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	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Ridge Healthcare Center	1151 Torrey Pines Dr. Las Vegas, NV 89146

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, interview, record review, and document review, the facility failed to comply with the prescribed meal consistency and dietary preferences for 1 of 28 sampled residents (Resident #13). The deficient practice had the potential to disregard resident autonomy and preference, negatively impacting meal satisfaction, leading to reduced appetite, and increase meal refusal that could have affected the resident's nutritional intake and quality of life. Findings include: Resident #13 (R13) R13 was admitted on [DATE], with diagnoses including hypertension, chronic debility, hypothyroidism, atrial fibrillation, type 2 diabetes, and chronic obstructive pulmonary disease. Physician order dated 03/21/2025, documented R13 had a consistent, constant, or controlled carbohydrate diet (a diet used to manage blood sugar levels, particularly for individuals with diabetes), minced and moist texture, and regular thin consistency. On 04/08/2025 at 12:15 PM, Resident R13 was observed in their room during lunch. The resident did not eat the provided meal and expressed no longer required a pureed diet. R13 stated had already been removed from the pureed diet and did not understand why meals continued to be served in that consistency. On 04/09/2025 at 12:00 PM, R13 was in the dining room when a Certified Nursing Assistant (CNA) served their lunch, which consisted of a pureed diet including ham, bread, and mashed potatoes. The resident refused the meal due to its pureed consistency. The meal ticket, which provided essential details regarding the resident's dietary needs, preferences, and restrictions, indicated a minced moist consistency diet. Additionally, the meal ticket documented allergies and dislikes, including pork. R13 was upset because the facility continued serving puree diet and meals resident disliked such as pork (ham). On 04/09/2025 at 12:15, the kitchen manager confirmed the observation and inquired with the cook responsible for the tray line regarding the meal consistency served to R13. The cook stated a pureed diet was provided since pureed and minced/moist consistencies were considered the same. The cook confirmed that R13 was served a pureed diet that included ham, bread, and mashed potatoes. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The kitchen manager clarified a minced/moist diet consists of soft, moist, and finely minced foods that require minimal chewing, whereas a pureed diet includes foods blended into a smooth, pudding-like consistency, eliminating the need for chewing. Additionally, the kitchen manager acknowledged R13's documented food preference, specifically the dislike of pork, was not honored, as ham was included in the meal served for lunch. The nutritional care plan for R13 identified a risk of altered nutrition and hydration due to diabetes, depression, and gastroesophageal reflux disease (GERD). The care plan indicated R13 had multiple food preferences and experienced fluctuations in weight. The care plan interventions included encouraging a meal intake of more than 50% through the review date, ensuring the resident exhibits no signs or symptoms of altered hydration, and preventing significant weight change. The facility policy titled Resident Food Preferences dated November 2016, documented all food and dinning staff would be made aware of resident food preferences and allergies to prevent serving foods that could contribute to food allergies, and to meet resident's food preferences. The Resident [NAME] of Rights provided to the residents at the time of admission, listed the recognition of their individualities as part of their rights.

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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** 51395 Based on interview, record review and document review, the facility failed to notify the physician regarding resident post fall behavior and refusal of care for 1 of 28 sampled residents (Resident 126). The deficient practice had the potential for not exploring other physician interventions for resident care needs. Findings include: Resident 126 (R126) R126 was admitted on [DATE] and discharged on [DATE] with diagnoses including chronic obstructive pulmonary disease, pleural effusion, and chronic pulmonary edema. A Change in Condition dated [DATE] at 1:47 PM, documented R126 had a fall and complaints of back pain and pain in the back of head. Recommendation of physician was to send R126 to the hospital to be checked. The hospital after-visit summary dated [DATE], documented diagnoses of closed head injury, with education of certain problems the caregiver should watch for and to call for an ambulance if acting confused or disoriented, sudden, and persistent change in behavior, have trouble speaking or slurred speech. Skilled evaluation notes documented the following: -[DATE] at 11:28 PM, mood is pleasant, no unwanted behaviors witnessed. -[DATE] at 8:33 AM, mood is pleasant, no unwanted behaviors witnessed. -[DATE] at 6:42 PM, mood is pleasant, no unwanted behaviors witnessed. A Nursing note dated [DATE] documented the following: - 6:30 AM, the Supervising Nurse got a report from night nurse the resident was agitated the whole night after came back from the hospital from getting a CT scan. The night nurse reported there were no new orders. R126 was really confused and combative with transport. R126 was cursing and kicking and continued to do so when transferred to room. R126 refused to receive care and for vitals to be taken. R126 scratched, hit, and kicked staff if nearby. R126 also repeatedly tried to throw themselves on the floor the whole night shift. -6:40 AM, the dayshift Certified Nurse Assistant (CNA) and night shift CNA helped R126 to change clothes due to taking clothes off and trying to get out of bed. -7:20 AM, a CNA went to R126's room to give resident a water pitcher and R126 was talking to themselves. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7:35 AM, a CNA reported to the Supervising Nurse R126 was unresponsive. The Supervising Nurse checked R126 to confirm and immediately paged code blue and called 911 right after the page. The Supervising Nurse and other staff started Cardiopulmonary Resuscitation (CPR) Protocol. - 7:40 AM, 911 came and started working with R126. - 8:08 AM, 911 pronounced the R126 expired. R126's medical record lacked documented evidence the physician was notified of R126's behaviors and refusal of care, post fall. On [DATE] at 9:42 AM, a Licensed Practical Nurse 1 (LPN1) explained when a fall event occurs the resident would be assessed with notification made to family and physician. If the resident was sent to the hospital and returns the staff would continue monitoring the resident for 72 hours. If the resident was refusing treatment or vitals the staff would notify the physician and the family and document in the resident's clinical record. On [DATE] at 10:41 AM, a Supervising Nurse explained when a fall event occurs staff will assess the resident and call the doctor to notify and obtain orders. Staff would send resident to the hospital for a CT scan if it was a suspected head injury. When the resident returns staff would continue monitoring vitals. Staff would notify the doctor if the resident was refusing care, and this would be documented in the medical record. On [DATE] at 10:45 AM, the Supervising Nurse reviewed R126's medical record and confirmed R126 was refusing care, and the physician was not notified. On [DATE] at 12:04 PM, a Licensed Practical Nurse 2 (LPN 2) confirmed being familiar with R126's fall event. LPN 2 explained receiving report from the night shift nurse indicating R126 had returned from the hospital and was aggressive, throwing a urinal, fighting, and kicking and staff did a one on one with R126. The LPN explained staff would need to notify the physician if a resident was exhibiting behaviors and refusing care after a fall event. On [DATE] at 11:43 AM, the Director of Nursing (DON) explained if a resident was refusing care the expectation would be for staff to notify the physician. The facility policy titled Change of Condition, undated, documented the Licensed Nurse was to appropriately assess, document and communicate changes of condition including diagnostic results to the primary care provider.

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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** 51395 Based on interview, record review and document review, the facility failed to provide documented evidence wound care treatments were provided per the physician's order for 1 of 28 sampled residents (Resident 42). The deficient practice had the potential to place the resident at risk for delayed healing of a wound. Findings include: Resident 42 (R42) R42 was admitted on [DATE] with diagnoses including type 2 diabetes mellitus with other circulatory complications, pressure ulcer of sacral region stage 3, and atrial fibrillation. A Physician order dated 03/25/2025 documented cleanse wound to coccyx with normal saline and pat dry. Apply Medihoney & Triad cream topically to site and cover with 2x2 and secure with border gauze every day shift for pressure wound. R42's Treatment Administration Record (TAR) for the pressure wound of the coccyx lacked documented evidence wound care treatments were completed 03/25/2025 through 03/31/2025. On 04/11/2025 at 08:10 AM, a Wound Care Nurse explained the Admission Nurse was to complete the residents initial skin assessment. The wound care staff was to perform an additional assessment, obtain wound care treatment orders, and add residents to the wound care case load. The Wound Care Nurse reviewed the physician orders and TAR and confirmed R42's medical record lacked documented evidence wound care treatments were completed as per physician orders for 03/25/2025 through 03/31/2025. On 04/11/2025 at 08:55 AM, the Wound Care Nurse explained by not performing treatments as per physician orders could result in the wound not healing. On 04/11/2025 at 11:33 AM, the Director of Nursing (DON) explained the expectation was for the staff to document treatments performed on the TAR. The facility policy titled Pressure Ulcer, Prevention of, undated, documented if a pressure ulcer was present, the licensed nurse was responsible to record condition of the skin including stage, size, site, depth, color, drainage, and odor as well as the treatment provided.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observations, interviews, record reviews, and document reviews, the facility failed to ensure the water bag used for gastrostomy feeding hydration and the tubing system were properly dated upon initiation of use for 2 of 28 sampled residents (Resident #68 and #70). This deficient practice had the potential to compromise patient safety by increasing the risk of contamination and infections, and improper hydration management, potentially leading to adverse health outcomes. Findings include: Resident #68 (R68) R68 was originally admitted on [DATE], and readmitted on [DATE], with diagnoses including history of pneumonia, history of CVA with left side weakness, diabetes mellitus, atrial fibrillation, chronic kidney disease, and congestive heart failure. On 04/08/2025 at 4:42 PM, a gastrostomy tube (G-tube) feeding infusion pump was noted with a hanging bottle of feeding formula of Glucerna 1.2 dated 04/08/2025. However, the time of initiation for the bottle was not documented. The pump was turned off, and the tubing was undated and disconnected from the G-tube. Approximately 400 ml of formula remained in the bottle. Additionally, a bag of water was present, though it was undated and untimed, with around 700 ml remaining. On 04/08/2025 at 4:44 PM, a Licensed Practical Nurse (LPN) confirmed the observation and explained the feeding tubing, and the water bag should have been dated when initiated to ensure changed every 48 hours. A physician's order, dated February 22, 2025, documented the administration of Glucerna 1.2 via an enteral pump. The order specified an infusion rate of 65 milliliters (ml) per hour for a duration of 20 hours, with feedings commencing at 2:00 PM and continuing until the prescribed dose is fully delivered. A physician order dated 01/28/2025, indicated to change enteral feeding tubing every 48 hours and/or with each bottle or bag. Resident #70 (R70) R70 was originally admitted on [DATE], and readmitted on [DATE], with diagnoses including Parkinson's disease, hypertension, seizure disorder, and history of cerebral vascular accident (CVA). The resident was receiving nutrition via gastrostomy tube. The physician's order, dated 11/30/2024, had documented the administration of Jevity 1.5 via a gastrostomy tube (G-tube) at a rate of 50 ml per hour, totaling 1,000 ml. The order indicated feedings had been scheduled to begin at 2:00 PM and to continue until the prescribed dose had been fully delivered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 11/05/2024, indicated to change enteral feeding tubing every 48 hours and/or with each bottle or bag. On 04/08/2025 at 1:36 PM, a gastrostomy tube (G-tube) feeding infusion pump was noted with a hanging bottle of feeding formula of Jevity 1.5 dated 04/08/2025. However, the time of initiation for the bottle was not documented. The pump was turned off, and the undated tubing was disconnected from the G-tube. There was no bag of water attached to the infusion pump. On 04/08/2025 at 1:45 PM, an LPN explained the feeding was stopped after the prescribed amount was delivered and should have been restarted at 2 PM. The LPN confirmed the feeding formula did not document the time the bottle of formula was initiated, and the tubing was not dated. On 04/09/2025, at 7:40 AM, R70 was receiving feeding formula Jevity 1.5 via G-tube at a rate of 50 ml per minute. A Licensed Practical Nurse confirmed the feeding tubing was not dated. On 04/09/2025 at 12:00 PM, R70 was receiving the feeding at 50 ml per minute. At the time of observation, approximately 700 mL remained in the bottle. A bag of water was present, though it was undated and untimed, as well as the infusing tubing. On 04/10/2025 at 7:25 AM during med pass, R70 was receiving the feeding via G-tube. A water bag was present. The water bag was undated and untimed, the bottle of formula was dated 04/09/2025 but not timed. Additionally, tubing system was not dated. An LPN confirmed the observation and indicated bottles of formula, water bags and tubing should have been dated and timed. The LPN emphasized the importance of labeling the tube feeding items since formula should be discarded within 24 hours upon initiated. The facility policy titled Enteral Nutritional Therapy (Tube Feeding) dated 2006, indicated prefilled formula container and tubing should be changed every 48 hours or per manufacturer guidelines.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observations, interviews, and document review, the facility failed to remove expired medications from two of three medication rooms and one of five medication carts. This deficient practice had the potential to compromise patient safety by contributing to the risk of medication errors. Findings include: On the morning of April 10, 2025, inspections were conducted on four medication carts and two medication rooms. The following concerns were identified: Medication cart 200 Hall: 04/10/2025 at 8:28 AM, during a medication administration observation, a Licensed Practical Nurse (LPN) attempted to administer a 250-milligram tablet of Vitamin C to an unsampled resident (Resident #16). The LPN retrieved the tablet from a bottle in the medication cart and placed it in a cup in preparation for administration. The inspector advised the LPN not to administer the Vitamin C after noting the supplement had expired in December 2024. The LPN confirmed the observation and acknowledged that the expiration date should have been verified before placing the medication in the cup. Medication Rooms: Medication room [ROOM NUMBER] Hall: A bottle of Vitamin C 250 mg had expired in December 2024. A Licensed Practical Nurse (LPN) had confirmed this observation. Medication room [ROOM NUMBER] Hall: An opened vial of Insulin Lispro had been dated February 14, 2025. According to the label, the medication had been required to be discarded within 28 days of opening. A Licensed Practical Nurse (LPN) confirmed this observation and had acknowledged the medication should have been discarded after the designated period. The facility policy titled Medication Storage I, dated November 2011, indicated nurses should check the expiration date of each medication before administering. The policy revealed all expired medications should be removed from active supply and destroyed in the facility. The policy documented the expiration date of vial would be 30 days after being initiated.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37718 Based on observation, interview, and document review, the facility failed to ensure food was stored in a sanitary manner when perishable items in the walk-in refrigerator were not stored within the safe temperature range of 35-41 degrees Fahrenheit (F). The deficient practice had the potential to cause food-borne illness in all residents. Findings include: On 04/08/2025, in the morning, a tour of the kitchen was conducted with the Dietary Manager (DM). The walk-in refrigerator in the kitchen had heavy ice build-up on the back of two evaporator fans. The internal thermometer inside the walk-in registered 53 degrees F. - Sliced ham inside the refrigerator was at 53.2 degrees F - Chicken salad was at 52.9 degrees F. - Other perishable items in the walk-in included whole peeled eggs, liquid eggs in cartons, and mayonnaise. The DM verbalized the acceptable range for refrigerated foods was 35-41 degrees F and variance from this temperature range could cause food to spoil. The Refrigerator/Freezer Temperature Log (Form 603a), dated April 2025, indicated temperatures had been checked in the AM and the PM daily. The form documented the temperatures in the walk-in refrigerator in degrees F as follows: 04/04/2025 - AM: 45 PM: 53 04/05/2025 - AM: 45 PM: 51 04/06/2025 - AM: 35 PM: 53 04/07/2025 - AM: 51 PM: 35 04/08/2025 - AM: 55 On 04/08/2025, in the morning, the DM verbalized the temperature log documented a pattern of temperature readings over 41 degrees F starting on 04/04/2025 until present. The DM reported the temperature log indicated the walk-in refrigerator had not been holding food in the safe range for about four days. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/10/2025 at 9:35 AM, the Dietary Manager (DM) revealed all of the refrigerators in the kitchen were equipped with thermometers. The DM reported refrigerator temperatures were checked by cooks and documented twice daily, in the AM and in the PM. The DM stated temperatures above 41 degrees should have been reported to the Maintenance Director immediately. The DM reported having worked in the kitchen during these time frames but had been very busy and had failed to check the temperature log posted on the front of the walk-in refrigerator. On 04/10/25 at 9:41 AM, the [NAME] reported upon arrival to work on Friday morning, 04/04/2025, the walk-in refrigerator had a temperature of 45 degrees F. The [NAME] recalled reporting the out-of-range temperature to the Assistant Dietary Director. The [NAME] stated had returned to work the next morning, 04/05/2025, and the walk-in temperature was again 45 degrees. The [NAME] verbalized had also noted a temperature of 53 degrees F taken the prior evening. The [NAME] reported asking someone if maintenance had been notified of the PM high temp of 53, and someone said they had. The [NAME] did not remember who made the statement. The [NAME] recalled being very busy trying to get out two meals and did not think further on the matter. The [NAME] stated had next two days off, and upon returning to work on Tuesday, 04/04/2025, the AM temperature was 55 degrees F, which the [NAME] documented on the temperature log. On 04/10/25 at 09:50 AM, the Assistant Dietary Manager recalled on Friday, 04/04/2025, being notified by the [NAME] about the walk-in refrigerator being 45 degrees F. The Assistant Dietary Manager revealed had reported the concern to the Maintenance Assistant. The Assistant Dietary Manager verbalized the Maintenance Assistant checked the walk-in refrigerator. The Assistant Dietary Manager verbalized being not certain if the issue was resolved. On 04/10/25 at 09:55 AM, the Registered Dietician (RD) revealed storing food above 41 degrees F could allow harmful bacteria to grow in perishable items. The RD revealed residents ingesting spoiled food items which contained bacteria could experience nausea, vomiting, and diarrhea. On 04/10/25 at 10:44 AM, the Maintenance Assistant verbalized not recalling being notified by kitchen staff regarding an issue with the walk-in refrigerator. The Maintenance Assistant indicated not having examined the walk-in refrigerator. The Maintenance Assistant stated not being aware of any issues with the walk-in. 04/10/25 at 4:49 PM, the Maintenance Director verbalized on 04/08/2025, in the morning, having been alerted the walk-in refrigerator was not functioning properly. The Maintenance Director verbalized had called a service company to come out and check the walk-in. The Maintenance Director stated the service technician had found ice around the evaporation fans, and a small coolant leak in part of the walk-in cooling system located on the roof of the facility. The Maintenance Director verbalized having not been notified of the walk-in refrigerator issue prior to 04/08/2025. The Maintenance Director reported not knowing if the Maintenance Assistant had been notified of the issue. The Maintenance Director explained ideally we would both be notified. A Refrigerator Service Invoice dated 04/08/2025, indicated receipt of a service request from the Maintenance Director on 04/08/2025 at 8:11 AM, regarding the walk-in refrigerator frozen up and too warm. The service invoice documented frozen evaporation coils and a coolant leak were identified and addressed. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The policy and procedure titled Food Safety in Receiving and Storage, dated 02/2009 indicated food was stored by methods to minimize contamination by bacterial growth. Refrigerator temperatures would be checked and recorded daily. Temperatures not in the appropriate range should be reported to the Dietary Manager, or maintenance, immediately. The temperature of refrigerators would be maintained to hold cold foods at 41 degrees F or below. The policy and procedure titled Safe Food Temperatures, dated 02/2009, indicated the time the food was in the temperature danger zone (between 41 to 135 degrees F) should not exceed six hours.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50289 Based on interview and document review, the facility failed to ensure mandatory training which included abuse, fire, disaster, and dementia training was provided to 1 of 2 sampled Certified Nursing Assistants (Employee 10). The deficient practice placed residents at risk for inappropriate care. Findings include: Employee 10 (E10) E10 was hired as a Certified Nursing Assistant (CNA) on 03/04/2003. Employee file reviews revealed E10 had not completed Abuse, Fire and Disaster training. The employee file also lacked documentation of initial or annual dementia training. On 04/11/2025 in the afternoon, the Human Resource/ Payroll Clerk (HR) confirmed E10 had no record of abuse, fire, disaster, or dementia training in this employee's files. The HR indicated abuse, fire, disaster and dementia training were mandatory trainings which were expected to be completed by all new hires and refreshed annually. On 04/11/2025 in the afternoon, the Staff Development Assistant verbalized the facility was expected to abide by state and local laws which would include state-required training such as care of dementia residents, abuse, fire and disaster training. The Covenant Care Employee Training Requirements updated 12/2022, outlined new hire and annual compliance-related training for all employees which would include but was not limited to, abuse and neglect, safety-related training and training required by federal and state requirements and conditions of participation specific for Nevada. The State Operations Manual for Long Term Care Facilities documents required in-service training for nurse aides must include but are not limited to dementia management training and resident abuse prevention training.