| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295099 | A. Building<br>B. Wing | 08/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Coronado Ridge Skilled Nursing & Rehabilitation Ce | 2855 W. Horizon Ridge Parkway<br>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.

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a baseline care plan was initiated and completed for a resident who was admitted with a peripheral intravenous (IV) access for 1 of 24 sampled residents (Resident 3). The deficient practice had the potential to place residents at risk for not receiving IV access care.Findings include: R3 was admitted on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD).On 08/12/2025 at 11:23 AM, R3 had a purple-colored single lumen peripheral IV catheter in the right inner forearm. The admission assessment dated [DATE], revealed R3 was admitted on the evening of 08/10/2025 with an IV line with site location and purpose unspecified.The medical record lacked documented evidence that a baseline care plan was initiated and completed for R3's peripheral IV line.On 08/13/2025 at 1:51 PM, the Director of Nursing (DON) indicated the admission nurse must document the presence of an IV access for residents admitted with one. The DON reviewed R3's admission assessment which confirmed R3 was admitted with an IV line, but the site location and purpose was not documented. The DON indicated that the resident's peripheral line was considered an immediate care need and should be included in the baseline care plan. The DON confirmed R3's peripheral IV was not included in the resident's baseline care plan and should have been.The facility Baseline Care Plan policy revised December 2016, documented a baseline care plan to meet the resident's immediate care needs must be developed within 48 hours of admission. |

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 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) a clarification order was obtained for a resident's peripheral intravenous (IV) line for a newly admitted resident with no IV medication orders for 1 of 24 sampled residents (Resident 3); 2) a physician's order was followed regarding rotating sites for a peripheral IV line for 1 of 24 sampled residents (Resident 155) and 3) the facility policy was followed regarding removal of peripheral IV lines for 2 of 24 sampled residents (Residents 3 and 155). The deficient practice had the potential to place the residents at risk for phlebitis (site infection).Findings include: 1) Resident 3 (R3) was admitted on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD).On 08/12/2025 at 11:23 AM, R3 had a purple-colored single lumen peripheral IV catheter in the right inner forearm. The admission assessment dated [DATE], revealed R3 was admitted on the evening of 08/10/2025 with an IV line with site location and purpose unspecified.Review of R3's admission orders revealed R3 did not have IV medication orders. On 08/12/2025 at 11:45 AM, the Wound Care Registered Nurse (RN) confirmed R3 had a peripheral IV line in right inner forearm which was dangling due to dressing being loose. R3 explained the line was inserted at the hospital for IV antibiotic therapy but antibiotics were changed to oral route prior to hospital discharge on [DATE]. R3 indicated the IV line had not been used since admission to the facility on [DATE].On 08/12/2025 at 11:47 AM, an RN described R3's IV site as undated with gauze pad underneath a transparent dressing which was coming loose. The RN indicated the admission nurse should have contacted the physician for clarification orders on whether the line should be removed since there were no IV medication orders. The RN indicated a compromised IV dressing placed R3 at risk for phlebitis or infection. On 08/13/2025 at 2:57 PM, the Director of Nursing (DON) indicated if a resident was admitted with a peripheral line with an undated dressing with gauze covering the insertion site, the admission nurse was expected to seek clarification with the physician on whether to maintain or remove the line. The DON indicated if the line were to be maintained, the dressing must be replaced with a transparent dressing and maintenance protocol must be followed with site monitoring and flushing every shift, or the physician may opt to have the line removed. The DON confirmed there was no physician clarification regarding R3's peripheral line upon admission on [DATE].On 08/13/2025 at 3:00 PM, the DON reviewed R3's medical record and confirmed site monitoring and flushing were missed on 08/11/2025 and R3s peripheral line should have followed maintenance protocol until the line was removed on 08/13/2025.The facility admission Assessment and Follow Up: Role of the Nurse policy revised September 2012, documented the admission nurse would gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purpose of managing the resident and initiating the care plan. The nurse would notify the attending physician of the resident's immediate needs.2) Resident 155 (R155) was admitted on [DATE], with diagnoses including right femur fracture and anemia.On 08/12/2025 at 11:41 AM, R155 had peripheral IV access on the left hand with dressing dated 08/07/2025. R155 explained the IV was placed at the facility and was being used for medication administration.On 08/12/2025 at 11:57 AM, Licensed Practical Nurse (LPN) 1 indicated being assigned to R155 and explained using the resident's peripheral IV to administer IV Venofer (Iron Sucrose). LPN1 indicated peripheral IV lines were meant for short term use and LPN1 was familiar with physician's orders to rotate R155's IV site every three days. LPN1 confirmed physician's orders were not followed when the resident's IV line was not removed and placed at a different location on 08/10/2025. A Physician Order dated 08/07/2025, documented to insert peripheral IV Site Location: right hand for IV Venofer. A Physician Order dated 08/07/2025, change peripheral IV every three days and as needed for infiltration.The medical record lacked documented evidence that the physician order to rotate R155's peripheral site was followed.On 08/13/2025 at 3:36 PM, the Clinical Resource Nurse confirmed peripheral lines were meant for short<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | term use and the facility protocol was to rotate sites every three days unless the physician ordered the line to stay in place. The Clinical Resource Nurse confirmed the physician orders were not followed when R155's peripheral line was not rotated on 08/10/2025 (Day three).3) R3 was admitted on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD).The admission assessment dated [DATE], revealed R3 was admitted on the evening of 08/10/2025 with an IV line with site location and purpose unspecified.A Physician Order dated 08/13/2025, documented to discontinue IV line.On 08/13/2025 at 3:18 PM, the Infection Preventionist (IP) indicated removing R3's right forearm peripheral line around noon today and described the line as loose and not flushing well. The IP removed the IV line and acknowledged not notifying the physician regarding the removal and the IP did not document the procedure in R3's medical record.R155 was admitted on [DATE], with diagnoses including right femur fracture and anemia.On 08/12/2025 at 11:41 AM, R155 had peripheral IV access on left hand with dressing dated 08/07/2025. R155 explained the IV was placed at the facility and was being used for medication administration.A Physician Order dated 08/13/2025, documented to discontinue IV line.On 08/13/2025 at 3:42 PM, LPN2 reported R155's peripheral IV was removed by the floor nurse after lunch today. The medical record lacked documented evidence for nursing staff who removed the peripheral IV lines of R3 and R155 followed documentation requirements per facility policy.The facility Peripheral IV Catheter Removal policy revised March 2022, revealed the following information should be documented in the resident's medical record: 1) date and time of the procedure including resident's tolerance, 2) location where catheter was removed from, 3) reason for removal (end of treatment, rotating sites, complications, etc.), and 4) any communication with physician or oncoming shift. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, document review and record review the facility failed to ensure a resident who required oxygen therapy was not connected to an empty oxygen tank and to obtain a physician's order for oxygen for 1 of 24 sampled residents (Resident 157). This deficient practice had the potential to lead to serious complications, including hypoxia, respiratory failure, and damage to vital organs. Findings include: Resident 157 (R157) was admitted on [DATE] with a diagnosis of chronic respiratory failure with hypoxia, acute kidney failure, unspecified, chronic obstructive pulmonary disease, unspecified and pneumonia, unspecified organism.On 08/12/2025 at 10:35 AM, R157 was connected to a nasal canula, and an oxygen tank attached to the wheelchair, and the tank was empty and off.On 08/12/2025 at 10:45 AM, a Registered Nurse (RN) indicated the resident was on two liters of oxygen continuously due to a diagnosis of chronic respiratory failure and chronic obstructive pulmonary disease. The RN verified the oxygen tank was empty and turned off.On 08/13/2025 at 1:17 PM, a Certified Nursing Assistant (CNA) voiced R157 had been on two liters of oxygen since being admitted on to the unit.R157's care plan dated 08/08/2025 documented oxygen therapy pertaining to chronic obstructive pulmonary disease and chronic respiratory failure. The interventions were to administer oxygen and breathing treatments as ordered by the physician.On 08/13/2025 at 4:07 PM, a Registered Nurse (RN) verified R157 did not have an active order for oxygen. The RN indicated an order for oxygen was required. The facility Oxygen Administration policy revised on 10/2022, documented to verify there was a physician's order, to review the physician order and facility protocol for oxygen administration and review the residents care plan to assess for any special needs. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) a physician order was obtained for moderate to severe pain medication, 2) the resident's pain was routinely monitored and 3) pharmacological and non-pharmacological pain interventions were offered and/or provided for a resident who was assessed to be at risk for pain for 1 of 24 sampled residents (Resident 154). The deficient practice had the potential to negatively impact residents' overall wellbeing.Findings include: Resident 154 (R154) was admitted on [DATE], with diagnoses including fracture of lower end of left radius (one of two bones in the forearm), left ulna styloid process (a small bony projection located at the end of the ulna bone in the forearm), left orbital floor (a thin bone which forms the floor of the eye socket), unspecified phalanx (bones in fingers or toes) of left middle finger and maxillary fracture (upper jaw bone).1) On 08/12/2025 at 11:17 AM, R154 laid in bed with left arm wrapped in bandage and supported by a sling while the right arm had a black splint (immobilizing device). R154 had facial bruising more pronounced on the left side particularly around left eye. R154 reported falling in the front yard and sustaining several fractures. R154 reported current pain level was 8 out of 10 (severe) and indicated not knowing what pain medication was ordered.On 08/12/2025 at 11:20 AM, R154's family member indicated wanting to speak with a physician to request stronger pain medications since R154 was receiving Percocet at the hospital, which was effective in managing the resident's pain, but the medication was not ordered at the facility.An admission assessment dated [DATE], revealed R154 was admitted to the facility at 6:20 PM and was assessed to have current or recent pain and was at risk for pain related to generalized body pain for bilateral wrist fractures. Pain care plan interventions included administering pain medications as ordered, monitoring for pain every shift with a goal of resident verbalizing improvement in pain level within one hour of pain management interventions.2) On 08/12/2025 at 2:24 PM, R154 laid in bed and appeared to be in discomfort as evidenced by facial grimace and a report of pain 10/10. R154 reported the wound nurse just unwrapped the resident's bandages which caused the resident severe pain. The resident's family member indicated the wound nurse did not ask the resident about pain during wound care.On 08/12/2025 at 2:36 PM, Licensed Practical Nurse (LPN) 1 was informed of R154's complaint of severe pain.A Physician Order dated 08/11/2025, documented to monitor pain every shift using pain scale: 0/10 (no pain), 1/10 to 2/10 (least pain), 3/10 to 4/10 (mild pain), 5/10 to 6/10 (moderate pain) and 7/10 to 8/10 (severe pain) and 9/10 to 10/10 (very severe/worst/ horrible pain).The medical record lacked documented evidence LPN1 conducted a pain evaluation on R154 on 08/12/2025 (day shift).A Physician Order dated 08/11/2025, documented to give Acetaminophen 325 milligrams (mg), two tablets by mouth every six hours as needed for pain level 1 to 3/10.The medical record lacked documented evidence pain medication to manage mild, moderate, severe to very severe pain was obtained by the admitting nurse upon R154's admission.3) A Physician Order dated 08/11/2025, documented to attempt non-pharmacological approaches to pain such as redirecting, repositioning, offer snacks, adjust room temperatures, offer fluids, offer distraction or activities.The medical record lacked documented evidence non-pharmacological interventions were offered or provided for R154's pain on 08/12/2025. On 08/13/2025 at 7:30 AM, R154 appeared weak and drowsy in bed. R154 reported barely getting any sleep due to being in pain all night. R154's current pain level was 8/10 (severe) pain. The facility Pain Assessment and Management policy revised October 2022, documented residents with acute or significant worsening of chronic pain should be assessed every 30 to 60 minutes after onset and reassessed as indicated until relief was obtained.A Physician Order dated 08/11/2025 (4:27 PM), documented to give Tramadol hydrochloride tablet 50 mg. Give one tablet by mouth every eight hours as needed for moderate to severe pain 4/10 to 10/10 in pain scale.The medical record lacked documented evidence that R154's acute and significant pain related to multiple fracture injuries was monitored in accordance with facility policy.The medical record<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | lacked documented evidence Tramadol (opioid used for moderate to severe pain) had been administered to R154 since the order was obtained from the physician on 08/12/2025 at 4:27 PM related to R154's complaints of severe pain. On 08/13/2025 at 7:28 AM, LPN3 recounted R154 complaints of pain with a level 4/10 yesterday afternoon and LPN3 administered Acetaminophen (ordered for pain level 1/10 to 3/10) at 3:28 PM because there was no pain medication ordered for pain level greater than 3/10. LPN3 reviewed R154's medical record which revealed an order for Tramadol on 08/12/2025 at 4:27 PM but LPN3 indicated the medication had not been administered. On 08/13/2025 at 7:55 AM, LPN2 indicated pain management should be a high priority for R154 given the resident's injuries on admission. LPN2 explained nurses were not allowed to retrieve pain medications from the medication-dispensing system until pharmacy received a copy of the order. LPN2 indicated notifying the physician group regarding R154's complaints of severe pain at 3:00 PM, the Nurse Practitioner (NP) expressed reservations regarding Percocet due to side effects and the resident's age and medical condition and discussed opting for Tramadol with R154's family member. The NP sent the order for Tramadol to pharmacy at 4:21 PM.On 08/13/2025 at 8:58 AM, the NP indicated R154 was receiving strong pain medications intravenously and orally while at the hospital, but opioids were not part of the discharge medication list. Upon being informed by facility staff of R154's pain, the NP decided to order Tramadol versus Percocet because it was associated with less side effects given the resident's advanced age and condition.On 08/13/2025 at 9:05 AM, the NP indicated pain management should be prioritized for residents such as R154, and facility staff should have communicated R154's report of moderate to severe pain with the providers sooner to prevent worsening pain. The NP indicated pain medications should have been obtained to cover the entire pain scale 1/10 to 10/10 for the medication to be made immediately available when moderate to severe pain was reported by R154 with no delay in intervention.On 08/13/2025 at 9:35 AM, a Consultant Pharmacist confirmed controlled medications may not be retrieved from the medication-dispensing system until pharmacy had received the physician order or script. The Pharmacist reviewed R154's medical record and indicated R154 received two tablets of Percocet at the hospital on [DATE] at 2:00PM.On 08/14/2025 at 8:27 AM, the Director of Nursing (DON) indicated R154 was admitted to the facility on the evening of 08/11/2025. The DON confirmed the resident was admitted with multiple injuries related to a fall and was at risk for acute and worsening pain and medication orders were limited to Tylenol for pain level 1 to 3/10. The DON indicated expecting the admission nurse to obtain pain medications to cover moderate to severe pain (level 4-10) and confirmed this was not done by the admission nurse.On 08/14/2025 at 8:37 AM, the DON confirmed the LPN3 administered Tylenol to R154 on 08/12/2025 at 3:28 PM for pain level 4/10 as there was no pain medication ordered for pain level greater than 3/10. On 08/14/2025 at 8:40 AM, the DON verified R154 was not provided pharmacological and non-pharmacological pain interventions from admission on the evening of 08/11/2025 until 08/12/2025 at 3:28 PM.On 08/14/2025 at 8:48 AM, the Clinical Resource Nurse expected the night nurse to conduct more frequent checks for the resident due to the resident's clinical condition which placed the resident at risk for acute and worsening pain. The Clinical Resource Nurse was aware the facility policy required more frequent checks on residents with acute or worsening pain.On 08/14/2025 at 9:01 AM, the Clinical Resource Nurse verbalized the pain assessment and management policy was not followed with regards to lack of pain assessment on 08/12/2025 (day shift) and the admitting nurse failing to obtain pain medication orders to manage moderate to severe pain.The facility Pain Assessment and Management revised October 2022 revealed the purpose of the procedure was to help staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs that address the underlying causes of pain. Pain management was defined as the process of alleviating the resident's pain based on clinical condition. Pain management was multi-disciplinary which includes assessing for potential pain, recognizing presence of pain, monitoring effectiveness of interventions. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, document review, and interview, the facility failed to ensure a Physician Order for Life-Sustaining Treatment (POLST) form was witnessed and signed by two staff members, to validate a verbal consent for a do not resuscitate (DNR) status received from a resident's family member for 1 of 24 sampled residents (Resident 7). The deficient practice had the potential to result in a resident not receiving care consistent with their resuscitation preferences.Findings include: Resident 7 (R7) was admitted [DATE], readmitted [DATE], with diagnosis including unspecified mononeuropathy, chronic respiratory failure with hypoxia, and type 2 diabetes mellitus with diabetic neuropathy.A Care Plan dated 06/06/2025, documented R7 had a POLST-DNR and the code status would be reviewed on a quarterly basis and as needed. R7's electronic medical record documented a code status of do not resuscitate. A POLST form dated 06/02/2025, documented do not resuscitate (allow natural death). The words verbal consent were handwritten on both page 1 and 2 of the form. Section E, Validating Signatures (Required), provided options to be circled which included patient and agent signature, to identify who signed the form. None of the options were selected. On the signature line there were two words crossed out and one ineligible writing. The space provided for printed name and date were left blank.On 08/13/2025 at 11:47 AM, the Director of Nursing (DON), explained a verbal DNR consent on a POLST form required two nurses to witness and sign the form. The DON confirmed on R7's POLST form the signature line contained two writings that were crossed out and the remaining writing was not legible. The DON confirmed no indicators were circled to identify who signed the form. The DON was unable to determine if two nurses had signed R7's POLST. The DON confirmed R7's POLST form did not include the two signatures required for verbal consent and therefore it was not acceptable for a verbal DNR status determination. The DON explained that the consequences of incorrect code status could have resulted in life sustaining treatment not provided to a resident in error.On 08/15/2025 at 12:47 PM, a Licensed Practical Nurse reported a verbal consent for a do not resuscitate status on a POLST form required two staff members to witness and sign the form. The LPN explained best practice included following up with a signature at a later date when resident's representative became available.The facility Do Not Resuscitate Order policy revised March 2021, documented do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. The interdisciplinary care planning team would review advanced directives with the resident during quarterly care planning sessions to determine if the resident wished to make changes in such directives. |