Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295072	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Ridge Healthcare Center	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)
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** 40142 Based on interview, record review, and document review, the facility failed to ensure a baseline care plan was developed for a resident who was admitted with an infected left foot and was assessed to be at risk for developing pressure ulcers and other skin impairments for 1 of 4 sampled residents (Resident 1). The deficient practice potentially resulted in delayed interventions for the resident's skin impairments. Findings include: Resident 1 (R1) was admitted on [DATE], with diagnoses including left toe cellulitis of left lower limb, acquired absence of right leg, peripheral vascular disease and diabetes mellitus. A Braden scale (a formal tool used to assess a patient's risk for developing pressure ulcers) dated 04/23/2024, revealed R1 was at risk for developing pressure ulcers due to skin often being exposed to moisture, limited mobility, and chairfast status. The medical record lacked documented evidence a baseline care plan was developed for R1 for pressure ulcer prevention and maintaining skin integrity. A change of condition document dated 05/18/2024, documented R1 was identified with bilateral groin and excoriation, skin tear on left buttock half dollar size, right knee scab and left foot discoloration to foot and toes. On 01/16/2025 at 12:33 PM, the treatment nurse reviewed R1's medical record and confirmed R1 was admitted with left foot cellulitis and was assessed to be at risk for developing pressure ulcer but no care plan was initiated for R1. The treatment nurse indicated a care plan for pressure ulcer prevention and maintaining skin integrity typically included interventions such as: 1) floating heels, 2) monitoring incontinence and providing perineal care timely, 3) performing weekly skin checks and reporting new impairments immediately, and 4) use of an air loss mattress. The treatment nurse explained the admission nurse, minimum data set (MDS) nurse or any nurse assigned to the resident in the first 48 hours were jointly responsible for completing the baseline care plan. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/2025 in the afternoon, the treatment nurse indicated being involved in R1's care on 05/19/2024 after a nurse reported R1's multiple skin issues to the wound team. The treatment nurse indicated review of medical record revealed a potential delay in identification and necessary interventions for the resident of concern which resulted in development of a pressure ulcer, groin rash and complications to left foot and toes. On 01/16/2025 at 3:34 PM, the Director of Nursing (DON) confirmed a pressure ulcer and skin integrity care plan was not included in the resident's baseline care plan but should have been. The DON clarified the admission nurse, or any nurse assigned to the resident during the first 48 hours were responsible for development of the baseline care plan. The Baseline Care Plan policy dated October 2022, documented the baseline care plan would be developed in the first 48 hours of the resident's admission and include instructions needed to provide effective and person-centered care for each resident. Complaint #NV00071274

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review and document review, the facility failed to ensure a care plan was developed and implemented for a resident who was assessed to be at risk for developing pressure ulcers for 1 of 4 sampled residents (Resident 1). The deficient practice potentially resulted in delayed identification and interventions resulting in multiple areas of skin breakdown. Findings include: Resident 1 (R1) was admitted on [DATE], with diagnoses including left toe cellulitis of left lower limb, acquired absence of right leg, peripheral vascular disease and diabetes mellitus. A Braden scale (a formal tool used for assessing a patient's risk for developing pressure ulcer) dated 04/23/2024, revealed R1 was at risk for developing pressure ulcers due to skin often being exposed to moisture, limited mobility, and chairfast status. The admission minimum data set (MDS) dated [DATE], revealed R1 was at risk for developing pressure injuries, and was not admitted with any pressure injuries. R1 had an infection of the foot. The care area assessment summary (Section V) revealed pressure ulcer was a triggered care area for Resident 1. The medical record lacked documented evidence a care plan was developed for R1 for pressure ulcer prevention and maintaining skin integrity. A change of condition document dated 05/18/2024, documented R1 was identified with bilateral groin and excoriation, skin tear on left buttock half dollar size, right knee scab and left foot discoloration to foot and toes. On 01/16/2025 at 1:32 PM, the MDS Director reviewed R1's medical record and confirmed the admission nurse recorded no skin issues apart from R1's healed right leg amputation and the treatment nurse recorded no other skin issues apart from scarring to hip and shin upon admission on 04/23/2024. The MDS Director confirmed the pressure ulcer care area was triggered due to R1 being incontinent and requiring assistance for bed mobility. The MDS Director explained the admission nurse, treatment nurse or any nurse assigned to the resident was responsible for developing a care plan for preventing pressure ulcers or maintaining skin integrity. On 01/16/2025 in the afternoon, the Director of Nursing (DON) clarified if the admission nurse or any nurse assigned to R1 failed to initiate a care plan for pressure ulcer prevention and maintaining skin integrity, the MDS Director who completed the comprehensive assessment should have identified the care plan was missed and the MDS Director had time to include the pressure ulcer care plan in the resident's comprehensive care plan. The Baseline Care plan policy dated October 2022, documented the baseline care plan would be used until the inter-disciplinary team could conduct the comprehensive assessment and develop the comprehensive care plan within seven days of comprehensive assessment completion. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pressure Ulcer Prevention policy dated 2006, documented residents would be assessed for risk of pressure ulcer development and a care plan would be developed Complaint #NV00071274

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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** 40142 Based on interview, record review and document review, the facility failed to ensure a resident's left foot which was being treated for cellulitis (infection) was assessed and monitored in a timely manner for 1 of 4 sampled residents (Resident 1). The deficient practice potentially resulted in complications to the resident's left foot resulting in hospitalization . Findings include: Resident 1 (R1) R1 was admitted on [DATE], with diagnoses including cellulitis of left lower limb, acquired absence of right leg, peripheral vascular disease (PVD) and diabetes mellitus. A hospital discharge summary dated 04/22/2024, revealed R1 was admitted for left foot pain, swelling and cellulitis. R1 injured left foot 10 days ago after a mechanical fall at home. R1's problem list included diabetes mellitus type two, peripheral vascular disease (PVD) and history of above the knee amputation (AKA) and hypotension leukocytosis (low blood pressure and elevated white blood cells due to infection) most likely evolving sepsis. The discharge plan included physical therapy, completion of oral antibiotics, and discharge with a CAM (controlled ankle motion) boot device. A Clinical Admission note dated 04/23/2024, documented R1 was admitted with a healed right AKA with no other skin issues. A Skin/Wound Evaluation dated 04/23/2024, revealed R1 was seen by a treatment nurse and was noted to have a healed right AKA, scarring to left shin and right hip, with no other skin issues. The medical record lacked documented evidence R1's left foot condition or the presence/absence of a CAM boot device was documented in the admission skin assessments dated 04/23/2024 and a subsequent skin inspection on 05/10/2024. A skin inspection assessment dated [DATE], revealed R1's left foot had discoloration to foot and toes. A Skin/Wound Evaluation dated 05/18/2024, documented R1 had an arterial wound to left dorsum foot measuring 19.8 centimeters (cm) in length, 5.2 cm in width for a total area of 83.2 square cm. The wound was described to have eschar (black, dry necrotic tissue) to 100 percent (%) of the wound, surrounding tissue was dark reddish brown. A Skin/Wound note dated 05/19/2024, revealed the treatment nurse noted left dorsal foot and toes to be black, hard and cool to touch. The provider was informed and an arterial doppler ultrasound (a non-invasive test which could assess blood flow in arteries) was ordered and carried out. An arterial doppler of left extremity arteries performed 05/19/2024, revealed severe inflow stenosis (narrowing). Intermediate segment occlusion middle to distal femoral artery. Limited Outflow. Suggest CT (computed tomography) angiogram. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The discharge summary dated 05/20/2024, revealed R1's provider discussed results of R1's arterial doppler with R1's family members who were present in the resident's room. R1 expressed being in a lot of pain, staff reported R1's left leg was discolored, cool to touch with unappreciated pulses. Family requested R1 be transferred to the hospital for further evaluation and management. On 01/16/2025 in the afternoon, the treatment nurse reviewed R1's medical record and indicated the status or condition of R1's left foot should have been documented in the admission skin assessments which were completed by the charge nurse and the other treatment nurse, because the resident was admitted with primary diagnosis of left foot cellulitis. The treatment nurse confirmed weekly skin checks were missed on 04/30/2024, 05/07/2024 and 05/14/2024 could have identified any issues with R1's left foot much earlier. The treatment nurse emphasized being involved in R1's care on 05/19/2024 after a nurse reported R1's multiple skin issues on 05/18/2024 to include abnormalities to R1's left foot. On 01/16/2025 at 3:10 PM, the Director of Nursing (DON) confirmed the facility's practice for nurses to document weekly skin inspections in the electronic health record. The DON confirmed R1's weekly skin check was missed on 04/30/2024 and were completed late on 05/10/2024 (due 05/07/2024) and 05/18/2024 (due 05/10/2024). The DON confirmed weekly skin checks were done by licensed nurses per facility policy for the purpose of identifying new skin impairments and timely interventions. The DON indicated the admission skin assessment should have documented the appearance of R1's left foot due to the fact R1 was admitted with a primary diagnosis of left foot cellulitis. The Skin Integrity policy dated December 2016, documented skin integrity issues were identified post-admission to the facility and the following documented information was required: location and size of wound, description of wound bed, drainage if present, odor, signs and symptoms of infection, description of surrounding tissue and notation of the 24-hour report indicating the skin condition. Complaint #NV00071274

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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** 40142 Based on interview, record review and document review, the facility failed to ensure weekly skin assessments were not missed or late for a resident who was assessed to be at risk for developing pressure ulcers for 1 of 4 sampled residents (Resident 1). The deficient practice potentially contributed to the resident's facility-acquired pressure ulcer and a delay in necessary interventions to prevent and treat the resident's pressure sore. Findings include: Resident 1 (R1) R1 was admitted on [DATE], with diagnoses including left toe cellulitis of left lower limb, acquired absence of right leg, peripheral vascular disease and diabetes mellitus. A Clinical Admission note dated 04/23/2024, documented R1 was admitted with a right above the knee amputation (AKA) with no skin other issues. A Skin/Wound Evaluation dated 04/23/2024, revealed R1 was seen by a treatment nurse and was noted to have a healed right AKA, scarring to left shin and right hip, with no other skin issues identified. A Braden scale (a formal tool used in assessing a patient's risk for developing pressure ulcers) dated 04/23/2024, revealed R1 was at risk for developing pressure ulcers due to skin often being exposed to moisture, limited mobility, and chairfast status. On 01/16/2025 at 2:18 PM, the treatment nurse explained the admission nurse was responsible for conducting the initial head-to-toe skin assessment which was followed by an in-depth skin evaluation by the wound team. According to the treatment nurse, when a skin impairment was identified, the treatment nurse would include the resident on the wound team's case load for monitoring and treatment of wounds. The treatment nurse indicated weekly skin checks were performed by floor nurses and documented in the electronic health record (EHR) under skin inspection assessments. The medical record lacked documented evidence weekly skin checks were completed on 04/30/2024, 05/07/2024, and 05/14/2024. On 01/16/2025 at 2:20 PM, the treatment nurse reviewed R1's medical record and confirmed weekly skin checks were missed on 04/30/2024, 05/07/2024 and 05/14/2024. The treatment nurse explained weekly skin assessments were necessary for timely identification and interventions for any new skin impairments. A general note dated 05/18/2024, revealed a Certified Nursing Assistant (CNA) noticed a wound on R1's left hip while changing R1, a nurse assessed R1. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin/Wound Evaluation dated 05/19/2024, revealed R1 was identified to have a pressure wound, deep tissue injury on the front left trochanter (a bony prominence toward the end of the thigh bone or femur) which was in-house acquired and measuring 11.4 centimeters (cm) in length, 10.5 cm in width and 0.1 cm in depth. The wound was noted to be sanguinous (bloody). A physician's order dated 05/19/2024, documented to cleanse left buttock with normal saline, pat dry and apply dressing. A physician's order dated 05/19/2024, documented to provide R1 with a low air loss mattress for wound management. A physician's order dated 05/19/2024, documented to do weekly skin assessments every Tuesday on day shift. On 01/16/2025 at 2:25 PM, the treatment nurse confirmed R1 was not on the wound team's case load because admission assessments revealed R1 had no skin issues. The treatment nurse indicated meeting R1 for the first time on 05/19/2024 after multiple areas of skin breakdown were communicated by the floor nurse on 05/18/2024. The treatment nurse confirmed physician orders for wound management were obtained on 05/19/2024 but were unable to get carried out because R1 was transferred to the hospital on 05/20/2024. On 01/16/2024 at 2:30 PM, the treatment nurse indicated the purpose of conducting weekly skin checks was to identify areas of skin breakdown in a timely manner and to prevent a delay in appropriate interventions. The treatment nurse indicated the missed weekly skin checks may possibly have caused a delay in identification, prevention interventions such as use of an air loss mattress and treatment orders to R1's wounds. On 01/16/2025 at 3:10 PM, the Director of Nursing (DON) confirmed the facility's practice for nurses to document weekly skin inspections in the EHR. The DON confirmed R1's weekly skin check was missed on 04/30/2024 and were completed late 05/10/2024 (due 05/07/2024) and 05/18/2024 (due 05/14/2024). The DON confirmed weekly skin checks were done by licensed nurses per facility policy for the purpose of identifying new skin impairments and ensure timely interventions. The Discharge Summary dated 05/20/2024, revealed R1's family requested a hospital transfer for further evaluation and management. The Skin Integrity policy dated December 2016, revealed residents at risk for skin breakdown (pressure ulcers) would have a routine assessment to maintain and/or improve skin integrity. The objective was to create an on-going process to identify and actively manage risk and skin integrity issues to prevent infections and determine appropriate referrals or interventions to achieve positive clinical outcomes. Licensed nurses would perform weekly head to toe assessments. Complaint #NV00071274