STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295000	A. Building B. Wing	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pershing General Hospital Snf	855 6th Street Lovelock, NV 89419

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 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** 34524 Based on interview, clinical record review and document review, the facility failed to ensure residents were treated with dignity when residents felt bother, annoyed, or harassed by other residents' comments and behaviors for 2 of 15 Facility Reported Incident (FRI) residents (Resident #2 and #3). Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus with unspecified complications and acquired absence of right leg above knee. Resident #2 Resident #2 was admitted to the facility on [DATE], with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. FRI #NV00069712 documented on 10/23/23, Resident #1 was in the dining room getting coffee when Resident #2 walked by and stated you guys need to get Resident #1 black glasses, so I don't have to see them looking at me. A staff member encouraged Resident #1 to keep walking. Within hearing of Resident #2, Resident #1 stated Resident #4 is nothing but a piece of <expletive>, they think they are a man because they have a <expletive>. On 02/27/24 at 12:35 PM, Resident #2 verbalized they can not stand how Resident #1 stared at the resident. The resident explained Resident #1 did it on purpose because Resident #1 knew Resident #2 did not like it. On 02/28/24 at 10:21 AM, a Certified Nursing Assistant (CNA) explained Resident #1 would sit in the hallway and stare at the female staff and residents. In the dining room, some female residents have asked for the double doors to be closed so Resident #1 could not look at them. The staff attempted to redirect Resident #1 and told them staring was rude and made the other residents uncomfortable. Residents have complained to staff and have asked to have Resident #1 moved to a different area in the dining room or have the resident look out the window. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/28/24 at 11:31 AM, a License Practical Nurse (LPN) verbalized some of the female residents have complained about Resident #1's staring, including Resident #2. Administration has spoken with Resident #1 several times about their inappropriate behaviors. When staff saw Resident #1 staring inappropriately, they redirected the resident and asked the resident to quit staring. A Psychosocial Note dated 10/24/23, documented the Licensed Social Worker (LSW) met with Resident #1 to discuss the reported altercation that occurred on 10/23/23. Resident #1 reported Resident #2 was upset with the resident for an unknown reason and Resident #2 tried to make Resident #1 feel bad. On 02/28/24 at 1:06 PM, the LSW verbalized they interviewed Resident #1 regarding the incident and Resident #1 expressed they did not want to be around Resident #2. The LSW verbalized the LSW was unsure when they became aware Resident #1 stared at Resident #2. When the LSW interviewed Resident #2 regarding the incident, Resident #2 explained Resident #1 made them uncomfortable with the way Resident #1 stared and due to past trauma Resident #2 has experienced. The LSW explained Resident #1 was considered the victim of the incident because Resident #2 lashed out at Resident #1 and it was witnessed. Resident #2 was sent to an inpatient behavioral health facility due to their behaviors. The LSW verbalized Resident #2 was not investigated as a potential victim. On 02/28/24 at 2:46 PM, the Chief Nursing Officer (CNO) verbalized Resident #2 was walking down the hallway and made a comment to Resident #1 about getting glasses so Resident #2 did not have to see Resident #1 looking at them. Resident #1 was interviewed and stated they felt safe. The CNO verbalized they did not recall speaking with Resident #2. The CNO explained the LSW interviewed Resident #2. Resident #2 was sent to an inpatient behavioral health facility due to their recent outburst, to include this situation. On 02/28/23 at 2:59 PM, the Administrator verbalized the administration was not aware of concerns with Resident #1 leering at Resident #2. The FRI was not substantiated as abuse because there was not psychosocial harm to Resident #1. Resident #2 was not assessed for psychosocial harm related to the incident; however the resident was sent to an outpatient behavioral facility because Resident #2 appeared to be off baseline at the time of the incident. The Administrator verbalized they spoke with Resident #2 in the past week and the resident did not have any concerns. The Administrator admitted the Administrator did not ask Resident #2 about Resident #1's staring. Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including personal history of traumatic brain injury, anterograde amnesia, and mood disorder due to known physiological condition with mixed features. Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of vascular dementia, unspecified severity, with other behavioral disturbance. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pershing General Hospital Snf		STREET ADDRESS, CITY, STATE, ZIP CODE: 855 6th Street Lovelock, NV 89419	

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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	FRI #NV000069781 documented on 11/06/23, Resident #3 and Resident #4 were sitting in the dining room together when Resident #3 left the table looking upset. A Certified Nursing Assistant (CNA) followed Resident #3 and Resident #3 informed the CNA Resident #4 said some not nice things to the resident and the resident felt isolated in their room. On 02/28/24 at 11:40 AM, a CNA verbalized Resident #3 and Resident #4 were roommates. The CNA recalled Resident #3 would get frustrated with Resident #4 because Resident #4 would turn off the lights when Resident #3 was reading in the evening (around 7 PM). Resident #4 would leave the bathroom door open when using the bathroom and refuse to shut it when asked. The CNA verbalized witnessing Resident #3 leaving the table appearing upset. The CNA walked with the resident to their room and spoke with them privately. When asked what was wrong, the resident verbalized they were tired of Resident #4 instigating - leaving the light on, leaving the bathroom door open. Resident #4 would throw their clothing on Resident #3's side of the room. Resident #3 would close their curtain between Resident #3 and Resident #4's bed, however Resident #4 would open the curtains. The CNA recalled Resident #3 explained Resident #3 felt isolated in their own room. Resident #3 verbalized to the CNA the resident just wanted the behavior to stop. On 02/28/24 at 11:58 AM, a Licensed Practical Nurse (LPN) verbalized Resident #3 and Resident #4 were roommates. The LPN recalled Resident #4 would turn off the lights in the room. Resident #3 liked to read, and the facility got the resident a night light to accommodate both residents. Resident #4 would go on Resident #3's side of the room and turn off the night light. Resident #4 would leave the bathroom door open while using the bathroom and would refuse to shut it. Resident #3 felt they did not have privacy. Resident #3 was often tearful and felt Resident #4 was doing these things on purpose. Resident #3 was provided a room change. On 02/28/24 at 1:40 PM, the Licensed Social Worker (LSW) verbalized Resident #3 reported they felt uncomfortable with Resident #4 leaving the bathroom door open while using it and made Resident #3 feel like they did not have any privacy. Resident #3 reported that Resident #4 would make eye contact while using the bathroom. Resident #3 felt Resident #4 was intimidating them with the eye contact. Resident #3 liked to read and Resident #4 would turn off the lights while Resident #3 was reading. The residents were separated and a room change was provided. A Behavior Note dated 09/22/23, documented a Registered Nurse (RN) was attempting to give Resident #3 their medication when the resident yelled they were not going to take them. The RN asked the resident if something was bothering them, the resident replied they could not read because the lights were off so early in their room. The RN told the resident the resident could have the lamp on in their room and the resident responded they cannot because Resident #4 would complain about it. A Behavior Note dated 09/22/23, documented a CNA found Resident #3 in their room in tears stating they were tired of being treated badly by their roommate. A Physician Rounds note dated 09/24/23, documented nursing was concerned at Resident #3's episodes of anger toward staff and roommate had increased. The Provider recommended a medication change and a behavioral evaluation be completed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pershing General Hospital Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 855 6th Street Lovelock, NV 89419	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note dated 09/30/23, documented Resident #3 came out to the nurses station complaining I can't take it anymore! referring to their roommate, Resident #4 and their difficulty communicating and compromising to live together. Director of Nursing (DON) made aware. A Behavior Note dated 10/02/23, a CNA noticed Resident #3 left the dining room table during lunch. The CNA asked the resident where they were going and if they were ok and the resident responded no, I am going back to my room, and I am not hungry. The CNA went to check on Resident #3. Resident #3 stated they were not ok due to everything with their roommate. The resident explained Resident #4 will not shut the bathroom door when they use the toilet. Resident #3 has asked Resident #4 to shut the door and Resident #4 says no. The resident does not feel like going down for meals anymore because Resident #4 pushes their food on Resident #3's side of the table and Resident #4 talks about how Resident #3 wants the light on to read before bed, and Resident #4 wants it off. Resident #3 informed the CNA they do not want to sit with Resident #4 at meals anymore. The CNA told the resident the resident can sit wherever they want and offered to move the resident's plate to another table for the remainder of lunch. Resident #3 asked why they had to change where they sit. A CNA Note dated 10/14/23, documented Resident #3 was walking toward the nurses station in tears. When asked what was wrong, the resident replied I don't know why Resident #4 is so mean to me. They keep turning off the light when I am trying to read my book. The CNA told Resident #3 they would speak to Resident #4 and Resident #3 could come read their book at the nurses station. A Progress Note dated 11/06/23, documented Resident #3's Power of Attorney was contacted and advised that Resident #3 reported their roommate said not nice things and expressed their discomfort with being a roommate with Resident #4. The Power of Attorney (POA) gave approval for the room change. A Behavior Note dated 11/07/23, documented while giving Resident #3 their morning medication, the RN asked Resident #3 if they slept well. The resident responded not particularly and added their nerves are just shot. They did not know Resident #4 could be so weird. A Behavior Note dated 11/07/23, documented Resident #3 left the dining room during dinner. The CNA went to the resident's room to see if the resident was ok. The resident stated I'm fine. The CNA could tell something was wrong. The CNA repeated their question. Resident #3 then responded they were not coming back for dinner because they were mad. During follow up, Resident #3 stated they were fine, but Resident #4 keeps closing the drapes when Resident #3 wants them open, makes phone calls at 4:00 AM, which wakes up Resident #3. When Resident #3 turns on the light, Resident #4 turns the light off. Resident #4 throws their clothes on Resident #3's side of the room and when the resident throws them back, Resident #4 throws them back to Resident #3's side again. When Resident #3 is trying to sleep, Resident #4 turns on the lights. When Resident #4 goes poop or pee in the bathroom, the resident leaves the door wide open and did not close it when asked. Resident #3 tried to talk to Resident #4, however Resident #4 ignored them. Resident #3 felt isolated in their own room. Administration was notified. Roommate temporarily removed to prevent further problems at this time. A Psychosocial Note dated 11/07/23, documented the LSW met with Resident #3 to discuss the recent situations that had occurred in the past 24 hours. The resident expressed concerns with Resident #4. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pershing General Hospital Snf	855 6th Street Lovelock, NV 89419

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/28/24 at 3:28 PM, the Chief Nursing Officer (CNO) verbalized the FRI was not substantiated by the facility as there was no outcome of psychosocial harm for Resident #3. Resident #3 was interviewed by the Minimum Data Set 3.0 (MDS) Coordinator and the LSW and was provided with a room change. The CNO confirmed the resident's clinical record documented the resident was having problems with their roommate dating back to 09/22/23, and the DON was notified of the concerns on 09/30/23. The CNO verbalized the clinical record documented the resident was upset by the roommate's behavior. The CNO was not sure why the FRI was not substantiated. The facility policy titled Resident [NAME] of Rights, last revised 05/29/03, documented the resident had a right to be treated with consideration, respect, dignity, and individuality, including privacy and care of personal needs. NV00069781

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on interview and document review, the facility failed to ensure a non-verbal resident was not verbally abused by a staff member for 1 of 15 Facility Reported Incident (FRI) residents (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela, quadriplegia, unspecified, paraplegia, unspecified, and aphasia following unspecified cerebrovascular disease. FRI #NV00070158 dated 01/03/24, documented Resident #12 was receiving a beverage in the dining room on the morning of 12/28/23, when a Dietary Aide (DA) overheard a Certified Nursing Assistant (CNA1) say shut the (expletive) up to the resident. The DA reported the incident to the Dietary Manager on 01/03/24, and an investigation was initiated. Resident #12's clinical record lacked any documentation of the incident. Resident #12's Minimum Data Set 3.0 Assessment (MDS), Section C0500-Cognitive Patterns dated 10/02/23, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 00. The BIMS scoring method was as follows: 00-07: Severe cognitive impairment 08-11: Moderate cognitive impairment 12-15: Cognitively intact A BIMS Quarterly assessment dated [DATE], documented Resident #12 had severe cognitive impairment. Resident #12's MDS dated [DATE], documented the resident was unable to be interviewed because the resident was rarely/never understood. The staff assessment of the resident's mental status in Sections C0700-C0800 documented the resident had short term and long term memory loss. On 02/28/24 at 10:22 AM, the Social Worker (SW) explained a BIMS of 00 meant the resident had severe cognitive impairment. The SW had asked Resident #12 about the incident on 12/28/23, however the resident did not seem to remember. The SW could not provide documentation of the interview or explain how the resident would have answered the question. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/28/24 at 10:30 AM, the SW explained staff had noticed Resident #12 was experiencing increasing issues with the understanding of staff communication. The SW had requested the Psychiatric Nurse to evaluate Resident #12 for cognition capacity on 1/17/24 and 2/21/24, and it had not yet been completed. On 02/28/24 at 11:39 AM, the Administrator explained the investigation into the incident consisted of Resident #12's interview, the CNA1 interview, the Dietary Aide (DA) interview, and two other staff interviews. The Administrator verbalized the incident was unsubstantiated by the facility based on the lack of corroboration of multiple staff, communication with the resident, and CNA1's denial of the incident. CNA1 was suspended during the investigation and was terminated on 01/03/24, the same day as the investigation. On 02/28/24 at 11:42 AM, the Administrator communicated the Abuse Team was unable to ascertain if Resident #12 understood the investigative questions because the resident did not always accurately use the same signs for communication such as blinking one or two eyes, raising a hand, or shaking the head side to side for no. On 02/28/24 at 12:09 PM, the Chief Nursing Officer (CNO) explained Resident #12 was unable to inform staff if someone had shown abusive behavior towards the resident and staff had no way of knowing if the resident understood what was asked with a BIMS of 00. The CNO communicated the allegation of abuse was unsubstantiated based on the CNO's judgement of CNA1's denial of the allegation, the CNO did not feel CNA1 had behaved in the reported manner, even though the DA had witnessed CNA1's interaction with Resident #12. On 02/28/24 at 2:02 PM, the Dietary Manager confirmed the DA had reported overhearing CNA1 tell Resident #12 to shut the (expletive) up while the DA was serving the resident chocomoco (a hot chocolate drink) at breakfast. The Dietary Manager explained the DA felt CNA1 had directed the statement to the resident and believed the DA as the DA had never said anything negative about a CNA before. On 02/28/24 at 2:33 PM, the Dietary Aide confirmed serving Resident #12 chocomoco on the morning of 12/28/23. The resident was making noises of excitement while receiving a favorite breakfast drink when CNA1 told the resident to shut the (expletive) up. The DA confirmed CNA1 directed the statement at Resident #12. The DA explained the DA was directed to speak to Risk Management by the Dietary Manager. On 02/28/24 at 2:40 PM, the DA confirmed a discussion with the Risk Management Director (RMD) regarding what the DA overheard CNA1 say to Resident #12. The RMD told the DA no one had the right to speak to someone that way and it should have been reported right away. On 02/28/24 at 2:47 PM, CNA2 recalled an interview with the CNO about the statement made to Resident #12 by CNA1. CNA2 explained CNA2 was in the dining room the morning of 12/28/23, but was not sitting close enough to hear the conversation and could not say whether or not it happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/28/24 at 3:19 PM, the RMD explained Resident #12 was a difficult resident to get direct answers from and the resident would get flustered when asked too many questions at one time. The RMD could not explain how the resident was interviewed when the resident was non-verbal. The RMD recalled the incident was substantiated because CNA1's statement was a very inappropriate thing to say to a resident. The RMD communicated CNA1 was suspended and then dismissed by not renewing CNA1's agency contract because of the inappropriate actions towards Resident #12. On 02/28/24 at 3:57 PM, the Administrator explained the incident was not substantiated because two CNA's in the dining room that morning did not hear CNA1 make the statement to Resident #12, even though the DA reported witnessing the incident. The Administrator confirmed the two CNAs may not have heard what CNA1 said to Resident #12 if they were not sitting close enough to the resident. The Administrator verbalized the lack of more than one witness to the conversation did not mean CNA1 did not tell Resident #12 to shut the (expletive) up. The facility policy titled Abuse Prevention and Prohibition, last reviewed 08/25/23, documented each resident had a right to a dignified existence and to be free of physical, sexual, psychological abuse, and neglect. The facility would protect and promote the rights of each resident, including the right to be free from all forms of abuse or neglect, including verbal and mental abuse. The facility policy titled Resident [NAME] of Rights, last revised 05/29/03, documented the resident had a right to be free from mental abuse. The resident had a right to be treated with consideration, respect, dignity, and individuality, including privacy and care of personal needs. NV00070158

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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. 34524 Based on interview, record review and document review, the facility failed to ensure a Facility Reported Incident (FRI) was completed and submitted timely to the State Agency (SA) for allegations of abuse for 1 of 15 FRIs. Findings include: FRI #NV00069839 with the allegation of resident to resident abuse was submitted to the SA on 11/14/23. The allegation was made on 11/12/23. On 02/28/24 at 4:19 PM, the Chief Nursing Officer confirmed the FRI was submitted late and outside of the required timeframes. On 2/28/24 at 2:41 PM, the Administrator verbalized allegations of abuse and neglect were to be reported to the SA within two hours if bodily harm occurred, 24 hours for all other allegations of abuse and neglect, and the final report was to be submitted within five working days of the incident. The facility policy titled Abuse Prevention and Prohibition, last revised 08/25/23, documented the abuse investigation team would report suspected abuse via the Facility Reported Incident form for all alleged violations of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. All alleged violations would be reported immediately but not later than two hours if the alleged violation involves abuse or results in serious bodily injury. Alleged violations not involving abuse or serious injury would be reported within 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on interview, record review and document review, the facility failed to 1) ensure an allegation of employee to resident verbal abuse was thoroughly investigated and documented for 1 of 15 Facility Reported Incident (FRI) residents (Resident #12) and 2) report investigation results within five working days of the for 2 of 15 FRIs (NV00070209 and NV00070124). Findings include: Employee to Resident Altercation Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela, quadriplegia, unspecified, paraplegia, unspecified, and aphasia following unspecified cerebrovascular disease. FRI #NV00070158 dated 01/03/24, documented Resident #12 was receiving a beverage in the dining room on the morning of 12/28/23, when a Dietary Aide (DA) overheard a Certified Nursing Assistant (CNA) say shut the (expletive) up to the resident. The DA reported the incident to the Dietary Manager on 01/03/24 and an investigation was initiated seven days after the witnessed altercation. Resident #12's clinical record lacked documentation of the incident or investigation. Resident #12's care plan, undated, lacked documentation of the incident and did not include methods and interventions to prevent further abuse or monitoring for signs and symptoms of abuse or psychosocial effects. On 02/28/24 at 11:39 AM, the Administrator explained the investigation into the employee to resident verbal abuse consisted of Resident #12's interview, the accused staff interview, the Dietary Aide (DA) interview, and two other staff witness interviews. The Administrator verbalized the investigation was completed and unsubstantiated based on the interviews of staff present in the dining room, communication with the resident, and the CNA's denial of the incident. On 02/28/24 at 12:09 PM, the Chief Nursing Officer (CNO) explained Resident #12 was unable to inform staff if someone had shown abusive behavior towards the resident and staff were unable to ascertain if the resident understood what was asked. The CNO communicated the allegation of abuse was unsubstantiated based on the CNO's judgement, as the CNO did not feel the CNA had behaved in the reported manner, even though the conversation was witnessed by staff. The CNO could not provide documentation of the investigation, a statement from the CNA, or a statement from the DA witness. The CNO confirmed Resident #12's care plan was not updated with the incident and did not include interventions to implement or monitor related to the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/28/24 at 1:35 PM, the CNO confirmed Resident #12 was interviewed by the CNO and the Risk Management Director (RMD) regarding the incident and when the resident did not answer the questions regarding the allegation, it was taken as a no answer. The CNO explained there was no documentation regarding the resident interview or the incident in the clinical record. On 02/28/24 at 3:19 PM, the RMD explained Resident #12 was difficult to get direct answers from and could not explain how the resident was interviewed when the resident was non-verbal. The facility policy titled Abuse Prevention and Prohibition, last revised 08/25/23, documented it was the policy of the facility to report and investigate all allegations of actual or suspected abuse. The facility had a zero tolerance policy for any type of elder abuse or neglect, or the failure to report alleged abuse or neglect. Without exception, the person identifying potential abuse would immediately report to nurse leadership. The abuse investigation team would be notified of the facts giving rise to the concern and would investigate the matter. The Risk Manager would maintain a record of all incidents and reportable events. Timely Reporting FRI #NV00070209 with the allegation of an injury of unknown source for Resident #10 was submitted to the State Agency on 01/11/24. The final report was submitted on 01/17/24, one day late. On 02/28/24 at 12:22 PM, the Administrator confirmed the FRI final report was not submitted within the required five day timeframe. 34524 FRI #NV00070124 with the allegation of resident to resident abuse was submitted to the SA on 12/27/23. The final report was submitted to the SA on 01/03/24. On 02/28/24 at 4:30 PM, the Chief Nursing Officer confirmed the final FRI report was submitted late and outside of the required timeframes. On 2/28/24 at 2:41 PM, the Administrator verbalized the final report was to be submitted within five working days of the incident. The facility policy titled Abuse Prevention and Prohibition, last revised 08/25/23, documented final reports were to be submitted within five working days of the facility's awareness of the event.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on interview, clinical record review, and document review, the facility failed to ensure a care plan was developed and implemented related to 1) post-traumatic stress disorder and psychotic disorder with hallucinations for 1 of 15 Facility Reported Incident (FRI) investigated residents (Resident #14), 2) following an investigation for employee to resident verbal abuse for 1 of 15 FRI investigated residents (Resident #12), and 3) inappropriate behaviors for 2 of 15 FRI investgated residents (Resident #1 and #4). Findings include: Resident #14 Resident #14 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including post-traumatic stress disorder (PTSD), chronic, altered mental status, unspecified, and psychotic disorder with hallucinations due to known physiological condition. Resident #14's physician order dated 04/18/23, documented the following: Cymbalta oral capsule delayed release particles 60 milligrams (mg), give one capsule by mouth one time a day for anxiety and neuropathic pain related to PTSD. Resident #14's physician order dated 01/12/23, documented the following: Seroquel oral tablet 50 mg, give one tablet by mouth at bedtime for hallucinations/anxiety/sleeplessness related to PTSD. Resident #14's physician order dated 03/07/23, documented the following: Zyprexa oral tablet 10 mg, give one tablet by mouth at bedtime related to psychotic disorder with hallucinations due to known physiological condition. Resident #14's physician order dated 07/05/23, documented the following: Zyprexa oral tablet 7.5 mg, give one tablet by mouth at bedtime for paranoia and agitation related to psychotic disorder with hallucinations due to known physiological condition. Resident #14's clinical record lacked a care plan for the resident's diagnosis and treatment of PTSD and psychotic disorder with hallucinations to include problem areas, goals, and interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14's Minimum Data Set Assessment 3.0 (MDS) dated [DATE], Section E: Behavior, documented the resident had delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident had verbal behaviors toward others, physical behaviors towards themself, rejection of care, and wandering. On 02/28/24 at 10:50 AM, the Social Worker (SW) confirmed Resident #14's care plan did not document post-traumatic stress disorder and psychotic disorder with hallucinations. The SW explained a psychiatric diagnosis should 100 percent be included in the care plan. The SW verbalized the purpose of the care plan was to give everyone a full picture and idea of how to care for the resident. On 02/28/24 at 1:22 PM, the Chief Nursing Officer (CNO) confirmed the expectation of a diagnosis of PTSD and psychotic disorder with hallucinations was to be care planned for a resident. The CNO confirmed the diagnoses were not care planned for Resident #14. The CNO verbalized a care plan was used to provide the best nursing ad ancillary care for the best outcome of the resident. The CNO explained a consequence to not including a psychiatric diagnosis or PTSD as triggers for the diagnoses could occur unintentionally and unknowingly. Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela, quadriplegia, unspecified, paraplegia, unspecified, and aphasia following unspecified cerebrovascular disease. FRI #NV00070158 dated 01/03/24, documented Resident #12 was receiving a beverage in the dining room on the morning of 12/28/23, when a Dietary Aide overheard a Certified Nursing Assistant (CNA) say shut the (expletive) up to the resident. The Dietary Aide reported the incident to the Dietary Manager on 01/03/24 and an investigation was initiated. Resident #12's MDS dated [DATE], documented the resident was unable to be interviewed because the resident was rarely/never understood. Resident #12's care plan, undated, lacked documentation of the incident and did not include methods and interventions to prevent further abuse or monitoring for signs and symptoms of abuse or psychosocial effects. On 02/28/24 at 2:33 PM, the Dietary Aide confirmed serving Resident #12 a breakfast drink on the morning of 12/28/23, when a CNA told the resident to shut the (expletive) up. The Dietary Aide confirmed the CNA directed the statement at Resident #12 as the resident was making excited noises about the drink. On 02/28/24 at 1:35 PM, the Chief Nursing Officer (CNO) confirmed Resident #12 did not have a care plan created or implemented for the incident on 12/28/23. 34524 Resident #1 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus with unspecified complications and acquired absence of right leg above knee. On 02/28/24 at 11:31 AM, a License Practical Nurse (LPN) verbalized Resident #1 had inappropriate behaviors with staff and residents. Some of the female residents have complained about Resident #1's staring. Administration has spoken with Resident #1 several times about their inappropriate behaviors. When staff see Resident #1 staring inappropriately, they redirect the resident and tell the resident to quit staring. A Behavior Note dated 04/04/23 documented when Nurse Apprentices were walking down the hall, Resident #1 proceeded to lift the phone camera to take pictures of staff. The resident was educated to not take pictures of staff. A Behavior Note dated 04/06/23, documented a CNA reported Resident #1 was sitting in the hallway staring at staff. Staff noticed the resident had a chux on their lap and the resident's hand was under the chux and was moving up and down. It appeared the resident was masturbating in the hallway. Staff noticed the resident moving their hand in their private area while peeking around the corner at staff and when staff approached the resident, the resident stopped and started massaging their leg. The nurse educated the resident regarding sexual behavior and encouraged the resident to have the behavior in the privacy of their room. A Behavior Note dated 04/29/23, documented the DON received a message from a staff member stating Resident #1 was trying to get the staff member to tell them their age and proceeded to talk about the staff members body and gave the staff member compliments on their body. The staff member ignored the resident, but the resident kept going. Afterwards, the resident began being inappropriate in front of them. The staff member informed the DON the resident would sit in their wheelchair and touch themselves in their groin area repetitively. The DON advised the staff member to write a progress note and stated they would educate Resident #1 on the facility's intolerance to sexually inappropriate behaviors towards staff and other residents. A Behavior Note dated 05/20/23, documented an aide asked Resident #1 to move to a different table in the lunch room after a new plan was made following reports from staff the resident was watching the female staff inappropriately and making inappropriate comments to them during meal times. A Behavior Note dated 08/10/23, documented an Activity Aide reported to the a CNA Resident #1 was being inappropriate on an outing on 08/05/23, and reported more inappropriate behavior on an outing at the senior center on 08/10/23. A QRR report was submitted by the Activity Aide and documentation was submitted to the MDS Coordinator to submit to the DON on night shift. A QRR Report dated 08/10/23, documented Resident #1 was being inappropriate during an outing. The following comments were added to the report: - 08/10/23 - staff member was at the park with Resident #1 when towards the end of the day the resident made inappropriate comments, to include do you want to be my girlfriend? - 08/10/23 - the Risk Management Director documented the LSW was told about the incident and had a conversation with Resident #1. The LSW was informed this was not the first time Resident #1 had done this to younger girls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 08/14/23 - the Risk Management Director documented the LSW reported Resident #1 denied saying anything inappropriate. - 08/16/23 the DON documented Resident #1 was educated on inappropriate behaviors. An email was sent to the Ombudsman (OMB) seeking guidance on prohibiting Resident #1 from attending outings due to behaviors. The OMB advised the resident be given the sexual harassment policy to further educate on expectations. The DON provided the resident with the policy. The resident continued to deny any inappropriateness. The report further stated the DON spoke with Resident #1 about inappropriate behavior toward staff, especially underaged staff. The resident verbalized understanding however the DON was hesitant to believe the resident would not continue the behavior. A Behavior Note dated 01/20/24, documented Resident #1 said an inappropriate comment while a CNA was walking by. The CNA did not address the comment with the resident. The resident denied making inappropriate comments. Education was provided to the resident on respectful conversation with the staff. Resident #1's Comprehensive Care Plan lacked a care plan specific to inappropriate sexual behaviors. On 02/28/24 at 2:26 PM, the CNO confirmed Resident #1's care plan lacked a care plan for Resident #1's inappropriate sexual behaviors. Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including personal history of traumatic brain injury, anterograde amnesia, and mood disorder due to known physiological condition with mixed features. Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of vascular dementia, unspecified severity, with other behavioral disturbance. On 02/28/24 at 11:40 AM, a CNA verbalized that Resident #3 and Resident #4 were roommates. The CNA recalled Resident #3 would get frustrated with Resident #4 because Resident #4 would turn off the lights when Resident #3 was reading in the evening (around 7 PM). Resident #4 would leave the bathroom door open when using the bathroom and refuse to shut it when asked. Resident #4 would throw their clothing on Resident #3's side of the room. Resident #3 would close their curtain between Resident #3 and Resident #4's bed, however Resident #4 would open the curtains. On 02/28/24 at 11:58 AM, a Licensed Practical Nurse (LPN) verbalized Resident #3 and Resident #4 were roommates. The LPN recalled Resident #4 would turn off the lights in the room. Resident #3 liked to read, and the facility got the resident a night light to accommodate both residents. Resident #4 would go on Resident #3's side of the room and turn off the night light. Resident #4 would leave the bathroom door open while using the bathroom and would refuse to shut it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note for Resident #4 dated 09/21/23, documented at around 830 PM, Resident #3 was sitting in the dark room with the bathroom door open, using the lights to be able to read their book. Resident #4 was asked if the light could be turned turn on so Resident #3 could read a little before bed and Resident #4 said, No, I want to sleep. Resident #4 was told it was only 8:30 PM and Resident #3 would like to read before bed. The nurse was notified about the incident. A Behavior Note for Resident #4 dated 09/30/23, documented Resident #4 was rummaging through their roommate's personal belongings on the table and bed area. Resident was asked if they needed anything and the resident quickly walked away from their roommates living area and walked to their own bed and sat down and said no. A Behavior Note for Resident #4 dated 10/02/23 documented roommate Resident #3 reported Resident #4 poops and pees with door open. When Resident #4 was asked to shut bathroom door the replied no. Resident #4 opens roommates privacy curtains and ignores requests to please don't do that, per roommate. During meals CNAs and roommate also reported Resident #4 moved other resident's plates of food. Resident #4 has been educated on respect for other resident's space and privacy wishes. Staff will continue to attempt to redirect Resident #4's behaviors. A Behavior Note for Resident #4 dated 02/18/24, documented Resident #4 was observed running from their roommate's side of the room with something in their hand then jumped into their bed. Resident #4 was trying to open a packet of chocolate [NAME]. The nurse was notified, and it was confirmed the chocolate [NAME] belonged to Resident #4's roommate, Resident #3, who was out of the room. Resident #4's Comprehensive Care Plan lacked a care plan for the resident's behaviors. On 02/28/24 at 3:28 PM, the Chief Nursing Officer (CNO) confirmed Resident #4 had behaviors documented by the facility and those behaviors should have been care planned. On 02/28/23 at 2:59 PM, the Administrator verbalized a resident with inappropriate behaviors should be care planned for the behaviors. The facility policy titled, Baseline and Comprehensive Care Plan, reviewed on 04/13/23, documented the services provided or arranged by the facility, as outlined in the comprehensive care plan, would meet professional standards and quality. The comprehensive care plan would be provided by qualified persons in accordance with each resident's written plan of care, and would be culturally competent and trauma informed.