STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295109	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trellis Paradise	4375 S. Eastern Avenue Las Vegas, NV 89119

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review nursing staff failed to document physician notification, change in condition, nursing interventions or attempts to obtain a physician order to manage a resident's high temperature (fever) as documented in facility policy for 1 of 5 sampled residents (Resident 1). The deficient practice had the potential to place the resident at risk for harm or adverse outcomes due to delayed medical evaluation and treatment. Findings include:Resident 1 (R1) was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and pneumonia.On 08/14/2025 at 8:54 PM, R1 had an oral temperature of 102.9 degrees Fahrenheit (F) documented on the Weights and Vitals Summary. The next documented temperature was an oral temperature of 98.6 degrees (F) taken on 08/15/2025 at 12:39 PM.The Nursing - daily skilled charting form dated 08/14/2025 at 11:44 PM documented an oral temperature of 102.9 on 08/14/2025 at 8:54 PM. The document was electronically signed by a licensed practical nurse on 08/15/2025.R1's medical record lacked documented evidence of a change in condition, that staff contacted the family, or a physician order was obtained for interventions related to the high temperature. The temperature was not retaken until the following day, and there was no documented evidence of what occurred during the more than 15 hours between the first and second readings.A physician progress note dated 08/15/2025 documented a high temperature of 102.9 degrees (F) and noted patient with temperature signed by physician on 08/17/2025 at 7:49 PM. This note also revealed the chest x-ray on 07/30/2025 showed slight left lower lobe pneumonia treated with combination therapy of Augmentin and Doxycycline antibiotics both for 5 days, follow up chest x-ray on 08/12/2025 showed persistent left lower lung bronchopneumonia, infectious disease was consulted and escalation to intravenous antibiotic therapy may be required. Fever, monitor closely, repeat labs if persistent, Tylenol as needed. On 11/18/2025 at 1:00 PM, a Licensed Practical Nurse (LPN), explained a temperature above 100.3 degrees (F) was considered high and interventions such as lowering the room temperature, offering water, using a cool towel, and wiping down the resident's face and neck done prior to receiving physician orders. A change of condition assessment would have been completed, the charge nurse alerted, the physician notified for orders, and the resident's family contacted. The LPN stated a possible physician's order might have been Tylenol 325 milligrams give, one to two tablets, and confirmed an order was required to give Tylenol. The LPN indicated all interventions would have been documented and the temperature rechecked within the hour to report back to the physician.On 11/18/2025 at 1:10 PM, a Certified Nursing Aide (CNA 1), explained vital signs were taken at the beginning of shift or when a nurse requested them. The CNA would have notified a nurse if the resident's temperature was above 99 degrees (F). The CNA would have continued to monitor the resident and rechecked the temperature in 30 minutes to an hour and reported the findings back to the nurse. On 11/18/2025 at 1:16 PM, Certified Nursing Aide (CNA 2), a nurse would have notified if the resident's temperature was above 99 degrees (F)and the temperature rechecked within 15 minutes and reported the findings back to the nurse.On 11/18/2025 at 1:20 PM, a Registered Nurse (RN), explained that vital signs were checked in the morning and again later in the day if needed before medications were administered. A temperature above 100.3 F was considered high, and interventions would have been done, including giving Tylenol, applying a cold compress, wiping the resident down, providing hydration, removing blankets, lowering the room temperature, and rechecking the temperature in one hour. The physician would have been notified initially, and if the interventions did not work, the nurse would have contacted the physician again for further orders such as Tylenol or laboratory bloodwork. The situation would have been documented as a change of condition, the resident's family notified, and the temperature rechecked within the hour. The RN added that a high temperature raised concern for infection and possible sepsis, which was why laboratory bloodwork would be needed.On 11/18/2025 at 2:55 PM, the Director of Nursing (DON) explained a temperature above 99.1 degrees (F) was considered high, and a physician would have been notified. A change of condition would be completed, and the facility would get a physician order and place it in the system. The resident's family would have been notified but if the resident was alert and oriented the resident would be told to contact the family with their information. While waiting on the physician's order, interventions and cooling measures would have been done. The temperature would be rechecked within the hour. The DON stated there was no facility standing order for temperature medications.On 11/18/2025 at 3:43 PM, a Physician explained, documenting Tylenol as needed in a physician progress note should not be considered

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and document review, the facility failed to ensure medical record documentation was complete and accessible for 1 of 5 residents (Resident #1).Findings Include:Resident 1 (R1) was admitted on [DATE], with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease and pneumonia.A Licensed Practical Nurse completed a daily skilled charting form on [DATE] at 11:44 PM, which showed an oral temperature of 102.9 Fahrenheit. The nurse entered the temperature at 8:54 PM.An oral temperature of 98.6 Fahrenheit was entered on [DATE] at 12:39 PM, according to the weights and vitals summary.On an effective date of service progress note dated [DATE], a physician documented acknowledging the resident's fever with recommendations to continue to monitor closely, repeat labs if persistent and Tylenol as needed. The above note was e-signed at 6:49 PM on [DATE]. The resident expired on [DATE]. The above note was not transferred to the facility's software until late [DATE]. On [DATE] in the afternoon, the Director of Nursing (DON) was unable to provide information, despite attempting to get an answer, regarding whether the creation date in the facility's software (of late [DATE]) was the date the facility's software accepted the transferred note, dated [DATE], from the physician or not. When a copy was requested, the DON refused to provide one, saying a copy could not be provided because of HIPAA privacy. Section #7 of the Electronic Medical Records policy provided revealed authorized federal and state survey agents as outlined may be granted access to electronic medical records. On [DATE] at 1:00 PM, a Licensed Practical Nurse indicated a temperature of 100.3 Fahrenheit constituted a change in condition, requiring provider notification, intervention(s) to address the increased temperature, follow-up monitoring and change in condition documentation. All actions were documented.On [DATE] at 1:20 PM, a Registered Nurse indicated a temperature of 100.3 Fahrenheit constituted a change in condition, requiring provider notification, intervention(s) to address the increased temperature, follow-up monitoring and change in condition documentation. All actions were documented.On [DATE] at 2:55 PM, the DON indicated a temperature of 99. 1 Fahrenheit constituted a change in condition, requiring provider notification, intervention(s) to address the increased temperature, follow-up monitoring and change in condition documentation. All actions were documented.On [DATE] at 3:43 PM, R1's Physician verbalized it was expected there would have been documentation on the fever or interventions from facility nursing staff. The Physician expected the temperature to be rechecked, and interventions documented. The Physician did not recall any update from the covering physician regarding addressing an elevated temperature. The Physician did not know what 00:00 meant next to the effective date referenced in the progress note or why a visit time was not specified. Physicians had up to 48 hours after opening an electronic progress note to finish it. The covering physician did not specify labs to order, so a verbal order over the phone or put in an order himself for labs or Tylenol would have had to be given. On [DATE] at 4:08 PM, the DON claimed the [DATE] date of service progress note inferred the physician was notified. The medical record lacked documented evidence of physician orders and/or nursing interventions to address the increased temperature and follow-up monitoring and change in condition documentation. R1's medical record lacked documented evidence of any nursing interventions and/or monitoring related to the change of condition. The medical record and aforementioned physician progress note lacked documented evidence of visit time. The Change in a Resident's Condition or Status policy dated 02/2021 revealed a nurse notified a physician when there was a significant change in the resident's condition. Prior to notifying a physician, the nurse made detailed observations and gathered pertinent information for the provider. The nurse notified the resident and/or resident representative within 24 hours. The nurse documented in the resident's medical record information relative to changes in the resident's medical condition or status.R1's medical record lacked documented evidence, a nurse notified a provider and documented information relative to changes in the resident's medical condition or status. The Physician Services policy dated 2001 revealed physician orders and progress notes were maintained in accordance with facility policy.The aforementioned policy lacked documented evidence for holding physicians accountable for electronic entries or their software transfers accountable for timely transfer documentation, such as progress notes. Complaint #2591137