

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Ridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1151 Torrey Pines Dr. Las Vegas, NV 89146	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure 1) elopement measures were effectively executed for 2 of 5 sampled residents (Resident 1 and 2), and 2) elopement risk assessment tool intervention recommendations were implemented for 1 of 5 sampled residents (Resident 2). The deficient practice had a potential for residents to elope from the facility that could lead to resident's harm.</p> <p>Findings include:</p> <p>1. Elopement Measures</p> <p>Resident 1 (R1):</p> <p>R1 was admitted on [DATE] with diagnoses including bipolar disorder and psychosis.</p> <p>R1's Psychiatric Follow Up Notes dated 1/4/2024 and 5/9/2024, both documented:</p> <p>Staff Report: confusion, self-talk noted at times, wanders, and dysphoric mood. A physician Progress Note dated 03/25/2024, documented resident was confused and has wandering behaviors. Resident is on frequent monitoring.</p> <p>R1's Physician Order dated 04/21/2024, documented Wanderguard - check placement right arm every shift.</p> <p>R1's comprehensive care plan with a date initiated 09/30/2022, documented the following identified problems and interventions:</p> <ul style="list-style-type: none"> - Behavior of wandering/ exit seeking related to diagnosis of dementia. Putting resident at risk of getting into unsafe situations. Wander Guard in place. - Resident will have no psychosocial distress related to wandering/exit seeking. Resident will adhere to kind redirection daily as needed. - Administer medications as ordered. Monitor/document for side effects and effectiveness. <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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 295072
		If continuation sheet Page 1 of 5

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Anticipate and meet the resident's needs. - Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. - Provide reassurance to help resident feel safe. Ensure Wander Guard is operating properly. Change batteries in Wander Guard as needed. Check device placement. Evaluate effectiveness. - Potential Risk for Elopement Cognitive Deficit, exit seeking behavior (with purpose to leave). History of wandering. - 1 to 1 monitoring due to the risk of elopement. - Monitor the resident interactions with peers to identify escalating tension, frustration, or aggression. - Monitor whereabouts regularly. Recognize unsafe conditions or escalating patterns. - Respond to alarm promptly. <p>On 06/05/2024 at 7:10 PM, R1 was discovered by a certified nursing aide (CNA) missing and could not be found inside the facility. An elopement search was initiated with no discovery of R1 within the facility or the external grounds. The last reported visualization of R1 was at 6:15 PM near the front entry by the receptionist.</p> <p>An Alert Note: Nursing, dated 06/06/2024 at 7:00 PM documented:</p> <p>Addendum to note: Prior to CNA stating could not find R1, the following staff members saw R1 at these times: Night shift nurse on-coming 5:00 PM, saw resident in the 300 Hall. At 5:30PM, the charge nurse on 100 Hall gave R1 ice cream. At 6:00 PM, on-coming CNA, saw resident in the lobby speaking with the receptionist. At 6:15 PM, the receptionist confirmed talking with R1 in the lobby. This was the last time any staff members had seen the resident.</p> <p>On 6/6/2024 at 2:51 PM, the facility was notified R1 had been found and was at a local homeless shelter. R1 was picked up and taken to the hospital for evaluation. Shelter personnel indicated R1 spent the night at the shelter but was unsure as to how R1 got to the shelter.</p> <p>On 06/07/2024 in the afternoon, three license practical nurses (LPNs), an activity staff, a wound care nurse and two CNAs indicated not hearing or responding to any door alarm prior to or around the time R1 was discovered missing.</p> <p>Resident 2 (R2):</p> <p>R2 was admitted on [DATE], with diagnoses including altered mental status and homelessness.</p> <p>Review of R2's progress notes revealed the following occurrences:</p> <p>On 06/4/2024 at 8:20 PM, a nurse Alert Note documented:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/04/2024 at 8:55 PM, the nurse caring for R2 after identifying the new possible elopement behavior entered a Nursing Advanced - Elopement Evaluation:</p> <p>Elopement Evaluation: Recently admitted or readmitted (within past 30 days) and has not accepted the situation: Yes.</p> <p>Elopement Score: 3.0</p> <p>Actioned clinical suggestions: Nursing - Yes</p> <p>Assessment: Resident at Risk of Elopement - Score 3.0 (Score value of 1 or higher indicates Risk of Elopement).</p> <p>The Care Plan and the Clinical Suggestions section of the Evaluation were not completed. The incomplete evaluation prevented elopement interventions to be implemented.</p> <p>R2's medical record lacked documented evidence a care plan with interventions to prevent elopement were put into place after R2's elopement evaluation had determined the resident was a risk for elopement.</p> <p>On 06/07/2024 in the morning, the Director of Staff Development explained indications of elopement should have a corresponding assessment completed with a care plan intervention initiated.</p> <p>A floor nurse indicated if a resident was noticed to have signs and symptoms of exiting behavior, interventions should have been put into place. Example, every Q15 minutes checks.</p> <p>An LPN indicated triggers for an elopement evaluation would be exit seeking behaviors. If elopement risk score indicates risk, the interventions should be implemented. A corresponding care plan should have been initiated.</p> <p>A Unit Charge Nurse indicated Elopement Evaluations were completed on admission, for at risk patients and change of conditions (ex. exit seeking). The charge nurse reviewed R3's 06/04/2024 elopement assessment and verified a 1 plus or more Elopement Assessment score indicates a risk and interventions should have been in place and a care plan generated, update the staff during staff meetings, picture taken and provided at the main desk.</p> <p>On 06/08/2024 at 12:05 PM, reviewed R2's medical record with the director of nursing (DON) and the assistant DON (ADON). The DON and the ADON indicated any signs of exit seeking would require an elopement assessment. The ADON confirmed the care plan interventions for R2 were implemented on 06/05/2024 (day of the elopement incident) not on 06/04/2024 (day the elopement assessment tool was completed) wherein R2 was flagged as a risk for elopement. The DON acknowledged assessment tools should be coordinated with a care plan and interventions. The DON expressed assessment tools were there to be utilized by nurses to facilitate better care for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Elopement and Missing Resident dated December 2017, documented if wandering or exit seeking behaviors is identified for any resident who previously had not exhibited this behavior, a change of condition Interdisciplinary Team (IDT) Walking Rounds should be completed. The IDT is responsible for identifying residents at risk for elopement, implementing measures to reduce the risk, and providing a process for action.</p>		