Accepted 1/23/26

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295099	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORONADO RIDGE SKILLED NURSING & REHABILITATION CENTER	2855 W. HORIZON RIDGE PARKWAY , HENDERSON, Nevada, 89052

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F0000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Complaint investigation conducted in your facility from 08/29/2025 through 09/03/2025, in accordance with 42 Code of Federal Regulations (CFR) Chapter IV, Part 483, Requirements for Long Term Care Facilities. The census was 102. The sample size was nine. There was one complaint investigated. Complaint 2603300, deficient practice was identified. (See Tag F880) The investigation included: A tour of the facility. Interviews were conducted with the infection preventionist (IP) nurse, maintenance director, assistant director of nursing, clinical resource, and administrator. A review of nine clinical records which included the resident of concern. Document review included facility policies and procedures, infection control log/surveillance, and water management plan. The findings and conclusions of any investigation by the Division of Purchasing and Compliance shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiency was identified.	F0000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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 reverse for further 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
	Administrator	1/22/26

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F0880 SS = D	Continued from page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with	F0880	**F 880:** It is the expectation of the facility to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Immediate Corrective Action: Resident R1 no longer resides at the facility Identification of others: Other residents have the potential to be affected by the deficient practice. Eight additional other residents were investigated on September 3, 2025, in relation to same room assignments and symptoms potentially associated with respiratory infection or pneumonia. No other residents were affected by the deficient practice. Water sample testing was completed for the presence of Legionella on September 5, 2025 and October 13, 2025 on same room assignment and the following areas: Case Rooms – Shower head, hot water faucet; Distal rooms – shower head, hot water faucet; Hot Water return; Clinical sinks; Beauty salon basin; ice machines. No Legionella was present or positive in the sample testing. Systemic Changes: The Infection Prevention Nurse (IP) was educated on September 8, 2025 by the Director Of Nursing (DON) on the expectation of the facility to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	***Completion Date(s):*** ***1/21/2026***

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F0880 SS = D	Continued from page 2 residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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 08/04/2025 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 07/07/2025 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 08/02/2025 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	F0880	The IP was educated on September 8, 2025 by the DON to maintain a call log associated with reports of potential, suspected and actual positive cases of Legionella and other community and hospital acquired infections. And to report to the DON or designee and the Health District. The Maintenance Director updated the Water management plan on October 20, 2025 to include additional areas during annual testing, for the potential presence of Legionella, based on Health District recommendation to include: sample rooms – Shower head, hot water faucet; Distal Rooms – Shower heads, hot water faucet; Hot water Return; clinical sinks; beauty salon basin; ice machines. Facility staff were educated by the Staff Development Coordinator (SDC) on November 11, 2025 on the expectation of the facility to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Monitoring: The DON or designee will audit the on-going surveillance for Healthcare-Associated infecetions (HAIs) maintained by the Infection Prevention Nurse (IP) monthly. The DON or designee will audit the call log of the IP weekly for four weeks and monthly for three months. The DON or designee will review audits, identify any deficient practice/trends and report to the Quality Assurance and Improvement Committee monthly for 3 months to validate compliance.	

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F0880 SS = D	Continued from page 3 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: Detected Date/Time: 08/04/2025 at 10:55 AM Pacific Daylight Time (PDT) Legionella Source: Nasopharyngeal Legionella pneumophila by PCR: Detected Legionella species by qualitative PCR: Detected Source Type: Nasopharyngeal swab Source: Collected on 08/04/2025 at 10:55 AM PDT Interpretive Information: Legionella species by qualitative PCR (Legionella species was the broad genus of bacteria, while Legionella pneumophila was a specific species within that genus 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 08/06/2025 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	F0880	The QAPI committee will review findings and make recommendations to the Nursing Home Administrator and Corrective action will be taken.	

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F0880 SS = D	Continued from page 4 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 immediately by phone to the Health District if identified. The IP Nurse explained not remembering the name of the hospital IP who called on 08/06/2025. The IP Nurse revealed the caller introduced self as the hospital IP. On 09/03/2025 at 1:19 PM, the ADON confirmed being told by the IP Nurse about R1 testing positive for Legionella but not sure of the exact date when the notification occurred. The ADON indicated the conversation with the IP Nurse about R1 occurred	F0880		

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F0880 SS = D	Continued from page 5 sometime in August 2025 and prior to 08/28/2025 when the Health District notified the facility about what happened to R1. On 09/03/2025 at 2:15 PM, the Clinical Resource indicated the IP Nurse should have asked questions from the hospital IP like the date when the resident was tested positive for Legionella and the date when the resident was discharged from the facility. The Clinical Resource acknowledged the IP Nurse should have documented in the progress notes the conversation with the hospital IP and the actions taken in response to the information provided by the hospital. The Clinical Resource explained the IP Nurse should have reported the information to the Interdisciplinary Team (IDT) and the Administrator, and called the Southern Nevada Health District for guidance. The Clinical Resource revealed these actions and interventions were part of the surveillance for infections and the facility should have followed the water management plan. On 09/03/2025 at 2:44 PM, the IP Nurse explained the surveillance for infections included verifying who were the former occupants of the rooms where R1 stayed and reviewing medical records to determine if the residents manifested symptoms of respiratory infection or pneumonia. The IP Nurse confirmed these actions were not implemented after receiving the call from the hospital IP on 08/06/2025. On 09/03/2025 at 3:11 PM, the Maintenance Director confirmed being told by the IP Nurse about receiving a call from the hospital that somebody was tested positive for Legionella. The Maintenance Director revealed the IP Nurse did not mention the name of the resident. The Maintenance Director explained it was not important to know the name of the resident and the IP Nurse could not reveal the name of the resident to the Maintenance Director because of HIPAA (Health Insurance Portability and Accountability Act). The Maintenance Director indicated informing the Administrator on 08/11/2025 about the positive Legionella case reported by the hospital to the IP Nurse. The Maintenance Director confirmed the Administrator said no when asked if the facility would test the water system for Legionella. The Maintenance Director revealed not being aware of the period or timeframe when the resident stayed at the facility because the Maintenance Director did not know who the resident was. On 09/03/2025 at 4:05 PM, the Administrator indicated	F0880		

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F0880 SS = D	Continued from page 6 not being aware of the 08/06/2025 phone call from the hospital about a resident previously admitted at the facility and tested positive for Legionella at the hospital. The hospital Infection Preventionist Summary documented R1's Legionella reported, also notified (name of the facility) 08/08/2025 at 8:56 AM, and name of the IP Nurse. The facility's policy titled Surveillance for Infections dated September 2017, documented the Infection Preventionist would conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections was to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions and to prevent future infections. Complaint 2603300	F0880		