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	09/06/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 33980 Based on interview, record review and document review, the facility failed to ensure assistance with activities of daily living (ADLs) were provided to 3 of 29 sampled residents (R225, 226, and 229). The deficient practice had the potential for the residents' further decline and compromised the residents' skin integrity. Findings include: Resident 225 (R225) R225 was admitted on [DATE], with diagnoses including muscle wasting and atrophy, muscle weakness, abnormalities of gait and mobility, and need for assistance with personal care. R225's Care Plan documented the resident had self-care deficit as evidenced by needing assistance with ADLs related to pain. The following interventions/tasks were identified in the resident's care plan: - Bed Mobility - One person physical assist required. - Transfer - One person physical assistance required. - Toilet Use - One person physical assist required. On 09/04/2024 at 9:17 AM, R225 was lying in bed, alert, and oriented. R225 indicated the staff did not check the resident during night shift which made the resident felt insecure. R225 revealed being dependent, could not move, and had been lying in the same position for a long time. On 09/06/2024 at 9:20 AM, the Minimum Data Set (MDS) Director explained the certified nursing assistants (CNAs) would document in the electronic charting (point of care/POC) the assistance with ADLs provided to each resident at least every shift. The MDS Director revealed repositioning in bed or bed mobility could be documented on the following interventions/tasks in the ADL Flowsheet: - Lying to Sitting on Side of Bed: Move from lying on the back to sitting on side of bed with no back support. (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

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 09/06/2024
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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Roll Left and Right: Roll from lying on back to left and right side and return to lying on back on the bed. - Sit to Lying: Move from sitting on side of bed to lying flat on the bed. The MDS Director indicated R225 required a one person physical assist with bed mobility. R225's ADL Flowsheet for September 2024 was reviewed with the MDS Director. There was no documented evidence the resident was repositioned or provided assistance with bed mobility during the night shift on 09/02/2024 and 09/03/2024. The MDS Director confirmed the findings and indicated there was no documentation R225 had refused to be repositioned on the said dates and shift. The MDS Director explained when a resident refused to be repositioned, the CNA would document the refusal in the ADL Flowsheet and report to the nurse about the resident's refusal. On 09/06/2024 at 11:09 AM, a CNA revealed working on a 12-hour shift. The CNA explained the ADL documentation would be completed every shift using a tablet (electronic device). The CNA indicated the ADL assistance provided to each resident should be documented every time the care was given. When a resident refused the ADL assistance, the CNA would document the refusal in the ADL Flowsheet and would report to the nurse. The CNA confirmed R225 required maximum assistance with repositioning. The CNA revealed R225 should be repositioned every two hours and the resident could develop bed sores if not repositioned. The CNA indicated R225 had not refused to be repositioned. On 09/06/2024 at 1:13 PM, the Director of Nursing (DON) explained the CNAs were expected to provide personal care and hygiene to the residents upon request or should anticipate the residents' needs. The CNAs should document in the electronic charting the care or ADL assistance provided to the residents. The DON confirmed R225 was not using a low air loss mattress (LAL/provides airflow to help skin dry, as well as to relieve pressure) which could provide offloading or repositioning for the resident. Resident 226 (R226) R226 was admitted on [DATE], with diagnoses including muscle weakness, need for assistance with personal care, and chronic pain. The Admission MDS dated [DATE], documented R226 required substantial/maximal assistance with toileting hygiene. (The ability to maintain perineal hygiene, adjust clothes before and after urinating or having a bowel movement.) R226's Care Plan documented the following: - Resident had self-care deficit as evidenced by needing assistance with ADLs related to pain and weakness. The interventions/tasks identified in the resident's care plan included one person physical assistance with transfer, toilet use, and personal hygiene. (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	09/06/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident was incontinent of bowel/bladder related to functional, congestive heart failure, diuretics, and narcotics. The interventions/tasks identified in the resident's care plan included to check and change during personal care and to assist with toileting. On 09/04/2024 at 9:36 AM, R226 was lying in bed with a family member at bedside. R226's family member stated the resident was lying in urine for hours quite often. On 09/06/2024 at 9:40 AM, R226's ADL Flowsheet for August 2024 and September 2024 were reviewed with the MDS Director. There was no documented evidence the resident was provided with toileting hygiene during the night shift on 08/23/2024, 08/25/2024, 08/29/2024, 08/30/2024, 08/31/2024, and 09/02/2024. The MDS Director confirmed the findings and indicated R226 required substantial/maximal assistance with ADLs. The MDS Director revealed R226 needed help from staff with toileting hygiene which included changing the resident's adult briefs. Resident 229 (R229) R229 was admitted on [DATE], with diagnoses including lumbago with sciatica (left side), muscle weakness, need for assistance with personal care, and chronic pain. The Admission MDS dated [DATE], documented R229 had a Brief Interview for Mental Status (BIMS) score of 15 which could be interpreted as cognitively intact. The resident required substantial/maximal assistance with toileting hygiene, partial/moderate assistance with roll left and right, dependent with sit to lying and lying to sitting on side of bed. R229's Care Plan documented the following: - Resident had self-care deficit as evidenced by needing assistance with ADLs related to pain and weakness. The interventions/tasks identified in the resident's care plan included one person physical assistance with bed mobility, transfer, toilet use, and personal hygiene. - Resident was incontinent of bowel/bladder related to functional, narcotics, anti-psychotic, and anti-depressant. The interventions/tasks identified in the resident's care plan included to assist with toileting and clean perineal area with each incontinence episode. On 09/04/2024 at 12:05 PM, R229 was lying in bed, alert, and oriented. The resident revealed not being checked by staff for an hour and a half or longer which happened more at night shift. The resident stated feeling trapped and could not get up. The resident indicated having to wait for five hours not being changed at night even with bowel movement. On 09/06/2024 at 9:55 AM, R229's ADL Flowsheet for August 2024 and September 2024 were reviewed with the MDS Director. There was no documented evidence the resident was repositioned or provided assistance with bed mobility and toileting hygiene during the night shift on 08/23/2024. The MDS Director confirmed the findings and indicated R229 required a one person physical assist with bed mobility and toileting hygiene. On 09/06/2024 at 10:11 AM, R229 indicated during night shift the resident needed assistance with changing the adult briefs and repositioning. (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	09/06/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/06/2024 at 1:19 PM, the DON confirmed R229 was not using a low air loss mattress. The facility's policy titled Activities of Daily Living (ADLs) dated 10/22/2022, documented care and services would be provided for the following ADLs: - Bathing, dressing, grooming, and oral care - Transfer and ambulation - Toileting - Eating to include meals and snacks - Using speech, language or other functional communication systems A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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 09/06/2024
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)
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** 51397 Based on interview, document review and record review, the facility failed to follow physician's orders for one unsampled resident (Resident 276). The deficient practice had the potential to exacerbate a life-threatening medical condition. Findings include: Resident 276 (R276) R267 was admitted on [DATE] with diagnoses including pulmonary embolism (blood clot in the lung). On 09/05/24 at 8:15 AM, a Licensed Practical Nurse (LPN) was observed dispensing R276's medications. The LPN stated they could not find R276's blood thinning medication (Lovenox), used to prevent blood clots. The LPN then went to check the back-up supply but found none. The LPN stated when medications were low in the cart, staff could reorder the medication within medication administration record (MAR) in the computer. LPN stated they were not sure when the medication would arrive, and stated the resident would be late getting the medication. On 09/05/24 at 12:33 PM, the LPN stated the out-of-stock Lovenox had not been delivered. LPN stated R276 was taking the medication due to a pulmonary embolism and stated R276 was also taking another blood thinning medication, Warfarin. On 09/05/24 at 12:38 PM, R276 revealed three weeks ago, they were found unresponsive at home and taken to the emergency room . R276 was diagnosed with a pulmonary embolism and placed on the two blood thinning medications. On 09/05/24 at 2:33 PM, the LPN stated the Lovenox had not been delivered. On 09/05/24 at 4:00 PM, the LPN confirmed the Lovenox had just been delivered. Review of the physician orders for September 2024, showed the Lovenox was to be administered every 12 hours to prevent blood clots. Review of the MAR for September 2024 revealed R276 was scheduled to receive the Lovenox at 8 AM and 8 PM daily (every 12 hours). The MAR indicated this was to prevent blood clots from forming. The MAR also showed R276 last received the Lovenox the day before on 09/04/2024 at 7:48 PM. At the time of the medication delivery, it was more than 12 hours the resident did not receive the medication. On 09/06/24 at 10:57 AM, R276's Physician stated the reason R276 was placed on the Lovenox was due to the Warfarin not providing adequate therapeutic effects. The Physician stated if R276 did not receive the Lovenox for more than 12 hours, it greatly increased R276's risk for another pulmonary embolism. The physician stated the facility should have but did not notify them, R276 did not get the medication as scheduled. (continued on next page)

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 09/06/2024
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/06/24 12:30 PM, the Director of Nursing (DON) stated the medication should have been ordered by the nurse who administered the last dose. DON stated the situation would have been avoidable if the medication was ordered timely. Review of the facility Policy titled Medication Administration revised on 10/22/2023, indicated the following: - Administer medications 60 minutes prior to or thereafter scheduled time unless otherwise ordered by physician. - Report and document any adverse side effects or refusals. The policy lacked documentation to show how staff should handle medications running low or not available.

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 09/06/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 33980

Based on interview, record review and document review, the facility failed to ensure a pain medication was administered as scheduled for 1 of 29 sampled residents (R228). The deficient practice had the potential for the resident's pain management to be ineffective and inadequate and compromised resident safety.

Findings include:

Resident 228 (R228)

R228 was admitted on [DATE], with diagnoses including muscle wasting and atrophy, muscle weakness, and malaise.

On 09/04/2024 at 10:28 AM, R228 was sitting in a wheelchair, alert, and oriented. R228 revealed being on Gabapentin (a medication used to treat nerve pain). R228 indicated having told the nurses had a two-hour window time to administer the medication and left the resident without coverage. R228 confirmed having numbness and tingling when Gabapentin was not given as scheduled.

The physician's order dated 08/24/2024, documented Gabapentin Tablet 600 milligram (mg) Give one tablet by mouth three times a day for pain.

The physician's order and the Medication Administration Record (MAR) for August 2024 and September 2024, documented R228's Gabapentin was scheduled to be administered at 8:00 AM, 2:00 PM, and 8:00 PM.

The Medication Administration Audit Report for R228's Gabapentin documented the following dates and times when the medication was administered:

- 08/26/2024 at 8:33 AM, 2:08 PM, and 10:01 PM

- 08/27/2024 at 9:19 AM, 1:04 PM, and 10:37 PM

- 08/28/2024 at 9:09 AM, 1:33 PM, and 10:52 PM

- 08/29/2024 at 10:02 AM, 1:37 PM, and 8:17 PM

- 08/30/3024 at 1:02 PM and 8:25 PM

- 08/31/2024 at 9:25 AM, 3:22 PM, and 8:03 PM

- 09/01/2024 at 8:51 AM, 4:45 PM, and 7:50 PM

- 09/02/2024 at 8:01 AM, 1:13 PM, and 9:35 PM

- 09/03/2024 at 8:44 AM, 2:25 PM, and 9:09 PM

(continued on next page)

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 09/06/2024
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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 09/04/2024 at 8:29 AM, 1:40 PM, and 8:53 PM - 09/05/2024 at 11:07 AM and 1:47 PM On 09/06/2024 at 7:46 AM, the Director of Nursing (DON) indicated the medications could be administered one hour before and one hour after the scheduled times. The DON explained the need to review the administration times for R228's Gabapentin. On 09/06/2024 at 8:48 AM, the DON revealed per R228's MAR, Gabapentin was scheduled to be given at 8:00 AM, 2:00 PM, and 8:00 PM daily. The DON confirmed there were times the medication was administered to the resident more than one hour before and more than one hour after the scheduled times, as mentioned above. The DON explained the resident could have more pain if the medication was not given as scheduled. On 09/06/2024 at 1:05 PM, a Licensed Practical Nurse (LPN) indicated the medications should be given as scheduled or could be given one hour before and one hour after the scheduled time. The facility's policy titled Medication Administration dated 10/22/2023, documented administer medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.

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	09/06/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, and document review, the facility failed to ensure stored foods and cleaning agents were labeled, dated, and were stored properly and ice machines were properly cleaned in 2 of 4 ice makers in the facility. This deficient practice posed a potential risk to safety and health standards which could lead to contamination, inadequate storage, and place residents at risk of foodborne illness. Findings include: On 09/04/2024 in the morning, a walkthrough of the kitchen was completed. The following was observed: 1. A box containing some thickened liquid lemon flavored water cartons in the walk-in cooler with an expiration date of 09/03/2024. The Dietary Manager explained the water cartons should have been discarded. The Dietary Manager had a staff member dispose of the cartons during the survey. 2. A spray bottle with some type of liquid stored in the utility room in the kitchen. The Dietary Manager explained the spray bottle contained a de-[NAME] and would have it labeled and restored. On 09/04/2024 in the morning, a walkthrough of the kitchen and the nursing unit nourishment rooms was completed. The following was observed: 1. A water/ice machine in the kitchen with a wet brownish debris buildup on the ice spout side of the machine. 2. An ice machine in the 200-hall nourishment room with a wet brownish debris buildup on the ice spout of the machine. The Dietary Manager explained the ice machines are cleaned periodically and were recently cleaned. A document titled Safe Employee Work Practices, effective 02/2016 revealed chemicals will not be transferred to spray bottles or other containers unless the new container is clearly identified with chemical name, appropriate hazard warnings, and the name and address of the manufacturer. A document titled Ice Machine Sanitation effective 02/2009 revealed the facility shall maintain sanitary and clean ice machines to ensure proper service of ice.

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 09/06/2024
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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50289 Based on observation, interview, and document review, the facility failed to ensure resident's personal food items from outside or home were properly labeled and stored for 2 of 39 sampled residents (Residents #77 and #84). The failure to label, date, and store food items had the potential risk to cause psychosocial distress to the residents. Findings include: Resident #77 (R77) R77 was admitted on [DATE], with diagnoses including hypertension, protein-calorie malnutrition, type 2 diabetes, and chronic kidney disease. On [DATE] at 4:36 PM, R77 stated being a vegetarian sometimes can be a struggle when at a facility such as this. Occasionally, the facility will take people to a local grocery store to get some items they may want. Sometimes visitors will also bring in some food items. Things like ice cream, cottage cheese, and ice cream bars, R77 has stored in the nursing nourishment refrigerator. However, these items are thrown out in 3 days, long before the best buy date. The ice cream, ice cream bars, and cottage cheese are labeled by the manufacture, and all contain expiration (or best by) dates. Resident #84 (R84) R84 was admitted on [DATE], with diagnoses including peripheral vascular disease, type 2 diabetes, depression, and protein-calorie malnutrition. On [DATE] at 03:47 PM, R84 was in lying in bed. R84 stated had a few goodies stored in the nursing nourishment room refrigerator to get through a meal or a snack if what they are serving does not sound appetizing. But the facility throws away the food with expiration dates that have not yet passed like bread and butter pickles. Resident questioned how are we supposed to eat all those pickles in the three days they give us? On [DATE] in the morning, multiple food items were on the counter that were open and not yet past the manufacturers date printed on the package, in the 200-hall nourishment room. The Dietary Manager stated these were to be thrown out. On [DATE] at 9:10 AM, the Dietary Manager indicated the dietary staff are responsible to check the nourishment refrigerators for expired, open, labeled and dated food and throw it out when appropriate. The Dietary Manager indicated when items such as jars or boxes (from manufactures) are open, they date them, then wait 3 days, and then throw them away per facility policy. The Dietary Manager stated they only follow the manufacturer's date if the item is unopened. The Dietary Manager confirmed the open food would be discarded after three days. The Dietary Manager confirmed prepared foods included take out/to-go foods and home-made foods. (continued on next page)

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 09/06/2024
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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:44 PM, the [NAME] indicated the food brought in by families or visitors would be labeled, dated, and stored in the nourishment refrigerator/freezer. The [NAME] confirmed the food is kept for three days once it is open, then it is thrown away. The [NAME] stated the process is the dietary staff goes to the nourishment room refrigerators to check for labels, dates, and expirations. If the food items were open and past the three days, it is to be taken out of the refrigerator, placed on the countertop, and notify the nursing staff. Then the nursing staff throws it away and notifies the resident. If the food is expired, the dietary staff is permitted to throw the food items away. The [NAME] indicated that prepared foods would include home-made food and takeout food, but do not include manufactures prepackaged food with a manufacturer's date on it. The [NAME] verified according to their facility documents it looks as though they should be using the manufacturer's date and not the 3-day rule. On [DATE] at 12:17 AM, the Administrator verified that prepared foods would be considered as anything that is not in a sealed manufactured package. The facility policy titled Use and Storage of Food Brought in by Family or Visitors revised ,d+[DATE], documented foods maintained beyond manufacturer expiration dates are subject to being discarded. It also documents that prepared food items brought in by family or visitor must be labeled and dated. This food should be consumed by the resident within 3 days of preparation. Items beyond the three-day window will be thrown out by staff. In a facility document titled Resource: Food Safety for your Loved One updated [DATE] documents food or beverages in the original containers marked with manufacturer expiration dates and unopened do not have to be re-labeled for storage. This document also states foods or beverages that have past the manufacturer's expiration dates should be thrown away.

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 09/06/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51397 Based on observation, interview and document review, the facility failed to ensure standards of infection control practices were followed during medication administration for one unsampled resident (Resident 276). The deficient practice had the potential to place the resident at risk for communicable diseases from cross contamination. Findings include: Resident 276 (R276) R276 was admitted on [DATE], with diagnoses including urinary tract infection. R276's care plan indicated R276 had safety concerns with interventions including: - Implementing strategies to reduce the risk of infection. On 09/05/2024 at 8:33 AM, observed a Licensed Practical Nurse (LPN) giving R276 pills that were dispensed into a medication cup. As R276 poured the medications into their mouth, one of the pills fell out of the medication cup and landed underneath R276's bedding. The LPN picked up the pill with their bare hands, placed the pill into the resident's hand, who immediately ingested the pill by mouth. The LPN stated they did not know what the facility policy was regarding handling contaminated medications. On 09/06/2024 at 12:00 PM, the Infection Control Preventionist (IP) stated it was the expectation that if a medication touched an unclean surface, it should not be administered to a resident but discarded. IP stated the contaminated medication should not have been given to R276 but discarded. Review of the Medication Administration Policy revised on 10/23/2023, indicated the following: - Medications were to be administered by licensed nurses in accordance with professional standards of practice and in manner to prevent contamination or infection. - Remove medication from source, taking care not to touch medication with bare hands. The policy lacked documentation to show how staff should handle contaminated medications.