

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Coronado Ridge Skilled Nursing & Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to establish and implement an enteral nutrition regimen for a resident after accepting the resident for admission, resulting in the resident receiving no enteral nutrition and only 240 milliliters (ml) of water flushes during the resident's stay at the facility for 1 of 37 sampled residents (Resident 128). The deficient practice had the potential to result in inadequate nutrition, dehydration, and avoidable decline in the resident's condition. Additional deficient practice was identified in connection with this F600 citation: Refer to F628 (Transfer and Discharge Process): the facility failed to ensure a resident's transfer was coordinated by failing to contact, make prior arrangements for the transfer, confirm the receiving facility agreed to accept the resident, communicate the resident's enteral nutrition needs, document the discharge process in the medical record, and provide a telephone report to the receiving facility prior to transfer. This breakdown in transfer safety metrics left the resident vulnerable without continuous clinical oversight, compounding the care and nutrition neglect cited under F600. Refer to F693 (Enteral Nutrition): the facility failed to verify the resident's prescribed enteral nutritional orders and ensure the necessary enteral formula was available prior to accepting the resident for admission, and after admission failed to implement an enteral nutritional regimen. This pre-admission and post-admission clinical failure directly caused the wholesale lack of therapeutic nutrition and systemic hydration neglect identified under this F600 citation. Findings include: Resident 128 (R128) was admitted [DATE] and discharged [DATE], with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction, gastrostomy status, and aphasia following cerebral infarction. A Care Plan dated 04/01/2026, documented R128 had a swallowing problem, was admitted with an abdominal gastrostomy tube (G-tube) related to impaired oral intake, received enteral feedings related to dysphagia and was at risk of dehydration. R128's medical record lacked documented evidence of the following: - A physician order for an enteral feeding formula following admission. - An enteral nutrition regimen was implemented during R128's admission at the facility from 03/31/2026 through 04/01/2026. - The facility offered alternative enteral feeding formulas or intravenous (IV) fluids. - Enteral nutrition was provided during R128's stay at the facility. A Medication Administration Record (MAR) for April 2026, documented a bolus of flush gastrostomy (G) tube with water for a total volume of 240 milliliter (ml) every 4 hours, start date 04/01/2026. The MAR documented R128 received one 240 ml water flush on 04/01/2026. R128's medical record lacked documented evidence of any additional water flushes during R128's stay at the facility. On 07/23/2026 at 10:35 AM, the Registered Dietitian (RD), reported beginning employment at the facility on 06/01/2026 and was not employed at the time of R128's admission. The RD recalled previously caring for R128 at another facility and indicated R128 was vegan and wanted a specific vegan or plant-based tube feeding (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enteral formula brand and sent a message to the Dietitian. The RN reported the facility purchased four bottles of the enteral formula preferred by R128 at a local grocery store and the RN administered two bottles of the enteral formula. The RN explained the Dietitian at the time, R128 required 12 bottles of the enteral formula per day, and the facility could not supply that amount of formula to cover the two days of feedings necessary until the facility received the enteral feeding formula order. The RN was unable to explain why only two bottles of enteral formula were administered or how the determination was made to administer R128 only two bottles of formula. The RN acknowledged R128's medical record lacked a physician order for enteral feeding formula. The RN acknowledged failing to document their actions in R128's medical record, including the alleged administration of two bottles of enteral formula, and offers of alternate enteral formulas. The RN reported providing the remaining two bottles of enteral formula to R128 to take to the receiving facility at discharge. On 07/24/2026 at 10:22 AM, the Administrator acknowledged options offered to R128 should have been documented in R128's medical record. A facility policy titled Abuse and Neglect, Clinical Protocol revised March 2018, documented neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility management and staff would institute measures to address the needs of residents and minimize the possibility of abuse and neglect. Complaint #2972095		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a resident's transfer was coordinated by failing to contact, make prior arrangements for the transfer, confirm the receiving facility agreed to accept the resident, communicate the resident's enteral nutrition needs, document the discharge process in the medical record, and provide a telephone report to the receiving facility prior to transfer for 1 of 37 sampled residents (Resident 128). The deficient practice had the potential to result in the resident transferring to a facility unprepared to receive the resident, meet the resident's care needs, and result in additional delays in receiving enteral nutrition. Additional deficient practice was identified in connection with this F628 citation: Refer to Tag F600 (Free from Abuse/Neglect): The facility failed to establish and implement an enteral nutrition regimen for a resident after accepting them for admission, resulting in the resident receiving no documented enteral nutrition and only 240 milliliters (ml) of water flushes during their stay. This total lack of therapeutic nutrition and systemic care neglect directly escalated the urgency of the poorly coordinated transfer cited under F628. Refer to Tag F693 (Enteral Nutrition): The facility failed to verify the resident's prescribed enteral nutritional orders and ensure the necessary enteral formula was available prior to admission. This failure necessitated the emergency transfer, which was then executed without proper communication or facility-to-facility coordination. Findings include: Resident 128 (R128) was admitted [DATE] and discharged [DATE], with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction, gastrostomy status, and aphasia following cerebral infarction. A Care Plan dated 04/01/2026, documented R128 had a swallowing problem, was admitted with an abdominal gastrostomy tube (G-tube) related to impaired oral intake, and received enteral feedings related to dysphagia. A physician order dated 04/01/2026, documented an order to send R128 to the receiving facility for MIC-KEY (a brand of gastrostomy tube) dietary needs. R128's medical record lacked documented evidence of the following: - The receiving facility was contacted regarding R128's discharge and transfer. - The receiving facility agreed to accept R128 or was aware R128 would be transferred. - The receiving facility was informed of R128's enteral nutritional needs. - A telephone report was given to the receiving facility prior to R128's transfer. On 07/23/2026 at 11:46 AM, the Case Manager acknowledged the receiving facility should have been called regarding R128's transfer and the facility should have received approval from the receiving provider prior to discharged. The Case Manager confirmed R128's medical record lacked documented evidence the receiving facility was contacted. The Case Manager explained they were the only staff member at the facility who contacted the receiving facility via email. The Case Manager acknowledged the medical record lacked documented evidence of the Case Manager's contact with the receiving facility and acknowledged the communication with the receiving facility should have been entered in R128's medical record and reported the emails had been purged from the facility's email account and could not be recovered. On 07/23/2026 at 2:20 PM, the Director of Nursing (DON), acknowledged R128's medical record lacked documented evidence the receiving facility was contacted regarding R128's transfer. The DON reported communication with the receiving facility may have been via email and explained facility emails were purged approximately every couple of months. The DON reported they did not know why it took so long to transfer resident out when the concern with the enteral feeding formula was identified. The DON indicated options may have been discussed or offered but acknowledged R128's medical record lacked documented evidence of any care, discussions or actions. On 07/24/2026 at (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:50 AM, the Director of Nursing (DON), acknowledged R128's medical record lacked documented evidence of the process, including communication with the receiving facility, notification the resident was sent to the receiving facility and details of the transportation used to transfer the resident. On 07/24/2026 at 10:01 AM, a Registered Nurse (RN), acknowledged they did not document the RN's actions in R128's medical record including the process of R128's discharge. The RN explained they were not involved in R128's discharge and did not perform a telephone report to the receiving facility because the RN assumed R128 was expected at the receiving facility. On 07/24/2026 at 10:22 AM, the Administrator acknowledged R128's discharge process and communication with the receiving facility should have been documented in R128's medical record. The Administrator was unable to provide any documented evidence the receiving facility was informed of the resident's transfer. The facility was unable to provide documented evidence of emails sent to the receiving facility regarding R128's transfer. A facility policy titled Discharging the Resident revised December 2016, documented preparation for resident discharge included if the resident was being discharged to a hospital or another facility, the facility was to ensure a transfer summary was completed and telephone report was called to the receiving facility. Documentation including the date and time of the discharge, all assessment data obtained during the procedure, and how the resident tolerated the procedure. A facility policy titled Transfer or Discharge, Facility-Initiated, dated October 2022, documented information conveyed to the receiving provider included the basis for the transfer or discharge. If the resident was being transferred or discharged because their needs cannot be met at the facility documentation should have included the basis for the transfer or discharge, the specific resident needs that cannot be met, the facility's attempt to meet those needs and the receiving facility's services that were available to meet those needs and special instructions or precautions for the care of the resident. Complaint #2972095		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to verify a resident's prescribed enteral nutritional orders and ensure the necessary enteral formula was available prior to accepting the resident for admission, and after admission failed to implement an enteral nutritional regimen for 1 of 37 sampled residents (Resident 128). The deficient practice had the potential to result in delayed implementation of the resident's prescribed enteral nutrition regimen, inadequate nutritional and hydration support, compromised nutritional status, and avoidable decline. Additional deficient practice was identified in connection with this F693 citation. Refer to: Refer to Tag F628 (Discharge Process): the facility failed to ensure a resident's transfer was coordinated by failing to contact, make prior arrangements for the transfer, confirm the receiving facility agreed to accept the resident, communicate the resident's enteral nutrition needs, document the discharge process in the medical record, and provide a telephone report to the receiving facility prior to transfer. Refer to Tag F600 (Free from Abuse/Neglect): the facility failed to establish and implement an enteral nutrition regimen for a resident after accepting the resident for admission, resulting in the resident receiving no documented enteral nutrition and only 240 milliliters (ml) of documented water flushes during their stay. Findings include: Resident 128 (R128) was admitted [DATE], discharged [DATE], with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction, gastrostomy status, and aphasia following cerebral infarction. A Care Plan dated [DATE], documented R128 had a swallowing problem was admitted with an abdominal gastrostomy tube (G-tube) related to impaired oral intake and received enteral feedings related to dysphagia. A Medication Reconciliation Summary dated [DATE] received from the sending facility documented the following orders: Jevity (non-plant based, non-vegan enteral formula) 1.5 calories, take one can via feeding tube six times a day for enteral feeds, order status expired. Compleat(R) Standard (plant-based, vegan enteral formula) 1.4 calories, take one container by mouth six times a day via peg tube, order status discontinued. Compleat(R) Standard (plant-based, vegan enteral formula) 1.4 calories, take one container via peg tube six times a day, order status on hold. R128's medical record lacked documented evidence the facility contacted the sending facility to clarify the enteral feed orders, nutritional needs and preferences, and the need for a vegan enteral formula was addressed during the admission process. An admission assessment dated [DATE] lacked documented evidence of information regarding vegan or plant-based feeding formula preferences. A facility census list documented R128 was admitted to the facility [DATE] at 8:10 PM and discharged [DATE] at 9:00 PM. R128's medical record at the facility lacked documented evidence of a physician order for an enteral feeding formula following admission, an enteral nutrition regimen was implemented during R128's admission at the facility from [DATE] through [DATE], and the facility offered R128 alternative enteral feeding formulas or intravenous (IV) fluids. On [DATE] at 10:35 AM, the Registered Dietitian (RD), reported beginning employment at the facility on [DATE] and was not employed at the time of R128's admission. The RD recalled previously caring for R128 at another facility. The RD indicated R128 was vegan and wanted a specific vegan or plant-based tube feeding formula. The RD explained the facility was supposed to admit residents whose specific care needs they could accommodate. The need for a vegan or plant-based formula should have been identified prior to admission or during the admission process. The RD confirmed R128's medical record lacked documented evidence of a physician order for an enteral feeding formula. On [DATE] at 11:46 AM, the Case Manager explained the type of (continued on next page)		

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