

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 08/10/2020
NAME OF PROVIDER OF SUPPLIER CORONADO NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 0842 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices, for 11 out of 11 residents whose records were reviewed for accuracy and completeness in that: The facility did not initiate an admission/discharge inventory of medications for all residents whose records were reviewed. This failure could place the residents at risk of having incomplete/inaccurate records and at risk for not having sufficient information documented in the clinical records of their medications admitted /discharged with. The findings included: Residents 1 through 11 were admitted from Facility A between 07/13/2020 and 07/24/2020; discharged between 07/21/2020 and 07/28/2020 to Facility A or family. Medication reconciliation sheets on admission/discharge for residents #1,2,3,4,5,6,7,8,9,10 & 11 were missing from medical charts and could not be produced by Facility B. Interview on 7/31/2020 at 11:30am with Director of Nurses (DON) who stated that he/she was unaware of missing medication reconciliation sheets. Stated he/she expects the nurses to follow policy. Interview on 7/31/2020 at 4:20pm with RN A who stated that when the residents were transferred from facility A, the resident's medications were all mixed together in a brown paper bag. Stated that he/she did not fill out medication reconciliation sheets and does not remember there being any narcotics in the bag that he/she received. Interview on 7/31/2020 at 4:24pm with LVN A who stated that he/she was not on duty when the residents who transferred from facility A arrived. LVN A stated he/she was the nurse preparing the residents for discharge to facility A. LVN A stated that he/she prepared the medications to be given to Facility A upon discharge. He/She stated he/she did not fill out a medication reconciliation sheets to review with Facility A staff at discharge. Review of Policy and Procedure Discharge Medications dated 12/2016 documented; The nurse will reconcile pre-discharge medications with the resident's post-discharged medications. The medication reconciliation will be documented. The nurse shall review medication instructions with the resident representative before the resident leaves the facility. The nurse shall complete the medication disposition recorded, including .signature of the person receiving the medications; and .the nurse releasing the medications.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE (X6) DATE	

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.