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	09/20/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51397 Based on observation, interview, document review, and record review, the facility failed to honor resident rights related to the use of incontinence brief and repositioning for 1 of 26 sampled residents (R252). The deficient practice placed the resident at risk for negative psychosocial outcomes and diminished comfort. Findings include: Resident 252 (R252) Repositioning: R252 was admitted on [DATE] with diagnoses including muscle weakness. Review of R252's care plan revised on 09/09/2024, identified the resident at risk for pain related to a recent back surgery. Care plan Goals included: - The resident will be comfortable using non-pharmaceutical methods to control pain daily. Care Plan interventions: - Reposition as needed for position and comfort. - The care plan indicated R252 had the potential for skin integrity impairment and required the resident to be turned and repositioned every two hours when dependent. On 09/17/24 at 9:06 AM, R252 was observed awake lying on back in bed. R252 stated they did not get up as instructed by the medical doctor (MD) following their back surgery. R252 complained they were not repositioned and stayed in the same position all day. On 09/19/24 at 12:45 PM, R252 was observed lying in bed on their back. R252 stated the incontinent brief they were wearing was wet. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/24 at 1:48 PM, a Certified Nursing Assistant who was taking care of R252, stated R252 was total max assist (Staff Dependent) and unable to reposition or toilet self. The CNA stated the resident was alert and was able to communicate needs. The CNA stated when they needed to know resident preferences, it was communicated at shift report but did not know how to check resident preferences on the computer. On 09/20/24 at 3:37 PM, the Director of Nursing (DON) stated all residents were on a pressure relieving mattress but still required repositioning. DON was notified R252 had expressed not being turned or repositioned and stated they would investigate. On 09/19/24 at 4:53 PM, R252 was observed lying in bed on back with head of bed up thirty degrees. R252's family was at the bedside and stated were concerned R252 was not being repositioned frequently. Review of the Turn and Reposition daily log from 09/06/2024 to 09/18/2024 revealed the following regarding R252's repositioning: 09/06/2024- Not repositioned on the AM and night shifts 09/07/2024- Not repositioned on PM and night shifts. 09/08/2024- Not repositioned on night shift. 09/09/2024- Not repositioned on night shift. 09/10/2024- Not repositioned on night shift. 09/11/2024- Not repositioned on PM and night shift. 09/13/2024- Not repositioned on night shift. 09/14/2024- Not repositioned on night shift. 09/15/2024- Not repositioned on night shift. 09/16/2024- Not repositioned on PM and night shift. 09/18/2024- Not repositioned on night shift. On 09/20/24 at 4:49 PM, the DON was notified R252 did not like lying on back continuously. When asked if repositioning was attempted, DON did not answer. DON agreed R252 could have been repositioned for comfort as requested by the resident. Review of the policy titled Repositioning dated May 2013, documented: 1. The purpose of the procedure was to provide guidelines for the evaluation of resident repositioning needs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. To aid in the development of an individualized care plan for repositioning. 3. To promote comfort for all bed or chair bound residents. 4. Repositioning was critical for a resident who was immobile or dependent upon staff for repositioning. Incontinent Brief: On 09/17/24 at 9:06 AM, R252 stated did not get up as instructed by the medical doctor (MD) following their back surgery. R252 stated toileted using an incontinent brief while in bed. R252 stated had used a bedpan while in the hospital and were ok using the incontinent brief, if it made it easier for the nurses, but added would rather not. On 09/19/24 at 1:48 PM, a Certified Nursing Assistant who was taking care of R252, stated the resident was alert and was able to communicate needs. The CNA stated R252 was incontinent and needed to wear an incontinent brief. The CNA stated did not know if R252 chose to wear the incontinent brief. The CNA stated when needed to know resident preferences, it was communicated at shift report but did not know how to check resident preferences on the computer. Review of the care plan did not identify the R252's use of incontinent brief with goals and interventions. On 09/20/24 at 4:49 PM, the DON was asked who made the decision for the resident to wear an incontinent brief, DON stated it was done if the resident was incontinent. The DON did not give an answer when asked if R252 was asked if the resident wanted to wear an incontinent brief. Review of the policy titled Urinary Incontinence dated April 2018, lacked documentation to address resident use of incontinent briefs.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29141 Based on observation, record review, interview and document review, the facility failed to safeguard the privacy of a resident by posting the body weight on a room's board visible from the hallway for 1 of 26 sampled residents (Resident #203). The deficient practice had the potential to violate the rights of the resident to maintain health information in a private manner. Findings include Resident #203 (R203) R203 was admitted on [DATE], with diagnoses including COPD, acute hypoxic respiratory failure, and prediabetes with steroid induced hyperglycemia, sleep apnea. R203's medical record revealed R203 was alert and oriented and able to make their own decisions. On 09/17/2024 at 9:00 AM, a board in R203's room revealed the following information that was visible from the hallway: 268.4 LB (pound) 9/10/24. When R203 was asked about the weight information posted on the board, R203 conveyed it should not be visible to everyone since it was a privacy issue. On 09/18/2024 in the afternoon, a Registered Nurse confirmed the observation and proceeded to delete the weight information from the board. On 09/19/2024 in the afternoon, the Director of Nursing indicated a family member of R203 requested to document the weight on the board. The DON acknowledged posting weight information in a visible place could be considered a dignity and privacy issue. The medical record lacked documented evidence a family requested to post R203's weight information on the board. The facility policy, undated titled Dignity, documented signs indicating the resident's clinical status or care needs were not openly posted in the resident's room unless requested by the resident or family member.

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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** 29141 Based on interview, record review, and document review, the facility failed to ensure a total parenteral nutrition TPN (a medical method to directly deliver essential nutrients into the bloodstream to individuals with medical conditions that prevent normal food digestion) was administered by qualified Registered Nurses for 1 of 26 sampled residents (Resident #29). The deficient practice had the potential to expose the resident to medication errors that could cause health complications. Findings include: Resident #29 (R29) R29 was admitted on [DATE], and readmitted on [DATE], with diagnoses including severe protein-calorie malnutrition, dementia, dysphagia, and history of venous thrombosis and embolism. A physician's order dated 08/24/2024, documented an order for the TPN intravenous solution (Clinimix [trade mark]) 5 % amino acids electrolyte with calcium in 20% dextrose to be infused at 65 milliliter per hour (ml/h) for 16 hours intravenously. one time a day for malnourishment and poor oral intake. A new physician order dated 09/14/2024, documented TPN 5 % amino acids electrolyte with calcium in 15 % dextrose to be infused at 65 milliliter per hour (ml/h) for 20 hours intravenously. The medication administration record (MAR) for August 2024 and September 2024, revealed TPN was documented as administered by licensed practical nurses (LPNs) on 08/23/2024, 08/28/2024, 09/13/2024, 09/14/2024, and 09/16/2024. On 09/18/2024 at 10:00 AM, a licensed practical nurse (LPN) explained the check marks with numeric code initials documented in the MAR on the TPN orders meant the signing nurse administered the infusion. The LPN confirmed having documented with their initials in the TPN administration on 09/14/2024 but denied having administered the infusion and only monitored the infusion. The LPN verbalized only RNs could administer TPN. On 09/20/2024 in the morning, an LPN charge nurse explained LPNs had limited privilege for the intravenous administration of medications. The LPN verbalized only RNs were allowed to administer TPN. On 09/17/2024 in the afternoon, the Director of Nursing (DON) indicated LPNs were trained in TPN administration and had IV certification. The DON confirmed by reviewing the MAR that at least 5 LPNs documented in the MAR having administered TPN to R29. The DON was not aware LPN could not administer TPN per the Nevada Nursing Practice Act that specified LPN were not delegable for the administration of TPN. The review of personnel records for five LPNs (Employees #1, #2, #3, #4, #5, and #6), revealed the administration of TPN was not a task described in the LPN's job description; drug administration function.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20127 Based on interview, record review, and document review, the facility failed to ensure a resident was discharged to a licensed group home per physician order for 1 of 26 samples residents (Resident 161). The deficient practice had the potential to place a resident in an inappropriate care setting. Findings include: Resident 161 Resident 161 (R161) was admitted to the facility on [DATE] and discharged on [DATE], with diagnoses including restless leg syndrome, generalized muscle weakness, diabetes mellitus, unspecified protein-calorie malnutrition, legal blindness, and adult failure to thrive. The facility Initial History and Physical dated 02/07/2024, documented the resident presented to the hospital after being discharged from the Emergency Department (ED) to home on 02/04/2024 with plans to get help vs placement but went back for uncontrolled muscle spasm. Resident reported stopping Pramipexole for restless leg syndrome and whole body felt numb. Resident reported not having any food at home and could not go back home. Resident had leg tremors and anxiety when the resident arrived to the ED. Resident was recommended to be discharged to a skilled nursing facility and would need help with placement. The Assessment and Plan included the following: - Weakness debility - physical and occupational therapy - Chronic low back pain/muscle spasm - Cyclobenzaprine (muscle relaxant), discontinue Ibuprofen per resident request and restart Percocet 5-325 milligrams every 4 hours as needed - Restless Leg Syndrome - Pramipexole - Chronic hyponatremia, hypomagnesemia - monitor electrolytes and replace as needed - Failure to thrive - Hypertension - not on blood pressure medications Discharge Plan: lives alone with no stairs, resident had not been eating well because the resident had no access to meals and unable to cook for self. Resident would like assistance with placement. A Physician Progress note dated 02/08/2024, documented resident reported decreased vision that had been ongoing. Resident was alert, oriented to person, place, time. Resident calm, cooperative, appropriate mood and affect. Therapy levels as of 02/07/2024 - bed: caregiver assist, transfers: moderate assist, gait: 5 feet front wheeled walker with moderate assist, lower body dressing: maximum assist, toileting: moderate assist. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Conference note dated 02/09/2024, documented an interdisciplinary team (IDT) meeting with resident. Resident reported having no place to discharge to at this time. Case management provided options. Resident desired a group home in a specific area of town. Resident was currently receiving physical therapy (PT)/occupational therapy (OT) services. Bed mobility Minimum assist, Transfer Moderate assist at this time. No issues or concerns at this time in regard to care at facility, IDT would continue to monitor provider support and assist as needed. A Physician Progress note dated 02/09/2024, documented a request for the facility social worker and the insurance social worker to assist the resident with placement options. A Physician Progress note dated 02/13/2024, documented insurance social worker referral placed as the resident reported not finding a group home and had paid this month's rent for the resident's apartment. Resident was engaged in conversations about discharge and agreed the skilled nursing facility was not the correct place for the resident. The resident was concerned about a safe discharge location. This information had been forwarded to the insurance social worker. Anticipated discharge on 02/16/2024. Discharge medication list sent to the pharmacy for discharge reconciliation. A Physician Progress note dated 02/14/2024, documented discussed discharge planning with the resident. Resident was agreeable with discharge to a group home with hospice services. Social worker/case manager at the facility had participated in discharge planning. A Physician Progress note dated 02/15/2024, documented the resident was admitted to the facility for rehabilitation services and pain management. Resident had participated in therapy services and was cleared for discharge with 24/7 assistance at a group home. The resident was agreeable moving into a group home. The resident's family was able to assist with the group home expenses for the next two weeks. The resident was evaluated and accepted to a group home. Hospice services were requested by the resident, and the resident would be discharged to a group home on hospice services. Therapy levels as of 02/14/2024 were bed mobility: supervised, transfers: standby assist, gait: 40 feet front wheel walker standby assist, upper/lower body dressing: contact-guard assist/standby assist, toileting: moderate assistance. Resident was discharging to a group home with hospice services. Good family support. The resident had adequate access to a safe home environment. The resident was aware the home health nurse, home physical therapy, case management and social worker will be in contact once discharged . Resident verbalized an understanding of all discharge instructions and questions answered. A Case Management note dated 02/16/2024, documented resident would be discharged to a group home with hospice per resident and family request. No other questions and concerns at this time. The Discharge Summary dated 02/16/2024, documented the resident was discharged to a home (address was documented). A review of the Bureau of Health Care Quality and Compliance Health Facility Locater website revealed there was no licensed group home located at the address the resident was discharged . On 09/20/2024 in midmorning, the facility Case Manager indicated the resident was alert and oriented and chose to go the discharge address. The Case Manager did not check to determine if the home the resident was discharged to, was a licensed group home and left it up to the insurance social worker to ensure the resident was discharging to a licensed group home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record lacked documented evidence the resident was discharged to a licensed group home per physician order or the discharge plan was altered based on the resident not wanting to go to a group home and instead wanted to go to a private residence with hospice services. Complaint NV00071314

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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** 29141 Based on observation, record review, interview and document review, the facility failed to ensure an arm brace and sling were placed for a resident with arm fracture for 1 of 26 sampled residents (Resident #98). The deficient practice could lead to complications such as improper healing, increased pain, reduced mobility, increased risk of further injury, and nerve damage. Fundings include: Resident #98 (R98) R98 was admitted on [DATE], with diagnoses including right humerus fracture. On 09/17/24 in the morning, R98 was lying in bed with a visible bandage on the right upper arm. R98 indicated had suffered a fracture and was experiencing significant pain. R98 was holding the right arm with the left hand and explained should have been wearing a brace to immobilize the fracture but had been removed the previous night by a staff member and could not locate it. R98 verbalized the brace helped to improve the pain caused by the fracture. A physician order dated 09/05/2024, indicated right arm [NAME] brace and a sling with abduction pillow to be used at all times for a right humeral fracture. (A [NAME] brace is a plastic brace used to stabilize humeral shaft fractures, allowing elbow freedom and movement of forearm and hand). Care plan dated 08/30/2024, revealed R98 had fracture of the right arm. Approaches included [NAME] brace and sling with abduction pillow on at all times. Physician progress noted dated 09/12/2024, revealed R98 was seen and examined by an orthopedist who placed a [NAME] brace and abduction pillow to R98. After the placement of the brace, R98 reported improvement in pain. On 09/18/2024 at 2:45 PM, the Physical Therapy (PT) Director indicated an order for a [NAME] brace and sling was obtained from orthopedist and should be placed all the time until 10/14/2024. The PT Director confirmed the brace should have been placed all the time. The facility undated policy titled Assistive Devices and Equipment, documented the facility should maintain and supervise the use of assistive devices following recommendations dictated by the resident's care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29141 Based on observation and interview, the facility failed to maintain sanitary conditions in the kitchen. The deficient practice could potentially expose residents to foodborne illnesses. Findings include: On 09/17/24 in the morning, an inspection was conducted with the kitchen manager in the kitchen area. The following issues were identified: A cook was preparing meal to be distributed to the residents. The cook had facial hair but was not wearing a beard cover. The top surface of the oven was visibly soiled with greasy matter and dust. The top surface of the dish washer machine was visibly soiled with yellowish debris and dust. An open bottle of milk was open and not dated in the walk-in refrigerator. An open milk carton was on the floor under a rack with dairy products and the milk had spilled out in the walking refrigerator. A 4 pounds (Lbs.) can of tuna and two 6 Lbs. cans of pineapple chunk were in the dry storage visibly dented. The lid of the ice machine had white stains and the inside rim of the machine was dirty and stained. The kitchen manager indicated the ice machine was cleaned two weeks ago and a service order to be checked was sent to the Maintenance Department. On 09/17/2024 at 10:00 AM, the kitchen manager explained the oven was scheduled to be cleaned on a weekly basis. The kitchen manager acknowledged the oven, and the dish washer should have been cleaned more often if they were dirty. On 09/19/2024 at 11:40 AM, during the tray line observation, a fan was placed on the floor blowing air to the food preparation area. The kitchen manager explained the fan was used to dry the floor and acknowledged the fan should not have been placed in the preparation area due to potential food contamination with dust. During the tray line observation, a cook with a beard was not wearing a beard cover while setting up meal trays. The Manager confirmed the observation and acknowledged beard cover should have been worn.