

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Trellis Paradise		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure the Discharge Summary was completed before obtaining a resident's signature and prescribed discharge medications were appropriately coordinated and transferred with the resident upon discharge for 1 of 36 sampled residents (Resident 118).The deficient practice had the potential to result in an incomplete medical record and discharge instructions, interruption of prescribed medication therapy, lack of continuity of care, delayed treatment, inappropriate billing and medication charges, and adverse clinical outcomes following discharge. Findings include:Resident 118 (R118) was admitted on [DATE], with diagnoses including fracture of left femur and anemia.A Case Management Progress Note dated 04/28/2026, documented R118 expressed a desire to discharge to an assisted living facility. The receiving facility accepted the transfer, scheduled discharge for 04/30/2026, and arranged wheelchair transportation.1) The Packing Slip/Proof of Delivery dated 04/30/2026, documented the facility's receipt of the prescribed medications. The record indicated Nitrofurantoin 100 mg capsules, Rx #90512785/001, quantity 14, and Oxycodone, Rx #90512388/001, quantity 30 tablets, were delivered to the facility and received by nursing staff, as evidenced by the signature on the Proof of Delivery.On 07/09/2026 at 9:50 AM, the Director of Nursing (DON) indicated R118 was discharged on 04/30/2026, with the scripts to the accepting facility. The DON confirmed the Oxycodone and Nitrofurantoin were delivered to the facility and it was returned to the pharmacy post resident's discharge.On 07/09/2026 at 10:01 AM, the Pharmacist confirmed, upon review of the medication return log, there was no documentation indicating 30 tablets of oxycodone had been returned to the pharmacy. The Pharmacist indicated being unable to determine whether the nitrofurantoin had been returned because it was a non-controlled medication and was not tracked.On 07/09/2026, in the morning, the nurse who discharged R118 confirmed the facility had ordered and received the Oxycodone containing 30 tablets before R118's discharge; however, the medication was not provided to R118. The nurse acknowledged the Nitrofurantoin was received after R118's discharge. The nurse indicated R118 was discharged on 04/30/2026 after 11:00 AM and confirmed the prescribed discharge medications had not been appropriately coordinated and transferred with R118 upon discharge.On 07/09/2026, at 1:36 PM, the DON acknowledged the facility ordered and received the Oxycodone prior to R118's discharge. The DON indicated staff were expected to clarify discharge medication orders with the physician whenever there was uncertainty regarding whether a controlled substance, such as Oxycodone, was to accompany the resident upon discharge. The DON explained the physician's discharge orders should clearly specify whether the narcotic medication was to be sent with the resident, and staff were expected to obtain clarification before discharge.The DON located and presented R118's previously delivered unopened bubble pack containing 30 tablets of (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone. The DON indicated the Nitrofurantoin may have already been destroyed and acknowledged R118 may have been billed for the medication because the resident was private pay.2) On 07/09/2026, in the morning, the nurse who discharged R118 confirmed the Discharge Summary had not been completed before R118 signed the document and acknowledged the practice was not consistent with the professional standard of practice. The nurse explained the discharge information should have been completed, reviewed and explained to R118, and the resident's signature obtained to acknowledge understanding of the discharge instructions. On 07/09/2026, in the morning, the Medical Records staff confirmed R118's Discharge Summary contained blank sections despite documentation of R118's signature. On 07/09/2026, at 1:36 PM, the Director of Nursing (DON) confirmed R118's Discharge Summary had not been completed. The DON indicated nurses were expected to complete the discharge information before obtaining the resident's signature to ensure the discharge instructions were complete, appropriate, and understood by the resident. A facility policy titled, Discharge Summary and Plan, revised October 2022, documented when a resident's discharge was anticipated, a discharge summary and post-discharge plan were developed to assist the resident with discharge. The policy documented a copy of the evaluation of the resident's discharge needs, the post-discharge plan, and the discharge summary was provided to the resident and receiving facility, with a copy maintained in the resident's medical record. Complaint #3025672		