STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325114	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Care Center	1604 West 18th Street Portales, NM 88130

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident's current advance directive (a document which provides an individual's wishes for emergency and lifesaving care) was available in the resident's Electronic Health Record (EHR) and/or available in physical form for the facility staff for 1 (R #48) of 1 (R #48) resident reviewed for advance directives. This deficient practice is likely to cause confusion and delay potentially lifesaving procedures. The findings are: A. Record review of R #48's face sheet revealed R #48 was admitted into the facility on [DATE]. B. Record review of R #48's physician orders dated [DATE] revealed R #48 was a Do Not Resuscitate (DNR- a person has decided not to have cardiopulmonary resuscitation (CPR) attempted on them if their heart or breathing stops) for her advanced directive code status. C. Record review of R #48's care plan dated [DATE] revealed R #48 was a DNR for her advanced directive code status. D. Record review of R #48's EHR revealed the record did not contain an advanced directive form, the New Mexico Orders for Scope and Treatment (MOST). E. On [DATE] at 12:45 pm during an interview with the Director of Nursing (DON), she confirmed R #48's advanced directive code status, the New Mexico Orders for Scope and Treatment (MOST) was not uploaded into R #48's EHR nor was it available in physical form for nursing staff and should have been.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to keep residents free from physical restraints for 1 (R #8) of 1 (R #8) resident observed during random observations. This deficient practice could likely result in physical restraints being used for discipline or staff convenience; unnecessarily preventing residents from freedom, movement, or activity. The findings are: A. Record review of R #8's face sheet revealed R #8 was admitted to the facility on [DATE] with the following diagnoses: 1. Alzheimer's (a progressive brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out even the simplest tasks), 2. Dementia (a general term for a decline in mental ability severe enough to interfere with daily life), 3. Depression (persistent feeling of sadness, loss of interest in activities, and changes in appetite, sleep, and energy levels), 4. Cognitive communication deficit (a communication problem stemming from impairments in thinking skills, rather than language or speech difficulties themselves), 5. Unsteadiness on feet, 6. Psychotic disorder with hallucinations (characterized by experiencing sensory perceptions that aren't real, such as hearing voices or seeing things that aren't present). B. Record review of R #8's care plan dated 03/01/23 revealed the following approaches for risk of elopement safety awareness: 1. Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. 2. Provide structured activities. 3. Educate the resident and family of the risks. 4. Engage resident in activities of choice. 5. Report to medical provider. 6. Supervise closely and make regular rounds when the resident is in her room. C. On 06/09/25 at 12:00 pm, during an observation of R #8, she was in the dining room, sitting in her wheelchair. R #8 made three attempts to wheel herself out of the dining room. D. On 06/09/25 at 12:15 pm, a follow up observation with R #8 revealed her sitting in a recliner (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the foot part extended. R #8 was attempting to get out of the recliner. E. On 06/09/25 at 12:16 pm, during an interview with Certified Nursing Assistant (CNA) #3 she stated that R #8 was a wanderer so the recliner was used as a way to keep her safely in one place. CNA #3 confirmed that R #8 cannot get out of the recliner without assistance.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete and transmit (electronically sending encoded information) a Significant Change (major decline or improvement in the patient's health status) Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessment within 14 days after the facility determined a significant change in the resident's physical or mental condition for 1 (R #23) of 1 (R #23) resident reviewed for MDS assessment timing. This deficient practice could likely result in the residents not receiving the appropriate care and services they need. The findings are: A. Record review of R #23's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Major depressive disorder (depression; a mood disorder that causes a persistent feeling of sadness and loss of interest), 3. Cerebral aneurysm (a weak spot on an artery in the brain that fills with blood), 4. Chronic heart failure (an ongoing inability to pump enough blood through the body causing an insufficiency of oxygen). B. On 06/10/25 at 8:55 am, during an interview with R #23 she stated that she is on hospice (care and services for people nearing the end of life). C. Record review of R #23's MDS dated [DATE], revealed R #23 is not on hospice. D. Record review of R #23's electronic health record (EHR) revealed the following: 1. R #23's current clinical census showed Hospice Medicaid was started on 05/01/25. 2. An order dated 05/08/25 for hospice service to start effective 05/01/25. 3. A Significant Change MDS dated [DATE] revealed as In Progress indicated the assessment was started but not completed. E. On 06/13/25 at 12:30 pm, during an interview with the MDS Coordinator, she stated that she expects all Significant Change MDS assessments to be completed within 14 days and confirmed that R #23's was not.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 5 (R #2, R #23, R #54, R #56 and R #75) of 5 (R #2, R #23, R #54, R #56 and R #75) residents reviewed when staff failed to: 1. Update R #2's care plan to include the use of a trapeze bar (a short horizontal bar that is suspended from two ropes) for mobility. 2. Update R #23's and R #54's plan of care to include hospice (care and services for people nearing the end of life). 3. Update R #56's care plan to remove the use of a communication board (a tool used to help people with limited language skills or who are nonverbal to communicate) with word cards. 4. Update R #75's plan of care to include advanced directive. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #2 A. On 06/10/25 at 1:46 pm, an observation of R #2's room revealed a trapeze bar at the head of R #2's bed. B. Record review of R #2's face sheet revealed he was originally admitted to the facility on [DATE] with the following diagnoses. 1. Unsteadiness on Feet, 2. Unspecified Lack Of Coordination, 3. Muscle Weakness, 4. Multiple Sclerosis (a chronic disease that affects the brain and spinal cord), 5. Myoneural Disorder (conditions affecting where nerves and muscles communicate). C. Record review of R #2's care plan dated 06/28/24 revealed no interventions for the use of a trapeze bar. D. On 06/10/25 at 1:48 pm during an interview with R #2, he stated he uses the bar to help with repositioning himself while in bed. E. On 06/12/25 at 12:32 pm during an interview with the Director of Nursing (DON), she confirmed R #2's care plan was not revised to include the use of a trapeze bar and should have been. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #23 F. Record review of R #23's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Major depressive disorder (depression; a mood disorder that causes a persistent feeling of sadness and loss of interest), 3. Cerebral aneurysm (a weak spot on an artery in the brain that fills with blood), 4. Chronic heart failure (an ongoing inability to pump enough blood through the body causing an insufficiency of oxygen). G. Record review of R #23's care plan dated 05/01/25 revealed a focus area indicated R #23 has a terminal diagnosis of COPD and has the following interventions listed: 1. Adjust provision of ADLS (activities of daily living) to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate dated 02/28/24. 2. Assess resident coping strategies and respect resident wishes dated 02/28/24. 3. Consult with physician and Social Services to have hospice care for resident in the facility dated 02/28/24. 4. Encourage resident to express feelings, listen with non-judgmental acceptance, compassion dated 02/28/24. 5. Encourage support system of family and friends dated 02/28/24. 6. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free dated 02/28/24. 7. Keep lighting low and familiar objects near dated 02/28/24. 8. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain dated 02/28/24. 9. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met dated 02/28/24. 10. Work with nursing staff to provide maximum comfort for the resident dated 02/28/24. H. On 06/13/25 at 12:53 pm, during an interview with the Assistant Director of Nursing (ADON) #2, she stated R #23 was previously on hospice and was taken off hospice in 2024. ADON #2 stated that all interventions listed in R #23's care plan for hospice are over one year old. ADON #2 confirmed there are no current interventions included in R #23's care plan for hospice. R #54 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #54's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic kidney disease (kidneys are damaged and gradually lose ability to filter blood effectively), 2. Unspecified heart failure (condition where the heart cannot pump enough blood to meet the body's needs), 3. Gastroesophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining), 4. Adult failure to thrive (a syndrome that describes a decline characterized by weight loss, decreased appetite, poor nutrition, inactivity and often accompanied by dehydration, depressive symptoms, and impaired immune function, among others). J. Record review of R #54's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 05/20/25, revealed R #54 is on hospice. K. Record review of R #54's comprehensive care plan last revised on 05/23/25, revealed no mention of hospice care. L. On 06/13/25 at 12:53 pm, during an interview with ADON #2, she confirmed that R #54 is on hospice and hospice is not included R #54's care plan. ADON #2 stated her expectation is for a resident's care plan to be revised to include hospice if or when it becomes relevant to the resident. R #56 M. Record review of R #56's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Cognitive Communication Deficit (difficulties in communication arising from impairments in mental processes), 2. Dementia (a decline in mental ability severe enough to interfere with daily life). N. Record review of R #56's care plan dated 03/13/24 revealed a focus for cognitive communication deficit with the following approaches: 1. Ask simple questions that require short answers 2. Listen attentively and allow time to communicate 3. Use communication board with word cards 4. Speak slowing and clearly while facing resident 5. Use gestures an body movements. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. On 06/11/25 an observation of R #56 room revealed there was no communication board with word cards available for use. P. On 06/12/25 at 3:48 pm during an interview with Certified Nursing assistant (CNA) #3, she confirmed R #56 communicates by answering yes or no questions. She stated R #56 also uses nonverbal communication that require staff to pay attention to his body movements. CNA #3 confirmed R #56 does not have a communication board with word cards available. Q. On 06/13/25 at 12:32 pm during an interview with the Director of Nursing (DON), she stated R #56 does not have a communication board. The DON stated that the facility attempted to use a communication board and word cards with R #56, but it was ineffective. The DON could not remember the date of this trial. The DON confirmed the care plan should have been revised and was not. R #75 R. Record review of R #75's admission record revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Spinal Stenosis, cervical region (narrowing of one or more spaces within the spinal canal), 2. Type 2 diabetes mellitus with hyperglycemia (blood sugar levels rise significantly), 3. Depression, unspecified, 4. Chronic diastolic (congestive) heart failure. S. Record review of R #75's order dated 05/29/25, revealed an order for an advance directive of (do not resuscitate: DNR; lifesaving measures are not desired) code status in place. T. Record review of R #75's care plan dated 06/03/25 revealed R #75 was missing the advance directive for a DNR on his care plan. U. Record review of R #75's New Mexico Orders for Scope and Treatment (MOST) form dated 05/29/25 revealed R #75 has an advance directive of DNR code status in place. V. On 05/29/25 at 12:20 pm during an interview with the DON, she confirmed the facility failed to revise the care plan for R #75 after confirming his advance directive DNR code status.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, record review and interview, the facility failed to ensure the medication error rate did not exceed 5 percent (%) when staff performed 3 medication errors out of 29 opportunities for 3 (R #39, R #43, R #76) of 4 (R #36, R #39, R #43, R #76) residents reviewed during medication administration. This resulted in a medication error rate of 10.34%. This deficient practice could likely result in the spread of infectious agents (viruses and bacteria) between the residents. The findings are: A. On 06/12/25 at 9:40 am, during an observation of Certified Medication Aide (CMA) #1 revealed the following: 1. CMA #1 did not clean the blood pressure cuff and vital sign equipment prior to taking vital signs for R #76. 2. CMA #1 then failed to sanitize her hands before beginning her medication pass for R #39. 3. CMA #1 then failed to put gloves on (don) gloves to open a capsule for R #43. B. On 06/12/25 at 10:15 am during an interview with CMA #1, she confirmed she should have sanitized her hands before beginning the medication pass for R #39. She confirmed she should have sanitized all vital sign equipment before taking R #76's vitals and in between each resident afterwards. She confirmed she should have donned (put on gloves) gloves before she opened the capsule to pour the medication in the medicine cup for R #43. C. On 06/12/25 at 10:25 am during an interview with the Director of Nursing (DON), she confirmed she would expect all nursing staff to perform hand hygiene before and after each medication pass for each resident. She confirmed she would expect all nursing staff to sanitize the vital machines before and after use with each resident. She confirmed she would expect all nursing staff to don (put on gloves) gloves before touching any medications for any of the residents. D. Record review of the Medication-Administration policy (not dated), provided by the Administrator (ADM) on 06/12/25, under the heading Procedure point number 2, wash hands before and after medication administration. E. Review of CDC guidelines Guideline for Disinfection and Sterilization in Healthcare Facilities, dated 2008, Section 4.c., stated staff should ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis, such as after use on each patient or once daily or once weekly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, and interview, the facility failed to store and serve food under sanitary conditions by not ensuring food items stored in facility's freezer were labeled and dated. This deficient practice is likely to affect 76 residents listed on the resident census list provided by the Administrator on 06/09/25 and could likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 06/09/25 at 11:03 am during observation of the facility's walk in freezer the following items were found open and undated: 1. Two bags of what appeared to be hash browns. 2. Two bags of what appeared to be French fries. B. On 06/09/25 at 11:05 am during an interview with the Dietary Manager (DM), he confirmed the items were not labeled and dated. DM stated that doesn't meet his expectations and everything in the fridge/freezer should be labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interviews, the facility failed to maintain proper infection prevention practices for 3 (R #39, R #43, and R #76) of 4 (R #36, R #39, R #43, and R #76) residents. This deficient practice could likely result in the spread of infectious agents (viruses and bacteria) between the residents. The findings are: A. On 06/12/25 at 9:40 am, during an observation of Certified Medication Aide (CMA) #1 revealed the following: 1. CMA #1 did not clean the blood pressure cuff and vital sign equipment prior to taking vital signs for R #76. 2. CMA #1 then failed to sanitize her hands before beginning her medication pass for R #39. 3. CMA #1 then failed to put gloves on (don) gloves to open a capsule for R #43. B. On 06/12/25 at 10:15 am, during an interview with CMA#1, she confirmed she should have sanitized her hands before beginning the medication pass for R #39. She confirmed she should have sanitized all vital sign equipment before taking R #76's vitals and in between each resident afterwards. She confirmed she should have donned (put on gloves) her gloves before she opened the capsule to pour the medication in the medicine cup for R # 43. C. On 06/12/25 at 10:25 am, during an interview with the Director of Nursing (DON), she stated she would expect all nursing staff to perform hand hygiene before and after each medication pass for each resident. She confirmed she would expect all nursing staff to perform hand hygiene before and after each medication pass for each resident. She confirmed she would expect all nursing staff to sanitize the vital machines before and after use with each resident. She confirmed she would expect all nursing staff to don (put on gloves) gloves before touching any medication for any of the residents.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure call lights in the residents' rooms were within reach of the residents while in the room for 2 (R #22 and R #56) of 4 (R #2, R #8, R #22, and R #56) residents reviewed for call lights. This deficient practice could likely result in residents being unable to notify staff when they are in need of assistance. The findings are: R #22 A. On 06/12/25 at 10:34 am during an observation of R #22's room revealed R #22 was asleep in her recliner. The call light laid on top of the bed where she could not reach it. B. On 06/12/25 at 10:36 am during an interview with Hospice Nurse (HN) #1, she confirmed the call light was not within R #22's reach and the call light should have been. R #56 C. On 06/11/25 at 8:58 am during an observation of R #56's room, revealed R #56 was asleep in his recliner. The call light laid on top of the bed where he could not reach it. D. On 06/11/25 at 9:05 am during an interview with Certified Nurse Assistant (CNA) #2, she confirmed the call light was not within R 56's reach and the call light should have been.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the hallway was accessible for residents. This deficient practice could likely result in residents living in an unsafe environment, could increase their risk for injuries, and decrease their quality of life. The findings are: A. On 06/09/25 at 8:10 am a random observation of the [NAME] Wing revealed the following: 1. A medication cart on the right side of the hallway near room [ROOM NUMBER]. 2. A shower chair on the left side of the hallway near room [ROOM NUMBER]. B. On 06/09/25 at 8:18 am during an interview with the Restorative Nursing Aide (RNA), she confirmed there were objects on both sides of the hallway blocking the residents' path. She stated that everything should be on one side of the hallway, so residents had a clear path. C. On 06/10/25 at 8:46 am a random observation of South Wing revealed the following: 1. A medication cart on the right side of the hallway near room [ROOM NUMBER]. 2. A medication cart on the left side of the hallway near room [ROOM NUMBER]. D. On 06/10/25 at 8:48 am during an interview with Certified Medication Aide (CMA) #1, she confirmed there were objects on both sides of the hallway blocking the residents' path. She stated that everything should be on one side of the hallway.