STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295106	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trellis Centennial	8565 W Rome Blvd Las Vegas, NV 89149

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and document review the facility failed to ensure nursing documentation accurately reflected the care provided. Nursing staff documented splint care was completed when the care had not been performed for 1 of 32 sampled residents (Resident 54). The deficient practice placed the residents are risk of not receiving ordered treatment interventions and inaccurate documentation of care provided.Findings include:Resident 54 (R54) was admitted [DATE], with diagnosis including fracture of left radius subsequent encounter for closed fracture with routine healing, nondisplaced fracture of left ulna styloid process, dementia, and cognitive communication deficit.A physician order dated 04/24/2026 documented, treatment: splint site, left wrist, check circulation and motion sensation every shift. On 05/07/2026 at 12:00 PM, R54 was lying in bed with eyes closed. R54's left arm was visible. No splint was observed on R54's left wrist or on visible surfaces within R54's room.On 05/07/2026 at 12:16 PM, a Licensed Practical Nurse (LPN), confirmed R54 did not have a splint to the left wrist. The LPN acknowledged there was an existing physician order for treatment to the left wrist splint site and the splint should have been applied as ordered. The LPN searched R54's room for a splint and acknowledged no splint was present in the room for application to R54's left wrist. The LPN reported a nurse had signed off splint care was applied on 05/07/2026 at 11:34 AM in the electronic medical record. The LPN acknowledged care should not have been documented as completed prior to the care being provided.A Treatment Administration Record (TAR) for May 2026 documented, Treatment: splint site, left wrist, check circulation and motion sensation every shift. The TAR documented the treatment was completed on 05/07/2026. On 05/07/2026 at 12:25 PM, a Wound Care Nurse, reported accidentally signing off splint care to the left wrist at 11:34 AM on 05/07/2026, prior to entering R54's room. The Wound Care Nurse acknowledged R54 did not have a splint for the left wrist available and should not have signed the medical record as completed until after the care was provided. The Wound Care Nurse acknowledged the documentation did not accurately reflect completion of the ordered intervention as there was no splint available for application to the left wrist.On 05/07/2026 at 2:06 PM, the Director of Nursing (DON) explained, nursing staff should have provided care prior to documenting care was completed on the electronic medical record to ensure the medical record accurately reflected the care provided.On 05/07/2026 in the afternoon, the Regional Medical Records Director, provided a copy of The American Nurses Association (ANA) Principles for Nursing Documentation, which revealed accurate documentation was an essential element of safe, quality evidence-based nursing practice which included care provided by nurses. Documentation entries into organizational documents or the health record must be accurate, valid, and complete.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician orders were followed for a resident's suprapubic catheter for 1 of 32 sampled residents (Resident 6). The deficient practice placed residents at risk of catheter complications such as infection and trauma.Findings include:R6 was admitted on [DATE], with diagnoses including cerebral infarction, dementia and urinary tract infection (UTI). The admission nursing assessment dated [DATE], revealed R6 was admitted with a French (Fr) 16 (diameter size)/10 milliliter (ml) balloon suprapubic catheter (a thin, flexible tube inserted in the lower abdomen into the bladder to drain urine).A physician order dated 04/11/2026, documented suprapubic catheter Fr 16/10 ml balloon due to neurogenic bladder. Monitor every shift. Change if dislodged, leaked or plugged.A physician order dated 04/11/2026, documented suprapubic catheter: cleanse site with warm soap and water and rinse. Pat dry and apply T-dressing everyday shift.R6's suprapubic catheter care plan indicated R6 had a Fr 16/10 ml balloon catheter. Provide care every shift.On 05/07/2026 at 2:29 PM, R6 was awake but had incomprehensible speech. R6's family member was at bedside and permitted surveyor to be present for the registered nurse's (RN) assessment of R6's suprapubic catheter.On 05/07/2026 at 2:30 PM, the RN pulled back blanket which revealed an Fr 18/10 ml balloon red port catheter anchored on R6's right thigh. The catheter insertion site did not have a dressing. The RN indicated not being familiar with site cleansing orders and would have to check but confirmed there was no dressing to reflect time of last care. On 05/07/2026 at 2:32 PM, the RN reviewed R6's medical record and confirmed the catheter order was a Fr 16 size, and the resident currently had a Fr 18 size. The RN recalled the night shift nurse reported changing the catheter appliance last night due to sediments in the urine, a urine sample was collected for urinalysis. The RN confirmed the night nurse did not follow physician orders for catheter size and did not document the procedure in accordance with facility policy. The RN confirmed there were orders to cleanse the catheter insertion site with warm water and soap, pat dry and cover with T-dressing but there was no evidence of care during the observation.On 05/07/2026 at 2:50 PM, the Director of Nursing (DON) confirmed the night shift nurse who exchanged R6's catheter did not follow physician orders when the nurse placed the wrong size. In addition, the DON indicated expecting nurses to document the procedure after an exchange such as date and time, reason and resident response. The DON confirmed there was no documentation from night nurse in accordance with facility policy. The DON indicated the catheter insertion site should have a dated dressing to reflect time of last care and they were the responsibility of the nurse who would perform site assessment at the same time.The facility's Urinary Catheter Care policy revised August 2022, documented to use soap and water or bathing wipes for routine daily hygiene. Document the following in the resident's medical record: date and time of catheter procedure, name and title of staff performing care, assessment data collected, any problems or complications, and how the resident tolerated procedure.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a resident's infection status was communicated to the dialysis provider for 1 of 32 sampled residents (Resident 93). The deficient practice placed the community at risk for transmission.Findings include:R93 was admitted on [DATE], with diagnoses including enterocolitis due to Clostridium difficile and end-stage renal disease (ESRD).On 05/05/2026 at 10:20 AM, there was a contact isolation precautions signage outside R93's room. Two certified nursing assistants (CNAs) were observed putting on gowns and gloves prior to entering room. The CNAs indicated R93 had loose stools and possibly had Clostridium difficile (C. diff - a highly contagious bacterial infection characterized by severe diarrhea from colon inflammation often caused by antibiotic use).On 05/05/2026 at 10:48 AM, R93 indicated being treated for C. diff at the hospital but had been having loose stools and staff informed the resident they would be testing for C. diff again.A hospital Discharge summary dated [DATE], revealed had loose stools and was treated for C. diff. Discharge plans included to continue outpatient dialysis and monitor stool output and recurrence signs of C. diff.A physician order dated 05/04/2026, contact isolation for C. diff, every shift.A nurse's note dated 05/04/2026, documented R93 had three episodes of loose stools since admission. Stool sample collected per physician.An infectious disease provider note dated 05/05/2026, documented R93 was a hemodialysis patient who had C. diff history and was reporting loose, watery diarrhea up to seven times a day today. Follow up on stool for C. diff.On 05/06/2026 at 1:00 PM, R93 was seated in wheelchair outside room. A CNA indicated R93 was leaving for a dialysis appointment.On 05/06/2026 at 3:23 PM, the CNA assigned to R93 indicated the resident was still at the dialysis clinic and reported the resident still had loose stools.On 05/06/2026 at 3:30 PM, the charge nurse indicated R93 was on contact precautions due to suspected C. diff as evidence by recent C. diff infection and persistent loose stools. A stool sample had been sent to the laboratory and results were pending.A physician order dated 05/04/2026, documented dialysis on Mondays, Wednesdays, Fridays, chair time 2:55 PM. Facility to transport. Ensure Hoyer sling and Oxygen tank are present during transport.A polymerase chain reaction (PCR) test collected 05/04/2026 and resulted on 05/06/2026, revealed R93 was positive for Clostridium difficile.The dialysis communication record dated 05/06/2026, lacked documented evidence of R93's contact isolation and suspected C. diff status was communicated to the dialysis provider.On 05/07/2026 at 9:45 AM, the Clinical Manager (CM) at the dialysis provider explained R93 was a new patient at this dialysis center with a scheduled admission date of 05/08/2026. According to the CM, the dialysis clinic did not expect R93 to be dropped off on 05/06/2026 and the CM had to obtain dialysis prescription orders from the nephrologist to accommodate R93 after a rushed admission. The CM indicated reaching out to the facility for pertinent documents such as identification and insurance cards but was not informed by the facility R93 was on contact precautions for C. diff.On 05/07/2026 in the morning, the CM indicated R93's infection status should have been communicated to the dialysis clinic because the clinic had a designated pod for patients infected with organisms transmissible by contact such as Candida auris, Clostridium difficile, Methicillin-resistant staphylococcus aureus and Vancomycin-resistant staphylococcus aureus. The CM explained patients on contact isolation were assigned to a pod managed by a dedicated dialysis technician and personal protective equipment (PPE) and supplies were confined to the patient's chair side. The CM indicated R93 was dialyzed in the general area on 05/06/2026 which placed staff and other patients at risk for cross-contamination.On 05/07/2026 at 9:57 AM, the Registered Nurse (RN) assigned to R93 indicated completing R93's dialysis communication record and confirmed the RN did not include the resident's contact isolation or suspected C. diff status with the dialysis provider.On 05/07/2026 at 10:07 AM, the charge nurse indicated getting a phone call from the dialysis CM on 05/06/2026 and was informed the clinic was not expecting R93 on 05/06/2026 but rather on 05/08/2026. The charge nurse recalled (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the CM requested the resident's identification and insurance cards and told the charge nurse R93 would be provided dialysis treatment. The charge nurse acknowledged not informing the dialysis CM regarding R93's contact isolation and suspected C. diff status because the charge nurse assumed the RN who completed the dialysis communication sheet had already done so.On 05/07/2026 at 10:20 AM, the Infection Preventionist (IP) indicated R93's contact isolation and suspected C. diff status should have been communicated to the facility for the purpose of protecting staff and other patients from cross contamination.The facility's Care of the ESRD resident policy revised September 2010, documented agreements between this facility and the contracted ESRD facility would include all aspects of care to include how information would be exchanged between facilities.