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	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Ridge Skilled Nursing & Rehabilitation Ce	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review, the facility failed to provide documented evidence of the actions taken and follow-up made after the facility was notified of a reported positive case of Legionella (a bacteria which caused Legionnaires' disease by spreading through contaminated water mist, not water itself, which people inhale) for a resident who was discharged from the facility on 08/02/2025 and tested Legionella Polymerase Chain Reaction positive (PCR test was a laboratory technique used to detect and amplify specific genetic sequences, such as those from viruses or bacteria) at a hospital on [DATE] for 1 of 9 sampled residents (Resident 1). The deficient practice had the potential to prevent early detection and possible transmission of infection among the residents.Findings include:Resident 1 (R1) was admitted on [DATE] and discharged on 08/02/2025, with diagnoses including cerebral edema, urinary tract infection, Escherichia Coli (E. Coli), and dependence on supplemental Oxygen. The Hospital Transfer form dated 08/02/2025, documented R1 was sent to a hospital on [DATE] at 5:40 PM. The reason for transfer was altered mental status. The Nurse's Notes dated 08/02/2025, documented the physician ordered to send R1 to the hospital. The American Medical Response (AMR) ambulance came and picked up R1 at 5:40 PM. The hospital's Emergency Department (ED) Physician Notes dated 08/02/2025, documented the provider contact time was 08/02/2025 at 5:52 PM. The chief complaints were altered mental status and shortness of breath. R1's hospital test results documented the following:Legionella species by qualitative PCR: DetectedDate/Time: 08/04/2025 at 10:55 AM Pacific Daylight Time (PDT)Legionella Source: NasopharyngealLegionella pneumophila by PCR: DetectedLegionella species by qualitative PCR: DetectedSource Type: Nasopharyngeal swabSource: Collected on 08/04/2025 at 10:55 AM PDTInterpretive Information: Legionella species by qualitative PCR(Legionella species was the broad [NAME] of bacteria, while Legionella pneumophila was a specific species within that [NAME] and the most common cause of Legionnaires' disease.) On 09/03/2025 at 11:53 AM, the Infection Preventionist (IP) Nurse revealed the duties and responsibilities of an IP Nurse included surveillance, prevention, and reporting of infections and overseeing the infection prevention program of the facility. The IP Nurse explained a community-acquired infection referred to an infection which was present on admission and the symptoms were manifested within 48 hours upon a resident's admission. The IP Nurse indicated a healthcare-associated infection (HAI) referred to an infection acquired at the facility and the symptoms developed after 48 hours from admission. On 09/03/2025 at 12:24 PM, the IP Nurse confirmed receiving a phone call from the hospital on [DATE] in the morning about R1 being tested positive for Legionella. The IP Nurse revealed not asking questions about the resident. After the phone call, the IP Nurse spoke to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) and relayed the information about the resident who was tested positive for Legionella at the hospital. The IP Nurse asked the DON and ADON on when was the last time the water system was tested for Legionella. The IP Nurse revealed being directed to the Maintenance Director. The IP Nurse indicated calling the Maintenance Director who told the IP Nurse the water system was tested in February 2025 for Legionella and the results were negative. The IP Nurse had another conversation with the Maintenance Director and the IP Nurse was told the facility would no longer test for Legionella because of the negative results in February 2025. The IP Nurse revealed after the phone call from the hospital, the IP Nurse reviewed R1's medical record including the chest X-ray results on 07/11/2025 which showed no infiltrates. The IP Nurse indicated R1 had no symptoms of pneumonia and the hospital transfer on 08/02/2025 was not related to pneumonia. The IP Nurse acknowledged they should have asked the hospital more questions about R1 such as the date when the resident was tested positive for Legionella and if the resident was symptomatic. The IP Nurse explained the conversation or the phone call with the hospital should have been documented. The IP Nurse confirmed not documenting the information received from the hospital about R1 being tested positive for Legionella. The IP Nurse indicated the details of the information that R1 was tested positive for Legionella could have been presented and discussed with the DON and ADON for further actions such as initiating an investigation, testing the water system for Legionella and resident tracking/tracing. The IP Nurse acknowledged by knowing the date the resident was tested positive for Legionella, the facility could have determined if the Legionella was acquired at the facility or not. The IP Nurse explained the water system should have been tested for Legionella, tracing or surveillance should have been done. The IP Nurse revealed Legionella was a reportable disease and should have been reported