STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295066	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Hills Health Care Center	3450 N Buffalo Dr Las Vegas, NV 89129

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 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 and record review, the facility failed to ensure a thorough investigation was completed and failed to report an allegation of misappropriation involving a certified nursing assistant to the State Board of Nursing. The deficient practice had the potential to place all residents at risk for unreported financial exploitation. Findings include:Resident 12 (R12) was admitted on [DATE] with diagnoses including Alzheimer's disease and dementia.A Nursing Progress Note dated 07/27/2025, documented a nurse had been asked by R12 for change for the vending machine. Having noticed the resident had multiple twenty dollar bills the nurse asked R12 about the cash. R12 explained asking a friend to get cash from the automated teller machine using R12's bank card.R12 was roomed with wife and upon further questioning by the nurse it was discovered the friend was a staff member assigned to provide care for both residents. The nurse documented information collected and entered into the electronic health record on 07/27/2025 for the social worker to address the following day.On 07/28/2025 the Social Services Director filed a grievance on behalf of R12 and notified the administrator.On 11/20/2025 at 2:05 PM, the Social Services Director (SSD) indicated being aware of incident which was reported to the social services department on 07/28/2025. The SSD verbalized that a nurse had an encounter with the resident of concern asking the nurse for change to get something from the vending machine. The nurse questioned where the money came from and was told the resident gave debit card to a friend, who was a staff member, to get cash for the resident and wife. The cash was returned however the debit card was not. The nurse kept the cash locked in the medication cart and completed a note for social work to follow up the following day.The SSD indicated after receiving information and talking with residents, Adult Protective Services (APS) were notified as R12 had an active case worker for unrelated concern. The Administrator was notified, and police were contacted for report. The SSD revealed the police had contacted the staff member in question and told the staff member to return items as soon as possible and indicated a garage remote control and keys were also missing. The other items were returned or found in the resident's room. The SSD indicated helping the residents to cancel the debit card with issuing bank.An email from the SSD to the Administrator dated 08/12/2025 documented information from the APS worker advising the facility the staff member who took the ATM card had wiped out the bank account. On 07/28/2025 there were two additional withdrawals of over $1000 each and a pizza [NAME] expense and rental care expense. APS was filing an updated police report.On 11/20/2025 at 2:58 PM, the Director of Nursing (DON) confirmed the incident and explained the staff member of concern was identified through description provided by residents and cross referenced with the schedule. The staff member was identified as a current certified nursing assistant (CNA1). The DON added it was confirmed by video evidence from the ATM and at the entrance of facility. The DON indicated the employee of concern was terminated for violation of policy, specifically for misappropriation of resident property and financial exploitation. The DON acknowledged the staff member should have been reported to the State Board of Nursing but was not at the time of termination. On 11/20/2025 at 3:30 PM, the Director of Staff Development (DSD) explained having been involved in human resource duties when CNA1 employment was terminated and indicated CNA1 was suspended on 07/28/2025 while investigation was conducted. The DSD verbalized, ultimately CNA1 was terminated for misappropriation of resident property, financial abuse.The investigation file provided by facility lacked documented evidence of interviews with CNA1, identification of CNA1 as the resident's friend, or determination by facility of outcome of in-house investigation.The investigation file provided by the facility lacked documented evidence that CNA1 was reported to the State Board of Nursing.The facility policy titled Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating (2001) documented all abuse, neglect, exploitation or misappropriation of resident property allegations would be thoroughly investigated, and all relevant professional and licensing boards would be notified when an employee was found to have committed abuse.Incident 2575106

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of misappropriation involving a certified nursing assistant was reported to the State Agency within the required timeframe for 1 of 1 allegation reviewed. The deficient practice had the potential to place all residents at risk for unreported financial exploitation.Findings include:Resident 12 (R12) was admitted on [DATE] with diagnoses including Alzheimer's disease and dementia.A Nursing Progress Note dated 07/27/2025 documented an allegation of misappropriation of resident property/funds.The facility reported the allegation of misappropriation of resident property to the State Survey Agency on 07/29/2025.On 11/20/2025 at 2:20 PM, a Licensed Practical Nurse (LPN) indicated being familiar with the abuse reporting policy and indicated the administrator was the abuse coordinator. The LPN verbalized abuse allegations including allegations of misappropriation were to be reported immediately by phone or in person. The LPN indicated abuse allegations were to be reported immediately and the facility had two to 24 hours to report to the state agency depending on the specific allegation. The LPN explained it would not be appropriate to consider an allegation of misappropriation to have been reported through electronic health record documentation.On 11/20/2025 at 2:58 PM, the Director of Nursing (DON) verified the timeline for reporting abuse to the state agency was within two hours if the allegation of abuse involved physical harm or within 24 hours for all other allegations, including allegations of misappropriation.On 11/20/2025 at 2:58 PM, the Administrator confirmed being the abuse coordinator and indicated all allegations of abuse were to be reported to the abuse coordinator immediately. The Administrator explained that the nurse notified the abuse coordinator by entering information into the electronic health record causing an alert for the next time a user logged into the system. The Abuse Coordinator confirmed the Social Services Director initiated an investigation the following day and acknowledged the initial report was sent on 07/29/2025.The facility policy titled Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating (2001) documented the administrator or individual making the allegation immediately reports suspicion to the state licensing/certification agency, local/state ombudsman, resident representative, adult protective services, law enforcement officials, attending physician, and the medical director. Immediately was defined as within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation which does not involve abuse or result in serious bodily injury.Incident 2575106