STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295099	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Ridge Skilled Nursing & Rehabilitation	2855 W. Horizon Ridge Parkway Henderson, NV 89052

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review and document review, the facility failed to ensure informed consent was obtained prior to administration of psychotropic medications for 1 of 4 sampled residents (Resident 1). The deficient practice potentially deprived the resident and/or resident representative of the right to be informed of the medications' risks, benefits and potential side effects. Findings include: Resident 1 (R1) R1 was admitted on [DATE], with diagnoses including puncture wound of right lower leg and fracture of upper and lower end of right fibula (a lower leg bone) and Alzheimer's disease. R1's medical record contained a legal document which revealed R1 had appointed a family member to be R1's legal representative or power of attorney (POA). A physician's order dated 09/02/2024, documented to give Buspirone (anti-anxiety) hydrochloride five milligrams (mg) by mouth two times a day for anxiety as evidenced by verbalization of feeling anxious and being uncooperative. The medical record lacked documented evidence an informed consent was obtained for R1's Buspirone prior to first administration on 09/03/2024. A physician's order dated 09/04/2024, documented to give Mirtazapine (anti-depressant) 7.5 mg by mouth one tablet at bedtime for anxiety as evidenced by being verbally abusive. The medical record lacked documented evidence an informed consent was obtained for R1's Mirtazapine prior to first administration on 09/05/2024. A physician's order dated 09/06/2024, documented to give Depakote (mood-stabilizer) 125 mg delayed release by mouth two times a day for agitation and aggressive behavior. The medical record lacked documented evidence an informed consent was obtained for R1's Depakote prior to first administration on 09/07/2024. (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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/02/2025 at 9:53 AM, the Director of Staff Development (DSD) explained informed consent forms were completed every time psychotropic medications (drugs which affect the brain and nervous system to treat mental illnesses and conditions which impact mind, emotions and behaviors) were ordered for a resident. According to the DSD, nurses were trained to explain the medication's purpose, risks, benefits and potential side effects to the resident and/or representative prior to administering the first dose. After discussion, the nurse would they themselves sign the document and obtain a signature from the resident or representative. On 01/02/2025 at 11:17 AM, a Registered Nurse (RN) who was familiar with R1 recalled the resident had been on a few psychotropic medications while at the facility. The RN explained informed consent forms were completed and signed by the nurse and residents and/or representative, but the RN could not recall if the RN was assigned to R1 when the medications were ordered by the physician. The RN explained two nurses would obtain a verbal consent from the representative by phone and the two nurses would sign the informed consent form if the resident's representative was not available. On 01/02/2025 at 12:27 PM, the Assistant Director of Nursing (ADON) indicated nurses were trained to complete informed consent forms for each psychotropic medication order. The informed consent form included information such as name of the medication, dose and frequency, indication for use, drug classification, target behaviors, risk and benefits and potential side effects. According to the ADON the completion of the form signified the resident and/or representative received education regarding the medication to include possible side effects and still consented to receive the medication. The ADON corroborated the DSD and RN's explanation on the facility's process where the nurses completing the form would obtain a signature from the alert resident, appointed representative or telephonically with two nurse's signatures. On 01/02/2025 at 12:38 PM, the DON reviewed R1's medical record and confirmed there were no consent forms completed for the resident's psychotropic medications. The DON indicated expecting nurses to complete a consent form every time a psychotropic medication was prescribed by a physician to treat psychiatric disorders. The DON confirmed the facility did not follow its antipsychotic use policy. On 01/02/2025 at 1:15 PM, the Consultant Pharmacist indicated medications such as Buspirone, Mirtazapine and Depakote all required informed consents primarily because it was a regulatory requirement to inform the resident and/or representative of risks and potential side effects with psychotropic medications prior to first administration. The pharmacist explained while Depakote was an anti-epileptic drug it was commonly used for bipolar disorder and dementia residents with behaviors as a mood stabilizer since the drug was known to decrease impulsivity. The Use of Antipsychotic Medications policy revised July 2022, documented residents would only receive antipsychotic medications when necessary to treat specific conditions for which they were indicated. Residents and/or their representatives would be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. The Psychotropic Drug Informed Consent form included the following information: psychotropic drug order, medical diagnosis, drug classification (e.g. anti-anxiety, mood stabilizer, hypnotic, anti-psychotic), risk versus benefits, drug purpose, possible side effects, date of informed consent, date and signature of licensed nurse and resident or resident representative.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 50289 Based on interviews, record review, and document review, the facility failed to ensure a care plan was initiated after a resident alleged physical abuse from a staff member for 1 of 4 sampled residents (Resident 3). The deficient practice placed the resident at risk for inappropriate care, supervision, and incidents. Findings include: Resident 3 (R3) R3 was originally admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage, encephalopathy, old myocardial infarction, essential hypertension, and dysphagia. Facility documentation revealed the resident had reported to direct care nursing staff, a certified nursing assistant (CNA) described as a female, was rough when handling the resident during peri care and resident was hit on the forearm/hand. The resident reported this to the direct care staff at approximately 8:55am who then reported it immediately to the administrator. On 01/02/2025 at 2:26pm, R3 stated one of the staff had hit R3 on the hand for no reason. R3 stated the staff member just came into the room and hit R3. R3 had told the other CNAs and caregivers this staff person hit R3. R3 remembered the incident but was unable to expand upon the details of the incident at this time of this interview. Facility documentation revealed, the facility noted the family of R3 indicated R3 had a history of false allegations against care staff at other facilities. The facility also documented would revise the care plans to include their Cares in Pairs program (two staff members during resident care) in relation to this resident's accusation of abuse. The facility lacked documented evidence the Cares in Pairs program was care planned as of the incident date of 10/21/2024 up to the survey date of 01/02/2025 at 8:00am. There were no psychosocial/behavioral care plans regarding the resident's potential/tendencies to make false allegations toward staff/others with goals and interventions to safeguard the resident from repeated behavior. On 01/02/2025 a Licensed Practical Nurse (LPN) was asked if the LPN was aware this resident was supposed to be Cares in Pairs, the LPN stated was not aware R3 was Cares in Pairs. On 01/02/2025, a CNA exiting R3's room stated R3 does not require two people to assist with care as the resident was easy to complete tasks with just one person. The only time R3 needed two people was when they needed to transfer the resident. Because R3 is total assist with transfers, two people are required for the safety of both the resident and the staff during the transfer. When asked if the CNA was aware this resident was supposed to be Cares in Pairs, the CNA stated was not aware R3 was Cares in Pairs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 01/02/2025 at 3:53 pm, the DON stated R3 was a Cares in Pairs resident which means two caregivers were required for the resident's care. The DON acknowledged there was no care plan related to this incident and agreed it would have been beneficial to have this allegation incident care planned to say what interventions the staff were doing, and should be doing, to not have this incident happen again. The facility's policy titled Care Plans, Comprehensive Person-Centered, documents a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs will be developed and implemented for each resident no more than 21 days after admission. The care plan interventions are to be derived after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.