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	04/16/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on interview, record review, and document review, the facility failed to ensure the resident's pain medication was administered as ordered and appropriately managed for 1 of 5 sampled residents (Resident 1), and the pain was timely assessed for 1 of 5 sampled residents (Resident 3). This deficient practice had the potential to result in unmanaged pain, delayed relief, and decreased quality of life for the affected residents. Findings include: A facility policy titled Pain-Clinical Protocol revised October 2022, documented the nursing staff would assess each individual for pain upon admission to the facility, whenever there was a significant change of condition, and when there was an onset of new pain or worsening of existing pain. Resident 1 (R1) R1 was admitted on [DATE], readmitted on [DATE], and discharged on [DATE], with diagnoses including fracture of the first lumbar vertebra, long-term use of opiates, and complex regional pain syndrome. A care plan initiated on 11/13/2024 documented R1 was at risk for pain related to generalized body pain, impaired mobility, history of falls, and self-care deficit. The goal was for R1 to voice or demonstrate a level of comfort within 30 minutes to 1 hour after interventions were rendered. Pain was to be managed through the review date. The Admission Minimum Data Set, dated dated dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognitive status. The pain assessment indicated over the 5-day assessment period, R1's pain almost constantly affected the ability to sleep at night and interfered with therapy activities. The Physician Progress Notes dated 12/13/2024, documented on 12/04/2024, R1 had difficulty tolerating physical therapy due to pain. On 12/06/2024, pain continued to be reported as a barrier by both the resident and therapy staff. The physician reviewed medications and discussed the ongoing pain issue. As a result, the Hydromorphone (Dilaudid) dosage was increased from 4 milligram (mg) to 6 mg every 4 hours, with instructions to monitor R1 closely. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Order dated 11/30/2024, documented Hydromorphone 4 mg every 4 hours as needed. A subsequent Physician Order dated 12/06/2024, documented an increase in the Hydromorphone dosage to 6 mg every 4 hours as needed. The Medication Administration Record (MAR), documented continued administration of Hydromorphone 4 mg from 12/06/2024 until R1's discharged on [DATE], despite the new order for 6 mg. A review of R1's medical records from 12/06/2024 to 12/17/2024, revealed a lack of documented evidence the increased Hydromorphone 6 mg dosage was administered as ordered to manage R1's pain. On 04/16/2025 at 11:56 AM, the Nurse Supervisor confirmed the new order for Hydromorphone 6 mg was received and confirmed on 12/06/2024 but was not administered as prescribed. The Nurse Supervisor explained the previous order for 4 mg had not been discontinued, but the dosage increase was communicated to the assigned nurse. The Nurse Supervisor verbalized a pain assessment should have been performed due to the increased dose but was not completed. On 04/16/2025 at 12:15 PM, a Registered Nurse (RN) assigned to the resident was uncertain why the Hydromorphone 6 mg was not administered as ordered. The RN conveyed the duplicate pain medication orders with the same frequency should have been clarified and documented, but there was no documentation it was done. The Occupational Therapy Treatment Encounter dated 12/09/2024, documented the Occupational Therapist (OT) arrived in R1's room and instructed R1 to begin getting out of bed. R1 stated a pain pill was needed. The OT reminded R1 the pain medication had been administered, and another dose could not be given until 4 hours had passed. R1 continued to argue with the OT and R1 was observed in severe pain. On 04/16/2025 at 2:39 PM, the OT confirmed R1 had complained of an increased level of pain and on occasions, R1 had declined therapy because the pain medication was either not administered or was ineffective. The OT acknowledged the pain had been an ongoing issue for R1. On 04/16/2024 at 2:33 PM, the Physical Therapist (PT) verified R1's previous treatment and explained R1 required standby assistance for bed mobility and minimal assistance for transfers and ambulated 10 feet with a walker using minimal assistance. The PT indicated R1's pain was reported at a pain level increased to 10 out of 10 on 12/06/2024. The PT explained the pain medication was vital for a resident receiving therapy to promote participation in therapy sessions. The PT indicated R1 was discharged from therapy services after leaving against medical advice. On 04/16/2024 in the afternoon, the Director of Nursing (DON) indicated the physician should have discontinued the previous order once the dosage was increased. The DON indicated the facility staff should adhere to the physician's prescribed orders to effectively manage the resident's pain. 41903 Resident 3 (R3) R3 was admitted [DATE] and discharged [DATE] with diagnosis including displaced intertrochanteric fracture of right femur, difficulty in walking, and need for assistance with personal care. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Weekly Skin Evaluation dated 02/12/2025, documented the following were identified during an admit wound care evaluation: Right lateral knee surgical incision, right medial knee surgical incision, right knee front surgical incision, right lower thigh surgical incision, right upper thigh surgical incision, and bilateral heels type protective. A Care Plan dated 02/13/2025, documented the resident had chronic pain. A Vitals and Pain Only Evaluation dated 02/11/2025 at 21:38, documented R3's vital signs were obtained on 02/11/2025 at 9:28 PM. The pain assessment section of the evaluation form documented a pain assessment was performed on 02/12/2025 at 7:22 AM. The Vitals and Pain Only Evaluation form lacked documented evidence a pain assessment was performed for R3 upon admission on 02/11/2025 and a pain assessment was not completed until 02/12/2025 at 7:22 AM. On 04/16/2025 at 2:25 PM, the Director of Nursing (DON) confirmed R3's Vitals and Pain Only Evaluation performed upon admission 02/11/2025 at 9:38 PM lacked documented evidence R3 was assessed for pain upon admission. The DON acknowledged the first documented pain assessment for R3 was completed on 02/12/2025 at 7:22 AM. The DON confirmed there was no documented evidence the resident was assessed for pain at admission. The DON confirmed R3 should have been assessed for pain upon admission. On 04/16/2025 at 3:35 PM, a Registered Nurse (RN), explained a pain assessment should have been done as part of the initial assessment upon admission. The RN reported if the pain assessment was not done, pain would not have been identified, orders for pain medication would not have been requested timely and the resident could have remained in pain for an extended period of time unnecessarily. A facility policy titled Pain Management, revised October 2022, documented the nursing staff would assess each individual for pain upon admission to the facility.