chronic alcohol abuse) Record review of Resident #3's Quarterly MDS, dated [DATE], revealed Resident #3's BIMS score was 09, which indicated moderate impairment. 4. Record review of Resident #4's Facesheet, dated 07/09/2025, a [AGE] year-old female, with an admission date into the facility of 04/23/2025. Resident #4 had a diagnosis which included Fracture of unspecified metatarsal bones (the five long bones in the midfoot located between the tarsal bones of the ankle and the phalanges [toe bones], left foot, initial encounter for closed fracture - 1st, 2nd, 3rd heads). Record review of Resident #4's admission MDS, dated [DATE], revealed Resident #4's BIMS score was 14, which indicated intact cognition. 5. Record review of Resident #5's Facesheet, dated 07/09/2025, revealed a [AGE] year-old male, with an admission date into the facility of 12/15/2023. Resident #5 had a diagnosis which included Alzheimer's Disease (most common form, where a person experienced the effects of more than one type of dementia). Record review of Resident #5's Quarterly MDS, dated [DATE], revealed Resident #5's BIMS score was 08, which indicated moderate impairment. 6. Record review of Resident #6's Facesheet, dated 07/10/2025, revealed a [AGE] year-old male, with an admission date into the facility of 07/24/2024 . Resident #6 had a diagnosis which included Generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable, and often irrational worry about everyday events or activities). Record review of Resident #6's Quarterly MDS, dated [DATE], revealed Resident #6's BIMS score was 15, which indicated intact cognition. During an interview on 07/10/2025 at 9:45 a.m., CNA B said she did not attend or participate in care planning or care plan meetings. CNA B said no one asked for her input related to the goals and interventions in the residents' care plans. CNA B said her input would be valuable because she had built a good rapport with the residents she worked with. CNA B said she knew her residents very well and provided the services they needed. During an interview on 07/10/2025 at 2:40 p.m., the Clinical Case Manager said the social worker was responsible for inviting the members of the IDT to the care plan meetings. The Clinical Case Manager said the CNAs did not participate in the IDT meetings. The Clinical Case Manager said she would obtain the CNAs' input through documentation from the residents' electronic records. The Clinical Case Manager said she would talk with the staff on the floor, but did not document her conversations. During an interview on 07/10/2025 at 2:50 p.m., the Social Worker said she sent out the invites to the members of the IDT care plan meetings. The Social Worker said CNAs attending the meetings had not been customary in the two (2) years she had been at the facility. The Social Worker said the CNAs were not invited because of their job responsibilities and their need to be on the floor to provide direct care. The Social Worker said if she needed information from a CNA, she would interview or talk to them because the CNAs worked very closely with the