

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Paradise		STREET ADDRESS, CITY, STATE, ZIP CODE 3455 Pecos-McLeod Interconnect Las Vegas, NV 89121	

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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure a resident was appropriately discharged for 1 of 6 sampled residents (Resident (R) 6). This failure could potentially lead to medical complications or adverse events which could result in rehospitalization. Findings include: Resident 6 (R6) was admitted to the facility on [DATE] with diagnoses including spondylosis, type 2 diabetes mellitus, hypothyroidism, and hypertension. A care plan dated 6/12/2025 documented the need for discharge planning. R6 was to be discharged from the facility with a safe and coordinated discharge to R6's home with family. The facility was to assist R6 and/or support person in locating and coordinating post discharge services and to plan for specific resident needs and continuing care needs after discharge such as home health care, durable medical equipment, oxygen (if needed), prescriptions, and other support services. On 07/24/2025 at 9:02 AM, a Case Manager (CM) stated a new resident assessment was completed within 48 hours of a resident's admission to the facility. This Assessment included finding out if the resident had a previous home health provider, or if the resident planned to go to a group home which may have had a preferred home health care provider. The CM affirmed the facility preferred to use the facility's own home health care agency when a referral for home health care was needed. The CM stated the facility had a form the resident could fill out on admission to the facility which documented the resident had allowed the facility to use the facility's home health agency as the resident's preferred choice for home health care services. The CM expressed when the resident did not fill this form out, discharge planning was completed by giving the resident other home health agency options. If the resident had already filled out the form, then the facility would have used their home health agency for care continuity when able. The CM affirmed the facility had no list of home health agency providers for case management to give to residents. On 07/24/2025 in the afternoon, R1, R2, R3, and R4 had a signed referral form to use the facility's preferred home health agency, however, explained had no recollection of signing the form. R5 had a signed referral form to use the facility's preferred home health agency and stated wanted to try the facility's home health agency. The facility failed to produce documented evidence R6 was presented with options and assisted to choose a post-acute care provider which was best suited to the resident's goals, preferences, needs and circumstances. On 07/23/2025 at 12:00 PM, the Director of Nursing stated there was nothing in writing, but case management had told the residents they had other options besides the facility's home health agency. On 07/23/2025 at 03:28 PM, the Administrator stated case management documentation of resident discharge planning was not always in the notes, but the results of the discharge planning were documented in the resident's discharge summary.</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
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