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No. 0938-0391

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	08/09/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40142

Based on observation, interview, record review and document review, the facility failed to develop a baseline care plan for a soft collar device, an ACE wrap dressing (an elastic compression bandage typically wrapped around a sprain or strain) and CAM (controlled ankle movement) boot device for 2 of 22 sampled residents (Residents 244 and 250). The deficient practice placed the residents at risk for discomfort, skin integrity issues to affected areas and complications to surgical sites.

Findings include:

Resident 244 (R244)

R244 was admitted on [DATE], with diagnoses including cervical disc disorder with myelopathy and status post cervical spine (C3 to C5 - neck region) decompression with anterior and posterior fusion.

On 08/06/2024 at 8:42 AM, R244 laid awake in bed with a family member at bedside. A white foam collar with areas of discoloration was observed around the resident's neck. R244 indicated undergoing neck surgery more than a month ago and was admitted to this facility with the soft collar device. R244 indicated no staff had removed the collar to clean or assess R244's skin underneath since the resident's admission. R244 reported getting a shower three days ago where staff cleaned the resident while avoiding the neck area. R244 indicated not being certain how the neck collar was supposed to be managed, cleaned, replaced, or removed since the resident had yet to see the surgeon.

A history and physical hospital report dated 07/18/2024, revealed R244 underwent a cervical procedure on 06/11/2024 and was being discharged to a skilled nursing facility with a soft collar.

An Admission note dated 07/24/2024, revealed R244 was admitted with a soft collar which had to be on 24 hours a day seven days a week (24/7) with steri-strips present on front and back of neck.

The medical record lacked documented evidence R244's baseline care plan included care and management interventions for the resident's soft collar device.

(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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/08/24 11:25 AM, the Licensed Practical Nurse (LPN) reviewed R244 's medical record and confirmed care and management of R244's soft collar device was not included in the resident's baseline care plan but there should have been. Interventions for use of the soft collar device should have included timely referral to surgeon, wearing schedule and duration, skin assessments, hygiene of the resident's affected site and the collar itself, and therapy and nursing duties. Resident 250 (R250) Resident # 250 was admitted on [DATE], with diagnoses including fracture of right tibia and encounter for change or removal of surgical dressing. On 08/06/2024 at 9:58 AM, R250 was alert and awake watching television. R250 indicated falling at home which resulted in a right leg fracture necessitating surgery. R250 pulled blanket up which revealed a black boot device on right leg with ACE wrap bandage underneath. R250 indicated a nurse removed the boot device a week ago and looked at the site but according to R250 the boot device had not been removed for about a week, no one checked on the surgical site routinely and no one had communicated plans for the surgical wound which included a post-operative appointment with the surgeon. A hospital discharge summary dated 07/08/2024, documented R250 fell at home and sustained a right tibia fracture and posterior malleolus fracture. Discharge to skilled nursing facility (SNF), follow up with specialists in one to two weeks. Integumentary wound information included right lower surgical leg incision CAM (controlled ankle motion) boot and ACE wrap. An admission/readmission note dated 07/17/2024, documented R250 had surgical incisions to the right thigh, right lateral shin, right medial shin, right medial ankle, and right ankle. A Consultation date dated 07/22/2024, documented R250 was at the facility following fall at home with right tibial shaft fracture and posterior malleolus fracture. R250 underwent open reduction and internal fixation (ORIF) surgery on 06/29/2024. Noted sutures on right leg, and CAM boot to right ankle. Physician documented sutures may be removed by the wound nurse and R250 would need to follow up with orthopedic surgeon. The medical record lacked documented evidence a care plan was developed for R250's ACE wrap dressing and CAM boot device. On 08/08/24 at11:08 AM, the Licensed Practical Nurse (LPN) explained baseline care plans were initiated on admission by the admitting nurse and completed by any nurse within 48 hours of admission. The baseline care plan should include immediate needs such as fall risk assessments, skin integrity and/or impairments, code status, allergies, transmission-based precautions, devices such as intravenous lines, Foley catheters, and breathing treatments. The LPN indicated the purpose of the baseline care plan was to ensure immediate needs were met and appropriate care could be given timely. On 08/08/24 at 11:17 AM, the resident's care plan was reviewed, and the LPN confirmed the baseline care plan did not include management of R250's ACE wrap and CAM boot device. According to the LPN, interventions should have been in place on how to manage the ACE wrap and boot device which would include a wearing schedule and duration, skin assessments, follow up with orthopedic surgeon and assessment for complications such as deep vein thrombosis. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/2024 in the afternoon, the Director of Nursing (DON) indicated interventions for R244's soft collar and R250's ACE wrap and boot device should have been included in the residents' baseline care plan. The Baseline care plan policy revised March 2022, documented the baseline plan of care was developed within 48 hours of admission to meet the resident's immediate health and safety needs. The baseline care plan included instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility failed to ensure documentation of application of an ordered Thrombo-Embolus deterrent (TED) stocking (stockings that help prevent blood clots and swelling in the legs) was completed for 1 of 22 sampled residents (Resident 3). The failure had the potential to adequately assess the resident's efficacy of treatment, determine resident's need for further intervention, and compliance with the physician's order. Findings include: Resident 3 (R3) R3 was admitted on [DATE], with diagnoses including heart failure and essential hypertension. On 08/06/2024 at 12:44 PM, R3 was observed sitting up in the wheelchair next to the foot of the bed. Noted R3 had edema (swelling) at both legs, skin was reddish and shiny. R3's lower pants elastic bands were making indentation markings onto the skin. R3 was observed with no TED stockings in place. R3's comprehensive care plan had a focus problem identified for: - Activities of daily living (ADL) self-care needs created 07/13/2023, documented as an intervention was TED hose on in the am and off at bedtime. - Dependent edema to bilateral lower extremities (1+ non-pitting) CHF and recurrent pneumonia created 07/13/2023, documented as an intervention included bilateral TED hose/Compression Stockings knee high. Apply in the AM and remove at bedtime. R3's physician orders dated 09/11/2024, documented apply bilateral knee-high TED hose/compression stockings in the AM, and remove at bedtime related to, dependent edema to bilateral lower edema. The physician's order was transcribed into the medication administration record (MAR) for nursing to sign off once the application and donning off the therapeutic device was completed. R3's MAR for the application of the stocking revealed the following dates were not completed or signed off: August 1 to 6 and August 8 to 9, 2024. R3's MAR and progress notes lacked documented evidence as to why the application of the stockings were not signed off. On 08/08/2024 in the morning, one Registered Nurse and one Licensed Practical Nurse confirmed TED stocking application orders were entered into the MAR to ensure the application were completed by nursing. The nurses indicated orders for application had to be signed off to signify the task was completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/09/2024 at 10:37 AM, the Assistant Director of Nursing (ADON) reviewed the medical record and confirmed the MAR was not signed off for the application of the TED stockings on the specified dates. The ADON during the review of the medical record, was not able to show additional evidence the morning shift nurses had justification on the unsigned orders. The ADON indicated the expectation was for nursing to sign off the task once completed for it was a physician's order and part of R3's plan of care. At 1:45 PM, the ADON indicated the facility had no specific policy for TED stockings and was able to provide a policy for heart failure management. The facility policies titled: Heart Failure - Clinical Protocol revised November 2018, documented the physician will review and make recommendations for relevant aspects of the nursing care plan. The physician will prescribe treatments for residents with heart failure that are consistent with relevant guidelines and protocols. Care Plans, Comprehensive Person-Centered revised March 2022, documented the comprehensive, person-centered care plan describes the services that are to be furnished to attain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review, and document review, the facility failed to ensure care and management orders were obtained, transcribed, and carried out for a soft collar device, an ACE wrap (an elastic compression bandage typically wrapped around a sprain or strain) and a boot device for 2 of 22 sampled residents (Residents 244 and 250) and a post-operative appointment was scheduled timely for 1 of 22 sampled residents (Resident 250). The deficient practice placed the residents at a potential risk for discomfort, skin integrity issues to the affected areas and complications to surgical sites. Findings include: Resident 244 (R244) R244 was admitted on [DATE], with diagnoses including cervical disc disorder with myelopathy and status post cervical spine (C3 to C5 - neck region) decompression with anterior and posterior fusion. On 08/06/2024 at 8:42 AM, R244 laid awake in bed with a family member at bedside. A white foam collar with areas of discoloration was observed around the resident's neck. R244 indicated undergoing neck surgery more than a month ago and was admitted to this facility with the soft collar device. R244 indicated no staff had removed the collar to clean or assess R244's skin underneath since the resident's admission. R244 reported getting a shower three days ago where staff cleaned the resident while avoiding the neck area. R244 indicated not being certain how the neck collar was supposed to be managed, cleaned, replaced, or removed since the resident had yet to see the surgeon. A History and Physical report dated 07/18/2024, revealed R244 underwent a cervical procedure on 06/11/2024 and was being discharged to a skilled nursing facility (SNF) with a soft collar device. An Admission note dated 07/24/2024, revealed R244 was admitted with a soft collar which had to be on 24 hours a day seven days a week (24/7) with steri-strips present on front and back of neck. The medical record lacked documented evidence the physician's order to wear R244's soft collar 24/7 was transcribed and clarification orders regarding duration of wear and management of the device related to hygiene and skin assessments were obtained. On 08/07/2024 at 9:57 AM, the Licensed Practical Nurse (LPN) who admitted R244 recounted speaking with the hospital nurse regarding keeping R244's soft collar on 24/7 but the LPN could not recall any other recommendations regarding R244's soft collar device such as duration of the 24/7 wearing schedule and instructions on how to manage the device until R44's post-operative appointment with R244's surgeon. The LPN reviewed R244's medical record and confirmed there were no orders entered for care and management of the resident's soft collar. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/2024 at 10:11 AM, the LPN acknowledged aside from failing to transcribe orders to keep R244's soft collar on at all times, the LPN indicated clarification orders should have been obtained regarding maintaining hygiene underneath the collar device to prevent infection of surgical sites, skin assessments to prevent skin impairments as well as assessing patient comfort. On 08/07/2024 at 10:05 AM, the Treatment Registered Nurse (RN) indicated admission orders which included medications, treatment services and management of devices should be entered immediately on admission and finalized within 24 hours from admission after a head-to-toe assessment had been completed. On 08/07/2024 at 11:00 AM, R244 laid in bed wearing a soft cervical collar. The treatment RN positioned R244 upright and removed the neck collar. The treatment nurse described the white collar as soiled, had outlines of sweat stains with areas of discoloration, the neck area had a moderate amount of hair, old steri-strips, purple lines which appeared to be old surgical markings and old scabs. R244 verbalized not having seen the surgeon since the surgery on 06/11/2024 and reiterated no staff had removed the collar to clean the skin underneath or to check for skin impairments. On 08/07/2024 at 1:58 PM, the treatment nurse indicated the admitting nurse should have entered care orders which included skin checks and clarification of the wearing schedule. The treatment nurse acknowledged care orders were not entered and transcribed and as a result there was a delay in appropriate monitoring and care which could have led to potential skin impairments. On 08/07/2024 at 3:26 PM, the Director of Nursing (DON) indicated the admitting nurse was expected to transcribe the 24/7 wear order of R244's soft collar device, obtain care orders which would have included skin checks, wearing schedule and duration. The DON indicated when the facility admitted a resident post-surgery, the surgeon's orders were to be followed until the post-operative appointment unless one of the attending physicians modified or made changes to the order. The Admission Criteria policy revised March 2019, documented prior to admission, the resident's attending physician provided the facility with information needed for the immediate care of the resident, including orders covering at least: routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed inter-disciplinary care plan. Resident 250 (R250) Resident # 250 was admitted on [DATE], with diagnoses including fracture of right tibia and encounter for change or removal of surgical dressing. On 08/06/2024 at 9:58 AM, R250 was alert and awake watching television. R250 indicated falling at home which resulted in a right leg fracture necessitating surgery. R250 pulled blanket up which revealed a black boot device on right leg with ACE wrap bandage underneath. R250 indicated a nurse removed the boot device a week ago and looked at the site but according to R250 the boot device had not been removed since. According to R250, no one assessed the affected leg routinely and no one had communicated plans for the ACE wrap, boot device and post-operative appointment with the surgeon. (continued on next page)

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A hospital discharge summary dated 07/08/2024, documented R250 fell at home and sustained a right tibia fracture and posterior malleolus fracture. Discharge to skilled nursing facility (SNF), follow up with specialists in one to two weeks. Integumentary wound information included right lower surgical leg incision CAM (controlled ankle motion) boot and ACE wrap.

A Consultation note dated 07/22/2024, documented R250 was at the facility following fall at home with right tibial shaft fracture and posterior malleolus fracture. R250 underwent open reduction and internal fixation (ORIF) surgery on 06/29/2024. After medical stabilization, R250 went to a rehabilitation facility. Due to non-weight bearing status, the R250 was currently at this SNF to continue with rehabilitation. Noted sutures on right leg, and CAM boot to right ankle. Physician documented sutures may be removed by the wound nurse and R250 would need to follow up with orthopedic surgeon.

A rehabilitation note dated 08/01/2024, documented follow up with orthopedic surgeon.

The medical record lacked documented evidence R250 had been scheduled for an orthopedic follow-up appointment since the surgery on 06/29/2024 and clarification orders were obtained regarding the wearing schedule of R250's ACE wrap and boot device as well skin checks to affected leg.

On 08/07/2024 at 10:34 AM, the treatment Registered Nurse (RN) explained the wound team signed off on R250's surgical wound after steri-strips were ordered to be removed for part of the surgical incision on 07/22/2024 and remaining steri-strips were removed on 07/23/2024. The treatment nurse indicated weekly skin checks still needed to be performed by the floor nurses.

On 08/07/2024 at 10:21 AM, the LPN who was steadily assigned to R250 indicated not being aware R250 had not been scheduled for a follow up appointment with the orthopedic surgeon. The LPN reviewed R250's medical record and indicated a skin assessment was performed to R250's affected leg on 07/18/2024 and 07/25/2024 but the scheduled skin check for 08/01/2024 was missed. The LPN indicated not being familiar with the wearing schedule of R250's ACE wrap and boot device and confirmed there were currently no care and management orders in place for R250's ACE wrap and CAM boot.

On 08/07/2024 at 10:24 AM, the treatment nurse indicated skin assessments were performed on admission and on a weekly basis. A wearing schedule for the ACE wrap and boot device should have been obtained or clarified at least. While the resident was no longer on the wound team's case load, floor nurses were expected to notify wound team of the following information: surgeon's consult report and use or presence of an ACE wrap and/or boot device to maintain skin integrity by entering care orders for the affected extremity.

On 08/07/2024 at 1:07 PM, LPN Case Manager #1 confirmed R250 had not been scheduled to see the orthopedic surgeon because the facility did not know who the resident's surgeon was and received no information from the previous rehabilitation facility regarding which hospital the surgery had been performed.

On 08/07/24 at 1:23 PM, LPN Case Manager #2 reviewed R250 's medical record and confirmed there was nothing to indicate R250 had been seen by the orthopedic surgeon since the surgery on 06/29/2024. LPN Case Manager #2 verbalized it was important for the resident to be seen by the surgeon post-operative to obtain care orders, clearance for upgrade weight-bearing status, diagnostic orders to make sure affected site was healing properly, identification of complications like infections and other treatment services such as wound care. The surgeon's input also helped determine discharge planning.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/2024 at 1:30 PM, LPN Case Manager #1 and #2 acknowledged there had been a significant delay from R250's surgery on 06/29/2024 because typically, most post-operative appointments occurred within two to three weeks of surgery. On 08/07/24 at 2:11 PM, the treatment nurse indicated being able to speak with the surgeon's office after determining the surgeon's name while reviewing R250's medical record. The treatment RN indicated the surgeon wanted R250 to wear the ACE wrap and boot device at all times for two weeks following the surgery on 06/29/2024. The surgeon's office indicated the previous facility communicated it was R250's preference to wear the ACE wrap and boot device at all times. According to the treatment nurse, the surgeon's office confirmed R250 had not been seen by the orthopedic surgeon since the surgery. The treatment nurse confirmed there was a delay with R250's post-operative appointment with the surgeon, failure to obtain care orders to R250's affected leg after the wound team had removed the steri-strips on 07/22/2024, and weekly skin checks were missed on 08/01/2024. On 08/07/2024 at 2:24 PM, the treatment RN and treatment LPN removed the boot device and ACE wrap from R250's right leg which revealed indentation marks. The treatment RN described R250's leg as being excessively dry with indentation markings. The treatment LPN applied Vitamin A and D cream on the affected leg and R250 reacted by stating, that feels so good! R250 stated being more comfortable when the ACE wrap and boot device were off, and the resident denied wanting to keep boot on nor even being asked regarding the devices. R250 indicated no staff member had discussed, explained, or communicated the care plan for the resident's affected leg which included a wearing schedule for the ACE wrap and boot device and appointment with the surgeon. The treatment RN acknowledged the resident expressed increased comfort after the ACE wrap and boot were removed. On 08/07/2024 at 3:41 PM, the Director of Nursing (DON) acknowledged there was a significant delay with the resident's post-operative appointment and a missed weekly skin check on 08/01/2024. The DON expected the nurses to be more proactive with regards to scheduling follow up appointments with surgeons and expected nurses to discuss and communicate care with patients and physicians. The Resident Mobility and Range of Motion (ROM) policy revised July 2017, documented residents with limited range of motion would receive treatment and services to increase and/or prevent further decrease in ROM. Residents with limited mobility would receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. As part of the comprehensive assessment, the nurse will identify conditions that place the residents at risk for pain, skin integrity issues, muscle wasting and atrophy and other complications. The care plan would include interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The care plan would include type, frequency, and duration of interventions, as well as measurable goals and objectives.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on interview, record review and document review, the facility failed to ensure psychoactive medication side effects monitoring was documented for 1 of 22 sampled residents (Resident 3). The failure to document side effects of psychoactive drugs had a potential to facilitate dose adjustments if needed and the efficacy of the medication for the resident. Findings include: Resident 3 (R3) R3 was admitted on [DATE], with diagnoses of anxiety disorder and schizophrenia. R3 physicians' orders documented the following orders: - 07/12/2019, Monitor for Adverse Side Effects (S/E): Anticholinergic (dry mouth, urinary retention, blurred vision); orthostatic hypotension (arrhythmias); sedation, confusion, hallucinations, and agitation- every shift. - 08/02/2019, Antidepressant Drug S/E Monitor: Dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium, hallucinations, flushing, increased blood pressure, postural hypotension, sedation, fatigue, dizziness, ataxia, insomnia, headache, dry eyes, increased or decreased appetite, weight loss or gain, nausea, diarrhea, anxiety, nervousness, seizures, sexual dysfunction, mania, possible liver enzyme or blood abnormalities, possible falls, suicidal ideation, serotonin syndrome, every shift for Medication: Trazodone - 08/02/2019, Antidepressant Monitor of Depression as evidence by (AEB): crying/tearfulness. Drug: Venlafaxine. Every Shift - 08/02/2019, Anti-Psych Drug Side Effect Monitor: Dry Mouth, Blurred Vision, Tachycardia, Urinary Retention, Constipation, Confusion, Delirium, Hallucinations, Flushing, Increased Blood Pressure, Sedation, Loss of Appetite, Photosensitivity, Possible Blood Abnormalities, Fainting, Falls, Cardiac Arrhythmias, Orthostatic Hypotension, Increased In Cholesterol & Triglycerides, Unstable or Poorly Controlled Blood Sugar, Weight Gain, Akathisia, Parkinsonism, Dystonia, Tardive Dyskinesia. Every shift for Medication: Risperdal. - 11/27/2019, Anti-Anxiety Drug S/E Monitor:0-NONE, 1-Sedation, 2-Drowsiness, 3-Lethargy, 4-Confusion, 5-Memory Impairment, 6-Apathy, 7-Fatigue, 8-Dizziness, 9-Depression,10-Nausea and/or Vomiting, 11-Change in Appetite, 12-Headaches, 13-Blurred Vision, 14-Impaired Coordination, 15-Possible Falls, 16-Subdued Behavior, 17-Withdrawal Compared to Baseline, or 18- Limitation in Functional Capacity. every shift; describe observations in progress note. - 06/18/2021, Anti-Psychotic Monitor of episodes of Schizophrenia, Unspecified AEB: Delusional - cannot tell what is real from what is imagined. Unshakable beliefs in something untrue. Drug: Seroquel. every Shift, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 02/16/2023, Anti- Anxiety Monitor of episodes of Anxiety AEB: compulsion behaviors (medication administration demands, requests to go out and smoke, plastic cups placement & designated beverages, brief and bra application, etc.) Drug: Vistaril/Hydroxyzine Pamoate Capsule; every shift - 05/09/2023, Anti-Psychotic Monitor of episodes of delusional behavior AEB: Irrational thoughts. Drug: SEROQUEL. Every shift. - 05/09/2023, Anti-Psych Drug Side Effect Monitor: 0-NONE, 1-Dry Mouth 2-Blurred Vision 3-Tachycardia 4-Urinary Retention 5-Constipation 6-Confusion 7-Delirium 8-Hallucinations 9-Flushing 10-Increased Blood Pressure 11-Sedation 12-Loss of Appetite 13-Photosensitivity 14-Possible Blood Abnormalities 15-Fainting 16-Falls 17-Cardiac Arrhythmias 18-Orthostatic Hypotension. every shift 19-Increased Cholesterol/Triglycerides 20-Poorly Controlled Blood Sugar 21-Weight Gain 22-Akathisia 23-Parkinsonism 24-Dystonia 25-Tardive Dyskinesia 26-EPS (shuffling/gait/rigid muscles/shaking) 27-NMS (rigid muscle/fever/labile BP/tremor), Notify MD. All the listed medications were transcribed onto the medication administration record (MAR) to be signed off by nursing once the observation of the side effects of the psychoactive medications were completed every shift. R3's MAR for the monitoring of the side effects for the listed psychoactive medications revealed the following dates were not completed or signed off: August 1 to 6 and August 8 to 9, 2024. R3's MAR and progress notes lacked documented evidence of any monitoring and as to why the monitoring was not signed off. R3's comprehensive care plan had a focus problem identified for: - The resident has a behavior problem of yelling/screaming, and hoarding things in room. Diagnosis: Schizophrenia. One of the intervention listed: Administer medications as ordered. Monitor/document for side effects and effectiveness. - At risk of becoming physically aggressive towards others related to biting at staff. One of the intervention listed: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift. - The resident has medical diagnosis - Depression. One of the intervention listed: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift. - Resident has medical diagnosis Anxiety AEB: compulsion behaviors (medication administration demands, requests to go out and smoke, plastic cups placement & designated beverages, brief and bra application, etc.). One of the intervention listed: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Administer anti-anxiety medications as ordered by physician. Monitor side effects and effectiveness every shift. (continued on next page)

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 08/09/2024

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's comprehensive care plan documented the resident should have been monitored for the current psychotropic medication regimen. 08/09/2024 at 10:37 AM, the assistant director of nursing (ADON) reviewed the medical record and confirmed the MAR was not signed off for the monitoring of the side effects of the psychotropic medications on the specified dates. The ADON during the review of the medical record, was not able to provide additional evidence the morning shift nurses had justification on the unsigned monitoring orders. The ADON indicated the expectation was for nursing to sign off the task once completed for it was a physician's order and part of R3's plan of care. On 08/09/2024 at 2:45 PM, a registered nurse explained behavior monitoring for psychotropic medication side effects was entered in the MAR. Next to the ordered medication would have an option to click Monitor and any observed side effect will be entered there. The facility policy titled Psychotropic Medication Use revised July 2022, documented residents receiving psychotropic medications are monitored for adverse consequences.

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 08/09/2024
NAME OF PROVIDER OR SUPPLIER: Coronado Ridge Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 2855 W. Horizon Ridge Parkway Henderson, NV 89052	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility to ensure medications were secured for 1 of 6 medication carts and 1 of 22 Residents (Resident 15). The deficient practice could have jeopardized the safety of both staff and residents, as unsecured medication carts increase the risk of unauthorized access to potent medications, medication errors, theft, or misuse, posing serious health hazards and compromising the overall well-being of individuals within the facility. Findings include: On 08/07/2024 at 2:55 PM, a nurse was standing by the medication cart parked next to room [ROOM NUMBER]. The nurse stepped away and left the medication cart unlocked. The nurse was observed to walk towards the nursing station and was not in line of sight of the medication cart. The nurse was away for four minutes with one resident and one facility staff member who had passed by the open cart. Another two nurses had approached the cart and had used the hand sanitizer on top of the cart, when momentarily the nurse manning had returned. The three nurses had a discussion next to the medication cart with the nurse attending the cart had left again. One of the two nurses left by the cart introduced self as the Unit Manager. The Unit Manger confirmed the medication cart was left open and indicated medication carts should always be locked when unattended. The Unit Manager reminded the nurse upon returning to the cart regarding keeping it locked when left unattended. Resident 15 (R15) R15 was admitted on [DATE], with diagnoses including senile degeneration of brain and unspecified dementia. On 08/06/2024 at 10:56 AM, observed at R15's bedside table was a partially used bottle of hydrogen peroxide. R15 indicated not using the bottle of chemical and was not able to recall how long the liquid chemical had sat there and where it came from. R15's medical record revealed no active physician's orders for hydrogen peroxide. R15 had a Self-Administration Medication Safety Screen dated 06/13/2023 at 3:09 PM. The screening documented: List all medications that are being considered for resident self-administration. 1. Medication Name: Flonase Allergy Relief Suspension clear 2. Medication Name: Triamcinolone Acetonide Cream 0.1 % clear. R15's Safety Screen did not include the assessment for the use of hydrogen peroxide. (continued on next page)

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 08/09/2024
NAME OF PROVIDER OR SUPPLIER Coronado Ridge Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2855 W. Horizon Ridge Parkway Henderson, NV 89052	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/2024 at 2:32 PM, the Licensed Practical Nurse (LPN) confirmed R15 had the bottle of hydrogen peroxide on top of the bedside table. The LPN confirmed the bottle of chemical was not supposed to be at the resident's bedside and should be taken when not being used. On 08/08/2024 in the morning, one RN and one LPN confirmed medications should not be left at a resident's bedside table unless the resident was screened for self-administration of medication. 08/09/2024 at 10:37 AM, the Assistant Director of Nursing agreed hydrogen peroxide was a medication and should not have been kept at a resident's bedside. The facility policy titled Medication Labeling and Storage revised February 2023, documented the facility stores all medication and biologicals in locked compartments. Only authorized personnel have access to keys.