| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295072 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/24/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Silver Ridge Healthcare Center | 1151 Torrey Pines Dr.<br>Las Vegas, NV 89146 |

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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record reviews, and document reviews, the facility failed to ensure a resident was protected from physical abuse for 1 of 29 sampled residents (Resident 13). The deficient practice had the potential to cause emotional and physical harm to the residents.Findings include: Resident 13 (R13) was admitted on [DATE] with diagnoses including local infection of the skin and subcutaneous tissue, extended-spectrum beta-lactamase (ESBL) resistance, and neuromuscular dysfunction of the bladder.A facility document verified on 04/10/2026 at approximately 7:00 PM, R13's roommate pushed a bedside table into R13 around 7:00 PM, while in the resident's shared room. The police department was contacted and responded to the incident. The roommate was moved to a separate room.On 04/24/2026 at 3:30 PM, during a telephone interview, the Supervisor indicated the charge nurse had called them regarding an altercation between two residents. When asked what occurred, R13 reported the roommate slammed the bedside table toward their face because the roommate had been upset about the television volume being too loud. The roommate attempted to move the bedside table out of the way, and it fell over onto R13.The R13 was observed with bleeding from the lip and reported having a loose tooth. The blood on R13's face and lip were cleaned, and the loose tooth was noted. R13 had a scheduled appointment with a dentist for further evaluation. The resident refused to transfer to the hospital. Law enforcement was notified, and both R13 and the roommate provided statements to the responding officer. R13 declined to press charges. Roommate was relocated to a separate room following the incident.On 04/23/2026 at 11:45 AM, R13, reported the roommate had pushed the bedside table and struck them in the face. R13 sustained a cut lip and a loose tooth because of the incident. R13 explained the roommate became angry because the television volume was too loud. R13 indicated the facility contacted the police, who obtained statements from both residents. R13 reported the facility was planning to arrange a dental evaluation for the loose tooth. On 04/23/2026 at 12:12 PM, the Social Worker reported the incident occurred on the evening of 04/10/2026. Since the event, the Social Worker regularly checked to ensure the residents continued to feel safe and everything remained stable and satisfactory with the residents' wellbeing.On 04/23/2026 at 12:40 PM, R78 (R13's former roommate) reported the bedside table had been positioned on the side of the bed. R78 indicated pushing the bedside table back toward the roommate's side, they were simply returning the bedside table to its proper place.A progress note dated 04/10/2026 documented an assessment of R13's face and face was done to determine if the resident required to be sent out for treatment. A Social Service visit note dated 04/13/2026 documented the Social Services Director and Administrator visited R13 regarding the report. R13 was provided with emotional support. Since the event, the Social Worker had been regularly checking on the resident to ensure they continued to feel safe and everything remained stable and satisfactory with the resident's well-being.A Care Plan dated 04/14/2026 documented R13 was involved in an altercation with a roommate. Interventions included the following:-Provide a safe environment for R13.-Monitor for coping strategies and respect resident's wishes.-Assist with conflict resolution as needed.-Notify MD (Medical Doctor) for any changes.During the onsite investigation on 04/21/2026,<br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the facility demonstrated correction of past non-compliance related to the incident, as evidenced by the following:-Observation of resident-to-resident interactions. -Interviews with residents revealed the residents were happy with their fellow residents and felt they were treated politely.-Interviews with Certified Nursing Assistants and Licensed Nurses indicated the facility provided continuing education regarding Abuse and Neglect.-Review of the facility's staff in-service sign-in sheets dated 04/13/2026 pertaining to elder abuse recognizing, prevention and reporting. FRI 2981818 |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a safe environment was provided to residents and staff when an unauthorized male intruder entered the facility and stole the personal belongings of 1 of 29 sampled residents (Resident 94) and a staff member. The deficient practice had the potential to cause physical harm to residents and staff members.Findings include:Resident 94 (R94) was admitted on [DATE], with diagnoses including anxiety disorder, major depressive disorder, and pain in left knee.On 04/24/2026 at 9:41 AM, R94 was lying in bed, alert, and oriented. R94 revealed around 5:00 AM, sometime in December 2025, seeing a guy inside the resident's room and took a cellphone with a phone case containing R94's driver's license, debit card, health insurance card, and RTC (Regional Transportation Commission) bus card. R94 indicated the guy said being a kitchen staff and just checking the resident's table to be ready for breakfast. R94 explained not knowing the guy and had not seen him before. The guy had a backpack.R94 confirmed the door alarms did not go off when the guy entered the building (facility). R94 indicated they would usually hear the door alarms if somebody had entered the building and did not press the correct code. R94 acknowledged the staff called the police and the resident was interviewed. R94 revealed there were two unauthorized charges from the debit card after the incident. The bank reimbursed the resident for the two unauthorized charges and the facility replaced R94's cellphone.R94 acknowledged the same incident did not happen again and they had not heard from other residents about their belongings being stolen by the same guy. R94 indicated feeling safe now.On 04/24/2026 at 10:03 AM, a Licensed Practical Nurse (LPN) revealed in December 2025, R94 reported there was a man who went inside the resident's room and introduced self as a kitchen staff when asked by the resident who he was. The guy (man) took the resident's cellphone according to the resident. The LPN explained the alleged incident was discussed by the Interdisciplinary Team (IDT) on the same day it was reported by the resident. The LPN was thinking R94 could have a delusional episode due to having a history of seeing a person. During the IDT meeting, the other nurse reported that the day prior to the alleged incident reported by R94, a stranger came into the kitchen and stole the iPhone of a dietary staff which happened about 5:30 PM. The same guy was seen from the camera entering the door by the kitchen by following somebody from behind. The incident happened the day before R94 reported about the guy entering the resident's room. The picture of the guy was posted throughout the building after the incidents.The LPN indicated a month later or in January 2026, the same guy climbed through the window to enter the facility. The purse, house key, and car key of a night shift nurse were stolen. The same guy was involved in these three incidents. The LPN revealed in between these three incidents, the same guy was seen twice in the parking lot and staff called the police immediately.The LPN confirmed it was only R94 and the night shift nurse who reported about missing belongings due to these incidents. The LPN acknowledged the same incident did not happen again. The facility put locks on the windows of the resident rooms and pictures of the intruder were posted throughout the facility. The police and detectives came. All visitors were required to check in at the front and wear a visitor's badge while at the facility.On 04/24/2026 at 12:44 PM, a Certified Nursing Assistant (CNA) indicated hearing about an intruder who was able to get inside the building. The CNA recalled about this guy who indicated having to pick up the belongings of a discharged resident. The guy asked for the Wi-Fi which the CNA provided. During the investigation of a security breach, the CNA indicated that the same guy was the one who was in the video camera and broke into the building. After the incident and corrective actions in place, there were no more intruders. The visitors were required to have a visitor badge while inside the building.On 04/24/2026 at 2:21 PM, the Administrator explained and read through the investigation report and final conclusion about the incident which happened 01/24/2026 - 01/25/2026 when an unauthorized individual gained access to<br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the facility. The report documented the following:- Location: South Side Case Management Office/300 Hall Egress- Description of Event: During the night shift, an unauthorized individual gained access to the facility by bypassing a window on the south side of the building. The window was not fully seated in the locked position, allowing the intruder to shimmy the frame open and enter an unoccupied administrative office. The individual exited the office into the hallway and proceeded to the nurse station where a wallet and set of keys belonging to a nurse were misappropriated. As the individual attempted to exit through the west doors near the end of 300 Hall, the door alarm was triggered. Staff responded immediately to the alarm, but the individual had already reached a getaway vehicle parked on the south paved access road and fled the premises. The Administrator met with the nurse to discuss findings and the incident that occurred. The police report was discussed as well as the interventions taken to ensure the staff and residents' safety.- Investigative Findings including a full internal investigation and calling the Las Vegas Metro Police Department (LVMPD). Security footage was reviewed and handed over to LVMPD who was in pursuit of the suspect. A floor-wide check was conducted immediately, and it was determined the individual did not enter a resident room or come into physical contact with any residents. No staff members were physically harmed during the encounter, though a theft of personal property occurred.- Corrective and Preventative Measures:1) Hardware Upgrades: The facility had installed new and State-approved secondary locks on windows. These locks would prevent a window from being shimmied or forced open from the exterior even if the primary latch was not full engaged. 2) Environmental Audit: Maintenance staff conducted a full sweep of the south side of the building to ensure all windows were fully functional and that no exterior landscaping would provide cover for unauthorized access and all lights and camera were fully functional.3) Law Enforcement Collaboration: LVMPD was working directly with the nurse to recover the stolen personal property. The Administrator had requested and secured an increase Active Patrols from Metro during the night shift hours for the next two to three weeks.4) Alarm System Review: The west door alarm functioned as intended, providing the immediate alert that led to the staff members' rapid response and the identification of the getaway vehicle.- Conclusion: The investigation concluded that while a theft of staff property occurred, no residents or staff were in immediate harm's way. The swift response of the nursing team and the subsequent physical interventions, specifically the addition of window locks and increased Metro presence, had successfully secured the facility against future breaches of this nature.The report included a staff in-service titled All Staff Meeting Agenda: Night Shift Security and Window Safety which was conducted on 01/26/2026, with sign-in sheets.The Administrator indicated there were no similar incidents which occurred after the January incident.<br>The police found out the guy was driving a stolen vehicle. The guy exited the door by the wound care team office in 300 Hall. There was no physical contact with the residents. The guy could have entered the kitchen door or the employee entrance.When asked if a similar incident had occurred prior to the January 2026 incident, the Administrator responded there was an incident in December 2025 where an intruder had entered the room of R94. The Administrator indicated the need to get and refer to the investigation report related to this incident.On 04/24/2026 at 2:47 PM, the Administrator revealed there an incident on 12/24/2025 about a security breach involving an unauthorized male intruder. The individual made his way into the room of R94. The incident was investigated and the Administrator read through the report which documented the following:- Date of Incident:12/24/2025- Location: Name of the Facility/Resident Room/Facility Perimeter- Findings: On 12/24/2025, the Administrator was notified of a security breach involving an unauthorized male intruder. It was reported that an individual bypassed the front lobby visitor kiosk and entered the facility. The individual made his way into the room of R94. The intruder removed a cellphone and personal items attached to the device from the resident's bedside. Upon staff becoming aware of an unrecognized individual, the male was immediately challenged, at which point he exited the building. A full facility sweep was conducted instantly to ensure no other unauthorized persons were present and to confirm the safety of all other residents. It was determined that no other resident rooms were entered and no physical contact or<br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | verbal threats were made toward any resident. Investigation included a review of the visitor kiosk logs, staff interviews, and a physical inspection of all egress points. Findings showed the individual was not an authorized visitor, family member, or vendor. LVMPD was notified immediately and arrived onsite to conduct an official report. LVMPD interviewed R94. During the interview, R94 remained alert and oriented. R94 did not wish to press criminal charges against the individual but expressed a desire to have the personal property restored. Clinical staff assessed theR94 for any signs of psychosocial distress, none were noted. R94 reported feeling safe once seeing the increased staff and police presence. The facility provided prompt reimbursement and replaced the cellphone and all attached items to the resident's satisfaction.- New Intervention and Systemic Measures including visual identification, mechanical hardware audit, access control update, law enforcement partnership and staff re-education.- Conclusion: The facility took aggressive and immediate measures to ensure R94 was supported and that the building was secured. R94 expressed full satisfaction with the resolution. The facility continued to monitor door security and kiosk compliance daily to ensure incidents of this nature would not happen again.The report included a staff in-service titled All Staff Meeting Agenda: Facility Security and Safety which was conducted on 12/29/2025, with sign-in sheets.The Administrator explained not being aware of an incident prior to the 12/24/2025 incident where an intruder entered the kitchen and stole the cellphone of the dietary staff.On 04/24/2026 at 3:01 PM, a night shift LPN indicated having heard about a guy who came through the window of the case management office during the night shift when the LPN was working. There were no residents harmed and no stolen items/belongings from the residents during this incident. The cellphone and keys of the other LPN were stolen. After the incident, locks were placed on all windows including the resident rooms and the code in the employee entrance was changed. The night shift LPN acknowledged feeling safer now.On 04/24/2026 at 3:22 PM, the Director of Nursing (DON) indicated R94's report about a stolen cellphone was treated and addressed as a grievance and it was resolved. The DON explained there were no IDT notes related to the incident.During the onsite investigation on 04/21/2026 through 04/24/2026, verification of the facility's correction of the past non-compliance related to the security breach and an intruder entering the facility occurred as evidenced by:- A tour of the facility on 04/22/2026 revealed the windows, including the resident rooms' window, had thumb screw clamp in place. An observation of the window to resident room [ROOM NUMBER] from the exterior revealed the window was intact, open approximately four inches, and the thumb screw clamp lock was in place. Allegedly, the intruder entered into room [ROOM NUMBER] during the 01/25/2026 incident. The room was next to the case management office. The egress doors were locked from the exterior and door alarms were functioning.- An observation of the window to resident room [ROOM NUMBER] (R94's room) from the interior revealed the window was intact and the thumb screw clamp lock was in place. This window led to an interior courtyard.- During the screening of the residents on 04/21/2026 and resident council meeting on 04/23/2026, the residents indicated they felt safe at the facility and there were no intruders or random guys entering their rooms.- A staff in-service titled All Staff Meeting Agenda: Facility Security and Safety was conducted on 12/29/2025, with sign-in sheets.- A staff in-service titled All Staff Meeting Agenda: Night Shift Security and Window Safety was conducted on 01/26/2026, with sign-in sheets.- The facility had investigated the incidents and implemented the corrective actions. Complaint 2730077 |