

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Silver Hills Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3450 N Buffalo Dr Las Vegas, NV 89129	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51396</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure an assessment was completed for the self-administration of medication for 1 of 6 sampled residents (Resident 6). The deficient practice had the potential for the resident's unsafe administration of medication.</p> <p>Findings include:</p> <p>Resident 6 (R6) was admitted on [DATE], with diagnoses including gout, Type 2 diabetes and generalized muscle weakness.</p> <p>On 02/04/2025 at 8:50 AM, observed on R6's bedside table was a purple bottle of Vicks ZzzQuil Pure Zzzs Sleep Aid Melatonin Gummies, 1 milligram for sleep support. R6 indicated the resident's family brought the bottle of melatonin two days ago, 02/02/2025. R6 verbalized taking two gummies last night.</p> <p>On 02/04/2025 at 2:01 PM, a Registered Nurse (RN) confirmed the observations and was unaware the resident had the medication at bedside. The RN indicated the resident's family should have notified the nurses if a medication was brought to the facility. The RN explained a physician's order should have been obtained for self-administration of the medication.</p> <p>R6's medical record lacked documented evidence of an assessment for the self-administration of medication and a physician's order.</p> <p>On 02/04/2025 at 3:03 PM, the Director of Nursing (DON) verified there was no evidence of a physician's order for self-administration of medication. The DON indicated the resident did not have a self-administration of medication assessment. The medication should have been kept in a secured bedside storage.</p> <p>The facility's policy titled Self-Administration of Medication from Covenant Care Resident Care Procedures dated 2008, documented the actions needed for any resident to self-administer medication within the facility. Prior to allowing any resident to self-administer medication the following items must be in place:</p> <ul style="list-style-type: none"> <li>- The resident's evaluation of self-medication from the nurse</li> </ul> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- The interdisciplinary team's assessment and outcome of the resident</li> <li>- Physician's approval</li> <li>- Bedside storage that prevents other residents from accessing the medication</li> </ul>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289</b></p> <p>Based on interview, record review, and document review, the facility failed to ensure an allegation of physical and verbal abuse were thoroughly investigated for 1 of the 6 sampled residents (Resident 3). This deficient practice could potentially compromise the safety and well-being of other residents.</p> <p>Findings include:</p> <p>Resident 3 (R3) was readmitted to the facility on [DATE], with diagnoses including urinary tract infection, chronic obstructive pulmonary disease, atherosclerotic heart disease, and personal history of transient ischemic attack.</p> <p>A facility Grievance/Complaint Resolution Report dated 01/10/2025, documented possible physical and verbal abuse which had occurred over the weekend. R3 reported two staff came into the room at night to take care of R3. While performing the care, R3 complained the staff were too rough when moving R3 and spoke rudely to R3. R3 remembered one staff had a beard on the side of their face.</p> <p>On 02/04/2025 at 2:12 PM, the Social Services Assistant (SSA explained the date of the incident was not correct on the form and the date should have been 01/13/2025. The SSA expressed R3 was not able to elaborate on how the staff person spoke to R3 rudely. The SSA stated was trying to determine whether it was the tone the staff person used or whether it was what the staff person said. The SSA said R3 stated it was both but could not elaborate because this happened in the middle of the night and R3 could not remember exactly what was said. The SSA was able to surmise from what staff was working who the staff person was based on the description provided by the resident. The information was passed on to the Director of Nursing (DON) who agreed with the SSA to remove the staff person from the resident's care.</p> <p>The facility Grievance/Complaint Resolution Report dated 01/10/2025, documented the grievance was confirmed. The facility adjusted the schedule to remove the staff from the room and educated staff members to be conscientious of conversations and tones and handling residents during care. The facility notified the resident of the adjustment in the nursing schedule.</p> <p>On 02/04/2025 at 3:53 PM, the Director of Staff Development (DSD) affirmed a grievance like this would go to Social Services. Social Services would talk to the resident who filed the grievance, talk to other residents around the resident, and talk to the staff. Social Services would request the DSD to provide education. The DSD confirmed there was no documentation interviews were conducted with staff or residents regarding the allegation of abuse.</p> <p>On 02/04/2025 at 4:06 PM, the Administrator confirmed being the Abuse Coordinator. The Administrator explained if a grievance were to come in where a staff person was rude and rough with a resident, the following would occur:</p> <ul style="list-style-type: none"> <li>- the resident would be checked to make sure they feel safe</li> <li>- the resident would be interviewed to obtain more detailed information about the incident</li> </ul> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- the resident would be assessed for any bruises and/or injuries</li> <li>- Interviews with the roommate and/or other residents in close by rooms cared for by the same staff would be conducted.</li> <li>- management would check the schedules to see what staff member was working on these days which might match the description given.</li> <li>- an interview with the alleged staff members would be conducted.</li> <li>- the alleged staff member would be suspended, and the facility would continue with the investigation.</li> </ul> <p>The Administrator confirmed there was no other documentation for this incident. and other residents and the alleged staff members were no interviewed and an investigation was not completed.</p> <p>A facility policy titled Alleged or Suspected Abuse and Crime Reporting revised on 10/2022, indicated it was the responsibility of all employees to immediately report to the facility administrator any incident of suspected or alleged abuse. All reports are timely and thoroughly investigated. All alleged victims and perpetrators, as well as others which may have direct knowledge of the incident should be interviewed. Staff members believed to be involved, would be suspended pending the outcome of the investigation. The facility would protect all residents and staff from harm or retaliation when the incident was being investigated.</p>

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289</b></p> <p>Based on interview, record review and document review the facility failed to provide and document sufficient preparation and orientation prior to notification of discharge for 2 of 6 sampled residents (Resident 3 and 5). This deficient practice had the potential to place the resident at risk for an unsafe discharge.</p> <p>Findings include:</p> <p>1.) Resident 3 (R3) was readmitted to the facility on [DATE], with diagnoses including urinary tract infection, chronic obstructive pulmonary disease, atherosclerotic heart disease, and personal history of transient ischemic attack.</p> <p>A Notice of Medicare Non-Coverage document was issued to R3 on 01/07/2025. The resident's family helped R3 file an appeal to the discharge. R3 won the appeal.</p> <p>A Notice of Medicare Non-Coverage document was issued to R3 on 01/14/2025. The resident's family helped R3 file an appeal to the discharge. R3 won the appeal.</p> <p>A Notice of Medicare Non-Coverage document was issued to R3 on 01/16/2025 with a discharge date of [DATE]. R3 did not file an appeal this time.</p> <p>On 02/04/2025 at 10:00 AM the Social Services Director (SSD) stated the Case Managers (CM) were responsible for resident discharges. The SSD stated Social Services did get involved with this discharge after the family of R3 and the CM were not able to work together amicably.</p> <p>The Social Services progress notes documented the SSD became involved in the discharge planning process for R3 on 01/17/2025.</p> <p>The medical record lacked documented evidence discharge planning had taken place prior to issuing the Notice of Medicare Non-Coverage document to R3. The first CM discharge note was on 01/07/2025 documenting the equipment needed for R3 and discussing hospice options with the family.</p> <p>On 02/04/2025 at 10:16 AM, CM1 stated the facility had a weekly inter-disciplinary meeting with the insurance company to determine which residents would be issued a Notice of Medicare Non-Coverage document. The CM would start discharge planning when the notice was issued. The CM stated discharge planning did not start prior to the Notice of Medicare Non-Coverage document being given to the resident. The CM contacted R3's family on 01/07/2025 to begin discharge planning and discuss the Notice of Medicare Non-Coverage document. The CM stated the SSD became involved with the discharge planning with R3 as the family was condescending, rude, and insulting to the CM.</p> <p>On 02/04/2025 at 11:28 AM, CM2 stated discharge planning began on admission. CM2 affirmed meeting the resident within 24 hours after being admitted was expected to get the pertinent discharge information like the resident's current living situation and if the resident could return to this place, any medical equipment the resident had at home, whether the resident had any family/friends which would be able to assist them at home with any care they may need.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/04/2025, the SSD confirmed it was best practice and expected that discharge planning began when the resident was admitted to the facility.</p> <p>51396</p> <p>2.) Resident 5 (R5) was admitted to the facility on [DATE], with diagnoses including partial left side paralysis due to stroke.</p> <p>The resident's insurance coverage ended on 01/01/2025 and the resident's discharge was to be effective 01/02/2025.</p> <p>The resident's medical record lacked documented evidence the facility provided discharge planning prior to the resident's discharge on 01/02/2025.</p> <p>On 02/6/2025 at 9:00 AM, Case Manager 1 (CM) indicated the discharge planning began when the insurance submits an intent to discharge. Upon admission, the CM would conduct a discharge assessment of the resident and annotate the notes from the assessment on a personal paper tracker. The notes would be kept on the CM's personal tracker until the resident's discharge which it would then be shredded. The CM indicated the notes were not scanned into the electronic medical record. The CM confirmed there were no CM notes within the medical record to determine what discharge planning was done for R5.</p> <p>On 02/06/2025 at 9:21 AM, Case Manager 2 (CM2), conveyed being the only CM working in the facility in the beginning of December 2024. CM2 did not participate in the interdisciplinary team (IDT) meetings during this time. The CM indicated discharge assessments were performed on all residents on admission. The assessments were not charted in the electronic health record. CM2 would make an internal note from the encounter to determine the resident's needs at discharge. CM2 explained having conversations with R5 and R5's family regarding discharge plans but admitted to not charting the conversations in the electronic medical record. CM2 indicted it should have been documented in the medical record.</p> <p>On 02/06/2025 at 2:15 PM, the Director of Nursing (DON) explained the expectations of the case manager. The case manager's duties included coordinating with the IDT and the insurance companies to create a discharge plan. Any conversations conducted with the resident or family from admission to discharge should be documented in the electronic medical record. The DON verified the medical record lacked documented evidence discharge planning was done for the resident.</p> <p>The job description for the case manager revised on 11/13/2017 documented the case manager would coordinate communication of IDT to accurately assess and manage resident clinical progress to attain goal necessary for discharge. The case manager would provide accurate and complete documentation.</p> <p>The facility did not have a policy for Discharge Planning. The facility provided a Discharge Planning Positive [best] Practice document revealing to facilitate effective discharge planning, it was imperative to have a clear picture of how the resident was functioning prior to the facility admission.</p> <p>Complaint NV00073123</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint NV00073228</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51395</p> <p>Based on interview, record review and document review the facility failed to provide bathing as scheduled for 1 of 6 sampled residents (Resident 1). The deficient practice had the potential to negatively impact the resident's overall well-being.</p> <p>Findings include:</p> <p>Resident 1 (R1) was admitted on [DATE] and discharged on [DATE] with diagnoses including displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, muscle weakness, and difficulty walking.</p> <p>The Admission Minimum Data Set (MDS) dated [DATE] documented R1 required maximal assistance to shower/bathe self, including washing, rinsing, and drying self (excludes washing of the back and hair).</p> <p>R1's shower day skin inspection sheets documented the following bathing activity:</p> <ul style="list-style-type: none"> <li>- Wednesday, 05/01/2024 a bed bath.</li> <li>- Sunday, 05/05/2024 a bed bath.</li> <li>- Sunday, 05/19/2024 a shower.</li> <li>- Sunday, 05/26/2024 a shower.</li> </ul> <p>A Progress note dated 5/10/2024 at 4:53 PM by the Director of Nursing (DON) documented the Restorative Nurse Assistant (RNA) gave R1 a shower that afternoon.</p> <p>On 02/204/2025 at 3:00PM, a Registered Nurse confirmed the bathing schedule for R1's assigned room was every Wednesday and Sunday on the day shift.</p> <p>R1's medical record and shower day skin inspection sheets lacked documentation of bathing for scheduled days of:</p> <ul style="list-style-type: none"> <li>- Wednesday, 05/08/2024</li> <li>- Sunday, 05/12/2024</li> <li>- Wednesday, 05/15/2024</li> <li>- Wednesday, 05/22/2024</li> <li>- Wednesday, 05/29/2024</li> </ul> <p>(continued on next page)</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/04/2025 at 10:52 AM, an RNA verbalized residents had showers scheduled twice a week. The showers were documented on a shower sheet.</p> <p>On 02/04/2025 at 1:20 PM, a CNA stated residents had showers twice a week.</p> <p>On 02/04/2025 at 1:30 PM, the DON confirmed the resident showers were documented under the CNA Activities of Daily Living task section of the electronic medical record and shower day skin inspection sheets were also to be filled out.</p> <p>Complaint NV00073143</p>