STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295066	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Hills Health Care Center	3450 N Buffalo Dr Las Vegas, NV 89129

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review and document review, the facility failed to ensure an alleged incident of neglect was reported to the state agency for 1 of 14 sampled residents (Resident 13). The deficient practice had the potential for the facility to not give the state survey agency the opportunity to investigate the alleged incident of neglect and other alleged incidents of abuse and neglect. Findings include: Resident 13 (R13) The Alleged or Suspected Abuse and Crime Reporting policy revised [DATE], defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident which were necessary to avoid physical harm, pain, mental anguish, and emotional distress. R13 was admitted on [DATE], with diagnoses including chronic kidney disease stage four, diabetes mellitus and atherosclerotic heart disease. A Physician's Order for Life Sustaining Treatment (POLST) dated [DATE], documented R13 had elected to be a full code (attempt resuscitation in the event of cardiopulmonary arrest). A nurse's note dated [DATE], documented a certified nursing assistant (CNA) informed the nurse R13 was unresponsive. The nurse entered the room and assessed R13 who was found to be without a pulse. Code blue was announced, cardiopulmonary resuscitation (CPR) was started. Emergency services arrived and assessed R13 who was declared deceased . On [DATE] at 11:06 AM, the Director of Staff Development (DSD) recounted being sent home and suspended by the Administrator who received a report regarding the DSD in relation to R13's code, and the Administrator would need to investigate the matter further. According to the DSD, the reason for the DSD's suspension was not specified or explained in detail. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:45 PM, the Administrator indicated receiving a report from an anonymous staff member on [DATE] regarding the code which occurred on [DATE]. According to the Administrator, the reporter specifically alleged the DSD did not perform CPR on R13 when CPR needed to be done. The Administrator indicated this report was recognized as an allegation of neglect. The Administrator confirmed sending the DSD home in accordance with protocol which required suspending staff members during an investigation. The Administrator indicated carrying out a full investigation into the DSD's inaction during R13's code blue which included obtaining verbal interviews and written statements from other staff members. On [DATE] at 2:50 PM, the Administrator indicated the incident was not reported to the state survey agency because at the time the report was received, the Administrator did not think the incident was reportable. The Abuse Coordinator explained being able to unsubstantiate neglect based on information gathered within two hours of receiving the report, but the DSD remained suspended because the Administrator wanted staff interviews to be provided in written form instead of verbal. Written statements were provided to the Administrator on [DATE] at 1:09 PM by the DSD, on [DATE] at 1:11 PM by a CNA and on [DATE] at 11:02 AM by a Licensed Practical Nurse. According to the Administrator, the DSD was reinstated on [DATE]. The Alleged or Suspected Abuse Crime Reporting policy revised [DATE], documented to protect residents from harm or retaliation during an investigation, the facility shall suspend staff members believed to be involved, pending outcome of an investigation. It is the responsibility of all employees to immediately report any incident of suspected or alleged abuse or neglect to the Facility Administrator. Allegations of abuse and neglect will be reported immediately but not later than two hours if the incident resulted in serious bodily injury and no later than 24 hours if it does not result in serious bodily injury from the time the allegation was made. Reporting is made to the Abuse Coordinator, the state survey agency, and other required agencies. The Facility Administrator or designee shall report investigative findings to officials in accordance with state law, including state licensing and certification agencies, within five working days of the incident.

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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** 40131 Based on interviews, record reviews, and document reviews, the facility failed to ensure a person-centered baseline care plan for a resident at high risk for falls had been formulated within 48 hours following admission for 1 of 14 sampled residents (Resident 1). The deficient practice resulted in inadequate management of existing fall-related injuries. Findings include: Resident 1 (R1) R1 was admitted on [DATE] and discharged on [DATE], with diagnoses including Parkinson's disease, muscle wasting and atrophy, weakness, obesity, a history of falling, and muscle weakness. The Brief Interview of Mental Status dated 04/19/2024, documented a score of 8/15, which indicated R1's cognitive status was moderately impaired. R1's Fall Risk assessment dated [DATE], documented a score of 75, which indicated a high risk of falling. R1's gait was weak, impaired, and had fallen within the last three months. The Morse Fall Scoring system classifies falls into three categories: high risk (45 and higher), moderate risk (25-44), and low risk (0-24). R1's medical records lacked documented a baseline care plan was formulated within 48 hours of R1's admission. On 06/13/2024 at 2:25 PM, a Registered Nurse (RN) confirmed the baseline care plan had not been developed for R1, who was at risk for falls. The RN explained the admission nurse was responsible for initiating the person-centered care plan upon the resident's admission. On 06/14/2024 at 8:42 AM, the Assistant Director of Nursing (DON) confirmed R1 was admitted as high risk for falls due to a history of falling at home and the reason for hospitalization . The ADON explained the Fall Risk assessment dated [DATE] indicated a score of 75, signifying R1 was at very high risk for falls. The ADON confirmed there was no baseline care plan developed to manage the fall of R1. The ADON indicated the care plan was crucial for fall precautions for a resident who was identified as high-risk for falls. On 06/14/2024 at 2:14 PM, the Director of Staff Development (DSD) indicated the baseline care plan should have been formulated to appropriately care for the high-fall-risk residents. The DSD explained at the time, fall risk indicators had not been implemented yet, so formulating a care plan was crucial for staff awareness and effective care and monitoring. A facility policy titled Baseline Care Plan dated October 2022, documented the baseline care plan would be developed within 48 hours of a resident's admission. Include the minimum amount of healthcare information required to properly care for a resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #NV00071056

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review and document review, the facility failed to ensure showers were provided as scheduled for 1 of 14 sampled residents (Resident 5). The deficient practice placed dependent residents at risk for not receiving assistance with activities of daily living (ADLs). Findings include: Resident 5 (R5) R5 was admitted on [DATE], with diagnoses including right femur fracture and head contusion. The admission minimum data set (MDS) dated [DATE], revealed R5 required maximum substantial assistance with bathing. On 06/14/2024 at 8:55 AM, the Director of Nursing (DON) indicated R5's showers were scheduled on Wednesday and Sunday by day shift staff. The medical record lacked documented evidence R5 was provided a shower or bed bath on 05/08/2024 and 05/12/2024. On 06/14/2024 at 9:32 AM, the DON recounted R5's family member called the facility regarding missed showers. The DON reviewed R5's shower sheets and confirmed there was no documentation R5's scheduled showers/bed baths were offered, provided, or refused on 05/08/2024 and 05/12/2024. The Activities of Daily Living (ADLs) policy revised 10/22/2022, documented the facility would provide care and services based on the resident's comprehensive assessment which included bathing. A resident who was unable to carry out ADLs would receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Complaint #NV00071117

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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 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** 40131 Based on interviews, record reviews, and document review, the facility failed to ensure the resident's skin or surgical incision site had been appropriately assessed, weekly skin assessments were completed per protocol, and the resident's skin conditions pre- and post-removal of the staples were appropriately documented for 1 of 14 sampled residents (Resident 2). The deficient practice could have the potential to compromise residents' health and providing ineffective treatment. Findings include: Resident 2 (R2) R2 was admitted on [DATE], and discharged on [DATE], with diagnoses including encounter for change or removal of surgical wound dressing, displaced intertrochanteric fracture of right femur. The Skin Inspection form dated 10/30/2023 documented: three surgical incisions on R2's right hip: 6 staples right upper thigh, 5 staples right lateral and 6 staples. The skin was intact other than surgical incision. The location of the staples was not clearly indicated. A Physician Order dated 10/30/2023 documented, surgical incision to right hip: to cleanse with normal saline, pat dry, apply dry dressing every day shift on Tuesday, Thursday, and Saturday. A Physician Order dated 10/30/2023 documented, surgical incision to right lateral thigh: to cleanse with normal saline, pat dry, apply dry dressing every day shift on Tuesday, Thursday, and Saturday. A Physician Order dated 10/30/2023, documented surgical incision to right upper thigh: to cleanse with normal saline, pat dry, apply dry dressing every day shift on Tuesday, Thursday, and Saturday. The Physician Progress Notes dated 11/13/2023, documented R2 was seen by ortho, staples removed. The note did not document how many staples were removed. R2's medical records lacked documented evidence the resident's skin or surgical incision site had been thoroughly assessed, weekly skin assessments were completed per protocol, and the resident's skin conditions pre- and post-removal of the staples were thoroughly documented. The Discharge Summary dated 12/04/2024, documented R2 was previously hospitalized following a fall and found with to have a right femur fracture. R2 underwent an intramedullary nailing on 10/27/2024. On 06/14/2024 at 8:42 AM, the Assistant Director of Nursing (ADON) indicated the wound team was responsible for skin or wound assessment and providing treatment to residents who had wounds following surgery. The ADON confirmed R2's baseline skin assessment was incomplete due to unclear documentation of the staple locations. The ADON indicated a thorough assessment of the surgical incision site should have been conducted and monitored, and weekly skin assessments should have been completed and documented to ensure appropriate care was provided and the goal had been achieved. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/14/2024 at 2:22 PM, the Wound Care Treatment Nurse (WCTN) indicated R2 was admitted on [DATE], and a skin inspection assessment was performed on 10/30/2023. The WCTN indicated upon R2's admission per documentation, there were three surgical incisions to the right hip, six staples to the right upper thigh, five staples, and another six staples documented, but the locations were not clearly indicated. The WCTN indicated the Wound Coordinator initially assessed R2 and confirmed there were no follow-through assessments of the surgical site, and weekly skin assessments were not completed. The WCTN explained the process of performing a skin assessment either during treatment or on a weekly basis, describing the appearance of the surgical incision site, the skin, or the wound, and any signs of drainage, redness, or swelling. After evaluating the surgical site to confirm the wound's sufficient healing for staple removal, the WCTN indicated it was critical to account for and document the number of staples. The WCTN confirmed the surgical site's condition with the staples was limited or incomplete. A facility policy titled Skin Integrity dated August 2014, documented residents identified to be at risk for skin breakdown would have a routine assessment and interdisciplinary care plan process implemented to maintain and improve skin integrity. Weekly head to toe assessment would be completed of all residents by a Licensed Nurse. If skin integrity issues were identified post admission to the facility, the following information was required: wound specifics: location of wound, size of the wound, amount of drainage, description of the wound, odor, stage, description of surrounding tissue. Complaint #NV00070513

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interviews, record reviews, and document review, the facility failed to ensure the resident's wound had been treated as ordered and appropriately documented when the treatment had not been provided for 1 of 14 sampled residents (Resident 14). This deficient practice could have the potential to result in worsening of the wound, increased risk of infection, delayed healing, and overall deterioration of the resident's health. Findings include: Resident 14 (R14) R14 was admitted on [DATE], with diagnoses including right hip arthritis due to bacteria and surgical aftercare, right hip primary osteoarthritis, and encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. A Care Plan initiated on 06/05/2024, documented R14 had impaired skin integrity related to right hip surgical wound status post-surgery. The interventions included were to provide or monitor treatment. The History and Physical Examination dated 06/06/2024, documented R14 was previously hospitalized for Strep bacilli bacteremia secondary to right hip septic arthritis. The Brief Interview of Mental Status dated 06/11/2024, documented a score of 15/15, which indicated R14's cognitive status was intact. The Skin and Wound Evaluation dated 06/06/2024, documented an open lesion to the front right trochanter (hip) present on admission. A Physician order dated 06/06/2024, documented to cleanse the right hip with normal saline, pat dry. Apply iodosorb and cover with dry dressing every day shift, every Tuesday, Thursday, and Saturday for open wounds. The Braden Scale for Predicting Pressure Sore Risk dated 06/12/2024 and 06/14/2024, documented a score of 17, which indicated R14 was at risk for developing skin issues. On 06/13/2024 at 9:38 AM, during wound treatment observation, R14 was in bed, alert and verbally responsive. The Wound Coordinator (WC), Wound Care Treatment Nurse (WCTN) and the Wound Care Nurse Practitioner (WCNP) were at bedside. The WC prepared to provide treatment, and the previous wound dressing on R14's right hip was revealed with a date of 06/08/2024. The WC confirmed the wound dressing was dated 06 /08/2024. The WC and WCTN proceeded to provide wound treatment, while the WCNP assessed R14's right hip wound and gave new orders. The Treatment Administration Record (TAR) documented the treatment was provided on 06/08/2024 and 06/11/2024. On 06/13/2024 at 9:40 AM, the WCTN confirmed the resident's treatment was scheduled three times a week on Tuesday, Thursday, and Saturday. The WCTN verified and confirmed treatment was not provided on 06/11/2024, despite being documented as completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/2024 at 9:50 AM, the WCNP indicated the wound care treatment should have been provided as ordered to promote healing and prevent further complications. The WCNP indicated the staff were expected to provide the wound treatment on time. On 06/13/2024 at 10:05 AM, R14 indicated had surgery on the right hip in the hospital and the incision site had become infected. R14 indicated receiving antibiotics and wound care treatment. R14 was unaware of the frequency of the treatment but indicated the last wound treatment had been provided five (5) days ago and again today. R14 expressed a desire for the wound to heal. On 06/13/2024 at 10:10 AM, the WC confirmed the dressing was dated 06/08/2024, which was five days old. The WC verbalized the treatment was not performed on 06/11/2024, despite being documented as completed. The WC explained had assumed another WCTN had provided the treatment. The WC explained the correct process was to verify wound care orders, provide the treatment, and document the procedure. If a resident missed their treatment, the physician should be notified. The WC indicated failing to provide timely treatment as ordered could lead to ineffective treatment and a potential wound infection. On 06/14/2024 at 8:42 AM, the Assistant Director of Nursing (ADON) acknowledged R14 had active orders for wounds. The ADON indicated the wound team was expected to provide treatments as ordered and document accurately in the TAR to promote healing. On 06/14/2024 in the morning, the Director of Nursing (DON) indicated timely provision of wound treatment as ordered and accurate documentation were expected. A facility policy titled Skin Integrity dated August 2014, documented to actively manage risk, and determine appropriate interventions to achieve positive clinical outcomes. Complaint #NV00071056

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on interviews, record reviews, and document reviews, the facility failed to ensure: 1) fall interventions and management had been implemented when a resident's risk factors were identified upon admission and categorized as high risk for falls for 1 of 14 sampled residents (Resident 1), 2) the post-fall incident had been thoroughly investigated when documentation indicated a resident had fallen during peri-care, the fall circumstances and root cause analysis had been determined and approaches or interventions based on actual causal factor had been implemented per policy for 1 of 14 sampled residents (Resident 1), 3) the physician and family had been timely notified following a post-fall incident per policy for 1 of 14 sampled residents (Resident 1), and 4) an assessment had been completed upon the resident's return from the hospital following a fall in the facility, care orders had been obtained to manage the resident's cast and appropriate care had been implemented to monitor the cast to treat a fractured wrist for 1 of 14 sampled residents (Resident 1). These deficient practices resulted in a fracture and inadequate management of existing fall-related injuries. Findings include: Resident 1 (R1) R1 was admitted on [DATE] and discharged on [DATE], with diagnoses including Parkinson's disease, muscle wasting and atrophy, weakness, obesity, a history of falling, and muscle weakness. The Brief Interview of Mental Status dated 04/19/2024, documented a score of 8/15, which indicated R1's cognitive status was moderately impaired. R1's Fall Risk assessment dated [DATE], documented a score of 75, which indicated a high risk of falling. R1's gait was weak, impaired, and had fallen within the last three months. The Morse Fall Scoring system classifies falls into three categories: high risk (45 and higher), moderate risk (25-44), and low risk (0-24). 1) R1's medical records lacked documented evidence R1's fall precautions and management had been implemented when R1's risk factors were identified upon admission and categorized as high-risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/14/2024 at 7:40 AM, an LPN who had been assigned to R1 on the night of the fall incident indicated on 04/11/2024 at 1:15 PM, a CNA reported finding R1 on the floor. The LPN responded immediately and found R1 on the floor, without a fall mat present, and the bed approximately at waist level. The LPN explained R1 had not been considered a fall risk upon admission, so no fall prevention measures had been implemented. On 06/14/2024 at 8:42 AM, the Assistant Director of Nursing (ADON) confirmed R1 was admitted as high risk for falls due to a history of falling at home and the reason for hospitalization . The Morse Fall Risk assessment dated [DATE] indicated a score of 75, signifying R1 was at very high risk for falls. The ADON confirmed no documented interventions were in place for R1. When the ADON started to work at the facility, the ADON observed no fall precautions were implemented for residents identified as high-risk. No fall indicators by the door or fall risk bracelets were in use. The ADON indicated that the facility was just beginning to implement precautions upon residents' admission, and staff members would receive training. The ADON indicated R1 had Parkinson's disease and was identified as high risk for falls. The ADON explained interventions could have been implemented, such as low bed positioning and the provision of fall mats since R1 was non-ambulatory. The ADON confirmed R1 had a fall incident on 04/11/2024, at the facility and during the time, no interventions were in place. On 06/14/2024 at 2:14 PM, the DSD indicated the facility had never implemented the fall indicators to signify precautions for the high fall risk residents. A facility policy titled Fall Prevention and Response revised August 2023, documented each resident would be assessed for fall risk factors and would receive care and services in accordance with an individualized level of risk to minimize the likelihood of falls. For residents with identified fall risk factors upon admission, the facility would implement bed in lowest position if a resident could not transfer. Providing supervision and physical assistance in accordance with assessed needs. 2) R2's medical records lacked documented evidence the post-fall incident had been thoroughly investigated when documentation indicated a resident had fallen during peri-care, the fall circumstances and root cause analysis had been determined and approaches or interventions based on actual causal factor had been implemented per policy. The e-interact dated 04/11/2024, documented by the Charge Registered Nurse (CRN), documented R1 was dependent on activities of daily living, was alert and oriented times 3-4, and was able to verbalize needs. R1 was incontinent due to immobility. The CRN documented R1 had fallen out of bed in the facility during pericare/brief change the night prior; R1 hit head. PCP ordered neurochecks, but no abnormal results were noted until early evening. R1 appeared groggier and complained of pain in the posterior R scalp & R anterior face (near nose). R1 complained of pain in the left hand, thumb, and first two fingers. Orders received to send to the emergency room for computed tomography (CT) of the brain and an X-ray of the left hand. A Care Plan dated 04/11/2024, documented R1 had an actual fall. The intervention consisted of monitoring neurochecks and vital signs. No fall precautions or management were indicated after the fall incident to prevent a recurrence. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Post Fall Notes dated 04/18/2024, documented by the ADON revealed, R1 rolled from bed to the floor, unwitnessed. R1 had a left arm injury on 04/11/2024, complained of pain in the back of R1's head and neck and the right side of R1's face, bump on the back of the head was observed. This writer was notified by the Licensed Practical Nurse (LPN) R1 had a fall. The LPN reported finding R1 on the floor, lying on the left side of the bed. Reports indicated R1 had rolled out of bed and slightly hit R1's head. On 06/13/2024 at 3:00 PM, the Director of Nursing (DON) indicated was aware of R1's fall from bed on 04/11/2023, and sustained a suspected fracture on the left wrist based on the X-ray conducted in the hospital. The DON indicated the Charge Registered Nurse (CRN) who documented R1 fell out of bed in the facility during pericare no longer worked at the facility. The DON indicated the ADON was responsible with fall incidents. On 06/14/2024 at 8:42 AM, the ADON acknowledged the post-fall report was completed by the ADON. The ADON acknowledged the e-interact information was a transfer document handed to the paramedics when R1 was picked up to transport R1 to the hospital. The ADON expressed unawareness R1 fell during pericare, as documented. The ADON indicated was responsible for following through on the fall incident investigation but had missed further investigating R1's fall incident during pericare or a brief change as documented. The ADON indicated the CRN, who no longer worked at the facility, completed the report. The ADON explained that the fall incident was being reviewed but had not been discussed with the Interdisciplinary Team (IDT). The ADON stated that stand-up meetings were conducted daily, but R1's fall incident on 04/11/2024 had not been discussed because the meetings focused on other matters. The ADON confirmed there was no documented evidence of attempts to determine the root cause of R1's fall incident, nor were any interventions implemented based on actual factors. A facility policy titled Fall Prevention and Response revised in August 2023, documented when a resident experienced a fall, the IDT should review the underlying circumstances and establish fall prevention interventions accordingly: a) meet as soon as practically possible following the incident; b) review fall circumstances and attempt to determine the root cause; c) customize interventions or approaches based on actual or suspected causal factors; d) coordinate appropriate care and referrals to address underlying circumstances; e) review any applicable accident trends and risk factors; and f) review and update the care plan/Kardex as indicated. 3) R2's medical records lacked documented evidence the physician and family had been timely notified following a post-fall incident per policy. The situation, background, assessment, and recommendation (SBAR) dated 04/11/2024, documented R1 had a fall on 04/11/2024 at 1:15 AM. R1 slid from the bed, and a CNA found R1 on the floor on the left side of R1's bed, lying on the left side of the body. The SBAR lacked documented evidence the family or representative was notified. A Physician Progress Note dated 04/12/2024 documented, nursing's report of a fall and left wrist pain on the prior evening, was sent to the emergency room , and R1 returned to the facility the previous night. The attending physician documented being informed about the initial fall only after R1's arrival from the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295066	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Hills Health Care Center	3450 N Buffalo Dr Las Vegas, NV 89129

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/14/2024 at 7:40 AM, an LPN who was assigned to the care of R1 on the night of the fall confirmed the SBAR was completed but could not remember if the physician or the family was notified. On 06/14/2024 at 8:42 AM, the Director of Nursing (DON) verified and confirmed there was no documentation the family had been notified. The ADON confirmed the SBAR documented as self, referring to R1 as self-responsible as indicated in the face sheet. The DON indicated for any change of condition, like a fall incident the physician should have been notified immediately, and the family should have been involved if the resident was alert or self-responsible. A facility policy titled Fall Prevention and Response revised August 2023, documented when any resident experienced a fall, the Licensed Nurse should notify the physician and responsible party. A facility policy titled Change of Condition (undated), documented the Licensed Nurses should notify the physician as soon as practical and notify the responsible party. 4) R1's medical records lacked documented evidence an assessment had been completed upon the resident's return from the hospital following a fall in the facility, and care orders had been obtained to manage the resident's cast and appropriate care had been implemented to monitor the cast to treat a fractured wrist. The hospital Radiology Report dated 04/11/2024, documented the impression of a suspected acute nondisplaced fracture of the distal radius extending to the articular surface. A Physician Progress Note dated 04/12/2024 documented nursing's report of a fall and left wrist pain on the prior evening. R1 was sent to the emergency room , and an X-ray showed an acute, nondisplaced left wrist fracture, leading to the application of a splint or cast. R1 returned to the facility the previous night. On 06/13/2024 at 2:25 PM, a Registered Nurse (RN) explained being off when the fall incident occurred, but upon returning to work, a cast on R1's left wrist was observed. The family was at the bedside, and R1 reported the fall to the RN, stating R1 told the CNA, I'm falling. I'm falling, but the CNA did not believe it. The RN indicated R1 was fully dependent on ADLs and bed-bound, requiring two-person assistance due to bed mobility dependence and obesity. The RN confirmed there were no orders in place to manage or monitor R1's cast to treat the fractured wrist. On 06/14/2024 at 7:40 AM, an LPN who had been assigned to R1 on the night of the fall incident on 04/11/2024, indicated had returned to work the next night. The LPN was advised by the CRN R1 had been transferred to the hospital due to pain and swelling in the left wrist. An X-ray had revealed a wrist fracture, and R1 had returned to the facility with a cast applied in the hospital. The LPN indicated went to check on R1 and observed a cast on R1's left wrist and a sling on. The LPN conveyed the Licensed Nurse who admitted R1 upon return to the facility was responsible for assessing R1 and obtaining orders. On 06/14/2024 in the morning, the Director of Rehabilitation (DOR) indicated R1 was seen upon return to the facility with a cast or splint in the left wrist, as documented. The DOR indicated R1's left wrist was non-weight-bearing and was not included in the treatment plan. The DOR indicated nursing was responsible for the assessment and obtaining orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295066	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Hills Health Care Center	3450 N Buffalo Dr Las Vegas, NV 89129

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/14/2024 at 12:35 PM, the attending physician reviewed and verified R1's fall incident in the facility on 04/11/2023, which resulted in a fractured wrist. The Physician indicated the facility did not mention the reason of R1's fall. The physician indicated R1 was transferred to the hospital due to complaints of pain and swelling in the left wrist following the fall. The physician indicated a CT and X-ray were performed in the hospital, and the X-ray revealed a non-displaced fracture to R1's left wrist. R1 returned to the facility with a cast to left wrist to treat the fracture. Although the hospital X-ray indicated a suspected acute nondisplaced fracture of the distal radius, the physician determined it was still a fracture. The physician further explained the X-ray impression would remain suspected until an MRI was performed, but it was most likely a fracture. R1 was referred to an orthopedic specialist. The physician confirmed R1 had a fall in the facility which resulted in nondisplaced left distal radial fracture. The Physician indicated assessment and appropriate interventions were expected. A facility policy titled Fall Prevention and Response, revised in August 2023, documented each resident would be assessed for fall risk factors and would receive care and services in accordance with their individualized level of risk to minimize the likelihood of a fall. The facility would assess each resident's individual fall risk factors and implement comprehensive, resident-centered fall prevention plans for those with a recent history of falls. When a resident falls, the IDT should review the underlying circumstances and establish person-centered fall prevention interventions, including customizing interventions or approaches based on actual or suspected causal factors, coordinating appropriate care, and reviewing and updating the care plan or Kardex as indicated. Complaint #NV00071056