

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 04/15/2024
NAME OF PROVIDER OR SUPPLIER Pershing General Hospital Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748</p> <p>Based on interview, clinical record review and document review, the facility failed to ensure a resident's right to be treated with respect and dignity was protected when a care plan was updated to include sexual behaviors of the resident, as the facility response to the resident experiencing abuse. A cognitively impaired, non-verbal resident without previously identified behaviors had a care plan initiated as part of their clinical record without evidence or assessment of a change in the resident's baseline, after facility staff observed physical and verbal abuse by a Certified Nursing Assistant (CNA1) toward the resident for 1 of 13 sampled residents (Resident #3).</p> <p>Findings include:</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter, dysphagia, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and quadriplegia, unspecified.</p> <p>A Facility Reported Incident (FRI) dated 03/21/2024, and concluded on 03/25/2024, documented a Dietary Aide (Food Services Supervisor) had overheard a CNA tell Resident #3 I told you I would slap you if you did that again and alleged the resident was touching the CNA's breasts. The FRI was unsubstantiated by the facility.</p> <p>A letter from a Behavioral Health Advanced Practice Registered Nurse (APRN), dated 03/21/2024, documented Resident #3 had been living in the facility since 2005, due to inability to care for self, related to a traumatic brain injury following an accident. During the resident's time at the facility, the resident had not shown a significant change to the resident's cognitive status. The resident had limited fine motor skills and was non-verbal which made traditional cognitive testing difficult. The resident was able to express approval or enjoyment by smiling, eye-tracking subjects and was able to answer yes or no questions about immediate needs with blinking, nodding or waiving of a hand response. The resident was unreliable with yes or no responses when approached with complex communication attempts.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/08/2024 at 2:34 PM, Resident #3's Guardian verbalized the facility had informed the Guardian there was an investigation into an abuse allegation toward Resident #3. The allegation included a staff member telling Resident #3 to shut up. It was alleged Resident #3 had reached out to a staff member and was touching the staff member inappropriately.</p> <p>The Guardian verbalized not understanding how Resident #3 could have touched an employee inappropriately because the resident had limited mobility and was non-verbal.</p> <p>The Guardian explained having been Resident #3's Guardian for nine years and had not been aware of the resident having any previous behaviors of touching anyone inappropriately and verbalized it was really disheartening staff would talk to a resident with limited cognition, in an abusive way. The resident also could not open hands due to contractures with limited mobility. The Guardian questioned the ability of the resident to be able to touch staff inappropriately.</p> <p>An Incident Progress Note dated 03/21/2024, documented Dietary staff had witnessed a CNA slap Resident #3 on the hand and verbalized to the resident I told you if you did that again that I would smack you. The incident was reported to the Chief Nursing Officer (CNO) and Chief Executive Officer (CEO) and alleged after breakfast on 03/21/2024, a CNA was assisting Resident #3 with feeding the resident when the resident had brushed the hand against the staff member's breast. The resident was spoken to about the behavior and explained to the resident the touching was unwelcome and inappropriate.</p> <p>A Care Plan initiated on 03/25/2024, documented Resident #3 had a behavior problem related to inappropriate sexual behaviors.</p> <p>The Behavior Monitoring Flow Sheet dated from 03/10/2024, through 04/09/2024, documented Resident #3 had only shown a behavioral issue on the afternoon of 03/21/2024, by projecting Public Sexual Acts. No other behaviors were documented within the 30-day timeframe.</p> <p>A Social Service assessment dated [DATE], documented Resident #3 did not have any mood or behavior diagnoses, however, had a diagnosis of dementia.</p> <p>The annual Minimum Data Set (MDS) 3.0 dated 04/01/2024, documented the resident did not exhibit behaviors, such as, hitting, kicking, pushing, scratching, grabbing, or abusing others sexually.</p> <p>On 04/10/2024 at 8:24 AM, the Food Services Supervisor recalled observing the incident on 03/21/2024. The resident had lifted a fist up, which was a common occurrence because the resident often gave fist bumps to staff, and the CNA slapped Resident #3's hand. The CNA told the resident you better stop or I am going to smack you and smacked his hand.</p> <p>On 04/10/2024 at 8:41 AM, CNA2 explained Resident #3 was non-verbal and could communicate with staff by touching with the resident's right hand. CNA2 could not explain the difference between Resident #3 attempting to communicate with staff and inappropriate touching because the resident could only move the right hand with limitation.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Investigation Packet dated 03/21/2024, documented Dietary staff's recollection of observed verbal and physical abuse toward Resident #3. The Dietary Aide (Food Services Supervisor) had overheard CNA1 tell Resident #3 I told you I was going to smack you if you did that again. An immediate assessment of the resident lacked observations of redness, bruising, signs and symptoms of pain, grimacing withdrawal, and skin integrity issues. Included in the packet were statements from staff, statements from residents, and abuse trainings completed by CNA1.</p> <p>A witness statement from the Administrator dated 03/21/2024, documented the Administrator had removed CNA1 from being in the same vicinity as Resident #3.</p> <p>A witness statement from CNA3 dated 03/21/2024, documented CNA3 heard CNA1, who was assigned to feed Resident #3, verbalize to the resident to stop touching CNA1's breasts.</p> <p>A witness statement from the Food Services Supervisor dated 03/21/2024, documented the Food Services Supervisor was serving drinks to residents in the dining room and overheard CNA1 tell Resident #3 you had better stop doing that right now or I am going to smack you next time. The Food Services Supervisor observed CNA1 smack Resident #3 and verbalized I told you I would smack you if you did it again. It appeared to the Food Services Supervisor, Resident #3 was attempting to fist bump CNA1 and CNA1 was irritated by Resident #3. The observation was reported to the Charge Nurse right away.</p> <p>A witness statement from CNA4 dated 03/21/2024, documented CNA4 overheard CNA1 verbalize to Resident #3 to not touch CNA1's breasts. CNA4 observed CNA1 put Resident #3's hand down in a non-aggressive way.</p> <p>CNA1's statement dated 03/21/2024, documented CNA1 verbalized Resident #3 was touching CNA1 inappropriately and warned the resident to stop. CNA1 explained telling the resident the touching would not be tolerated. CNA1 then tapped the resident on the resident's right hand and then held the right hand to prevent the resident from moving the right hand.</p> <p>On 04/10/2024 at 10:16 AM, the Licensed Social Worker (LSW) verbalized on 03/21/2024, a report was submitted regarding a CNA verbally and physically abusing Resident #3. The LSW immediately went to speak to Resident #3 to determine a baseline for potential negative psychosocial outcome, behavioral changes and patterns as a result of the abuse. The resident was monitored for three days by the LSW, however, the LSW determined no further monitoring was necessary because the resident was acting normally, as the resident had not exhibited any sexual behaviors prior to this incident.</p> <p>On 04/10/2024 at 3:03 PM, the Administrator verbalized on 03/21/2024, the Food Services Supervisor notified a Charge Nurse of abuse against Resident #3 by a CNA. The CNA deflected Resident #3's hand because the resident was touching the CNA inappropriately and told the resident I told you I would slap your hand if you did that again. The Administrator defined abuse as willful injury and confinement resulting in physical harm or anguish, including deprivation.</p> <p>The Administrator described Resident #3 as non-verbal and communicated with staff with right hand gestures to indicate a 'yes' or a 'no' to questions asked and could not demonstrate if the resident was trying to communicate to CNA1 regarding the resident needing something or if the touching was inappropriate. The Administrator acknowledged the care plan was not accurate related to the resident exhibiting sexual behaviors toward others.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/11/2024 at 12:27 PM, MDS Coordinator confirmed job duties included creating and revising care plans. That CP came from the FRI that was The care plan for Resident #3's behavior problem related to inappropriate sexual behaviors came from the FRI investigation and was contacted by the abuse investigation team to initiate it.</p> <p>The MDS Coordinator confirmed the APRN indicated cognitive difficulties and non-verbal state but nothing specifically regarding behaviors, and confirmed mental and physical abilities remained unchanged.</p> <p>Based on the evaluation of the APRN, it could not be definitively said the resident's touching was inappropriate. No further assessments were completed.</p> <p>The facility policy titled Abuse Prevention and Prohibition, last reviewed 08/25/2023, 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.</p> <p>The facility policy titled Baseline and Comprehensive Care Plan, reviewed 04/13/2023, documented care, treatment, and services shall be planned to ensure all were individualized to the resident's needs and goals. The planning for care, treatment, and services included regularly reviewing and revising the care plan and determining how the planned care, treatment, and services would be provided. Care planning would be implemented through the integration of assessment findings.</p> <p>The facility policy titled Resident [NAME] of Rights, last revised 05/29/2003, documented the resident had a right to be treated with consideration, respect, dignity, and individuality, including privacy and care of personal needs.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748</p> <p>Based on interview, clinical record review and document review, the facility failed to protect a resident's right to be free from verbal and physical abuse by a Certified Nursing Assistant (CNA) for 1 of 13 sampled residents (Resident #3).</p> <p>Findings include:</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter, dysphagia, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and quadriplegia, unspecified.</p> <p>A Facility Reported Incident (FRI) dated 03/21/2024, and concluded on 03/25/2024, documented a Dietary Aid (Food Services Supervisor) had overheard a CNA1 tell Resident #3 I told you I would slap you if you did that again. The FRI was unsubstantiated by the facility for failure to prove Resident #3 experienced a negative psychosocial outcome.</p> <p>A letter from a Behavioral Health Advanced Practice Registered Nurse (APRN), dated 03/21/2024, documented Resident #3 had been living in the facility since 2005, due to inability to care for self, related to a traumatic brain injury following an accident. During the resident's time at the facility, the resident had not shown a significant change to the resident's cognitive status. The resident had limited fine motor skills and was non-verbal which made traditional cognitive testing difficult. The resident was able to express approval or enjoyment by smiling, eye-tracking subjects and was able to answer yes or no questions about immediate needs with blinking, nodding or waiving of a hand response. The resident was unreliable with yes or no responses when approached with complex communication attempts.</p> <p>On 04/08/2024 at 2:34 PM, Resident #3's Guardian verbalized the facility had informed the Guardian there was an investigation into abuse toward Resident #3. The allegation included a staff member telling Resident #3 to shut up. It was alleged Resident #3 had reached out to a staff member and was touching the staff member inappropriately.</p> <p>The Guardian verbalized not understanding how Resident #3 could have touched an employee inappropriately because the resident had limited mobility and was non-verbal.</p> <p>The Guardian explained being Resident #3's Guardian for nine years and had not had any previous behaviors of touching anyone inappropriately and verbalized it was really disheartening staff would talk to a resident with limited cognition, in an abusive way. The Resident also could not open hands due to contractures and had limited mobility. The Guardian questioned the ability of the resident to be able to touch staff inappropriately.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Incident Progress Note dated 03/21/2024, documented Dietary staff (Food Services Supervisor) had witnessed a CNA1 slap Resident #3 on the hand and verbalized to the resident I told you if you did that again that I would smack you. The incident was reported to the CNO and CEO and alleged after breakfast on 03/21/2024, a CNA was assisting Resident #3 with feeding the resident when the resident had brushed the hand against the staff members breast. The resident was spoken to about the behavior and explained to the resident the touching was unwelcomed and inappropriate.</p> <p>A Care Plan initiated on 01/10/2024, and revised on 03/25/2024, documented Resident #3 was at risk for alteration in wellbeing secondary to risk of experiencing victimization of verbal/physical/emotional abuse related to cognitive impairment, communication barriers and physical limitations (paralysis).</p> <p>The Behavior Monitoring Flow Sheet dated from 03/10/2024, through 04/09/2024, documented Resident #3 had only shown a behavioral issue on the afternoon of 03/21/2024, by projecting Public Sexual Acts. No other behaviors were documented within the 30-day timeframe.</p> <p>A Social Service assessment dated [DATE], documented Resident #3 did not have any mood or behavior diagnoses, however, had a diagnosis of dementia.</p> <p>The annual Minimum Data Set (MDS) 3.0 dated 04/01/2024, documented the resident did not exhibit behaviors, such as, hitting, kicking, pushing, scratching, grabbing, or abusing others sexually.</p> <p>On 04/10/2024 at 8:24 AM, the Food Services Supervisor explained the facility had trained on abuse prior to employment with the facility and had received at least five trainings on abuse and neglect since hire. The trainings covered all types of abuse, procedures on what to do if an individual suspected or witnessed abuse, who to report the abuse to and exact timeframes to report the abuse.</p> <p>The Food Services Supervisor verbalized on 03/21/2024, while helping to serve residents beverages, the door to the kitchen was open to the resident dining room with a view of where Resident #3 was seated. There was a CNA with Resident #3 and the CNA had an attitude. The CNA's attitude was full of frustration because Resident #3 kept moving the right arm. The resident had lifted a fist up, which was a common occurrence because the resident often gave fist bumps to staff, and the CNA slapped Resident #3's hand. The CNA told the resident you better stop or I am going to smack you and smacked his hand.</p> <p>The Food Services Supervisor demonstrated the force on the slap on the resident's hand. The slap on the hand provided some discomfort. The Food Services Supervisor retrieved the Charge Nurse and reported the verbal and physical abuse toward Resident #3. The CNO was notified and assigned a different CNA to help Resident #3 with the rest of the breakfast. The Food Services Supervisor explained the way Resident #3 was treated was demeaning to an individual who was non-verbal and expressed the CNA knew it was abuse toward the resident, especially because the CNA had completed abuse training the day prior.</p> <p>On 04/10/2024 at 8:41 AM, CNA2 recalled overhearing a CNA1 tell Resident #3 to stop touching the CNA1's breasts. CNA2 did not report the incident to any staff members.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA2 verbalized Resident #3 was non-verbal and could communicate with staff by touching with the resident's right hand. CNA2 could not explain the difference between Resident #3 attempting to communicate with staff and inappropriate touching because the resident could only move the right hand with limitation.</p> <p>On 04/10/2024 at 9:45 AM, the Administrator explained there was an allegation of abuse against CNA1 on 03/21/2024, however, there was no disciplinary action toward CNA1 and would provide the investigation into the allegations.</p> <p>The Investigation Packet dated 03/21/2024, documented Dietary staff's recollection of observed verbal and physical abuse toward Resident #3. The Dietary Aid (Food Services Supervisor) had overheard CNA1 tell Resident #3 I told you I was going to smack you if you did that again. An immediate assessment of the resident lacked observations of redness, bruising, signs and symptoms of pain, grimacing withdrawal, and skin integrity issues. Included in the packet were statements from staff, statements from residents, and the abuse trainings completed by CNA1.</p> <p>A witness statement from the Administrator dated 03/21/2024, documented the Administrator had removed CNA1 from being in the same vicinity as Resident #3. A visual check was done on the resident and did not identify any redness to the resident's hand, arm, or face area.</p> <p>A witness statement from CNA3 dated 03/21/2024, documented CNA3 heard CNA1, who was assigned to feed Resident #3, verbalize to the resident to stop touching CNA1's breasts.</p> <p>A witness statement from the Food Services Supervisor dated 03/21/2024, documented the Food Services Supervisor was serving drinks to residents in the dining room and heard CNA1 tell Resident #3 you had better stop doing that right now or I am going to smack you next time. The Food Services Supervisor observed CNA1 smack Resident #3 and verbalized I told you I would smack you if you did it again. It appeared to the Food Services Supervisor, Resident #3 was attempting to fist bump CNA1 and CNA1 was irritated by Resident #3. The observation was reported to the Charge Nurse right away.</p> <p>A witness statement from CNA4 dated 03/21/2024, documented CNA4 overheard CNA1 verbalize to Resident #3 to not touch CNA1's breasts. CNA4 observed CNA1 put Resident #3's hand down in a non-aggressive way.</p> <p>CNA1's statement dated 03/21/2024, documented CNA1 verbalized Resident #3 was touching CNA1 inappropriately and warned the resident to stop. CNA1 explained telling the resident the touching would not be tolerated. CNA1 then tapped the resident on the resident's right hand and then held the right hand to prevent the resident from moving the right hand.</p> <p>On 04/10/2024 at 10:16 AM, the Licensed Social Worker (LSW) explained the definition of abuse was non-accidental injuries, physical damage and mental anguish of a resident to include willful action and unjustified injury. Abuse did not need to leave an obvious physical injury on an individual to prove abuse occurred.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The LSW verbalized on 03/21/2024, a report was submitted regarding a CNA verbally and physically abusing Resident #3. The LSW immediately went to speak to Resident #3 to determine a baseline for potential negative psychosocial outcome, behavioral changes and patterns as a result of the abuse. The resident was monitored for three days by the LSW, however, the LSW determined no further monitoring was necessary because the resident was acting normally.</p> <p>The LSW described a negative psychosocial outcome and behaviors associated would not necessarily be obvious within three days. A negative psychosocial outcome could develop a year later or even ten years after an incident had occurred.</p> <p>On 04/10/2024 at 1:35 PM, the DON explained there were five different types of abuse and abuse was any intentional or unintentional act toward another individual whether the abuse was psychological, physical, entrapment, verbal or sexual. Furthermore, an individual would not need to have obvious signs of physical injury for abuse to occur.</p> <p>The DON verbalized on 03/21/2024, the Administrator informed the DON there was an incident in the dining room between a CNA1 and Resident #3. The DON arrived at the facility and escorted CNA1 off of the facility premises.</p> <p>The DON explained Resident #3 was non-verbal and was a quadriplegic. The resident could not care for themselves and relied on staff for all activities of daily living, making the resident vulnerable.</p> <p>On 04/10/2024 at 3:03 PM, the Administrator verbalized on 03/21/2024, the Food Services Supervisor notified a Charge Nurse of abuse against Resident #3 by a CNA. The CNA deflected Resident #3's hand because the resident was touching the CNA inappropriately and told the resident I told you I would slap your hand if you did that again. The Administrator defined abuse as willful injury and confinement resulting in physical harm or anguish, including deprivation.</p> <p>The Administrator described Resident #3 as non-verbal and communicated with staff with right hand gestures to indicate a 'yes' or a 'no' to questions asked and could not demonstrate if the resident was trying to communicate to CNA1 regarding the resident needing something or if the touching was inappropriate. The Administrator verbalized CNA1 made a statement regarding the abuse. The statement documented CNA1 had asked the resident to stop touching CNA1 and had smacked the resident's hand as a result of frustration with the resident. The Administrator admitted CNA1 had completed abuse training the day prior to the incident and stated maybe the CNA1 was not paying attention to the training.</p> <p>The Administrator verbalized this was not abuse toward Resident #3 because the resident did not have any physical signs of injury, such as, a cut, scrape, red mark, or bruise. The Administrator referred to the State Operations Manual (SOM) abuse grid for pathways regarding resident-to-resident abuse and determined, based off of the grid in the SOM, abuse criteria was not met and the incident was unsubstantiated by the facility. The Administrator made no attempt to refer CNA1 to the Board of Nursing, nor investigate the allegation any further.</p> <p>On 04/10/2024 at 5:38 PM, during a joint interview with the DON and Administrator, the DON verbalized the CNAs actions against Resident #3 on 03/21/2024, did not meet the facility's definition of abuse and would have been discouraged.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Abuse Prevention and Prohibition, last reviewed 08/25/2023, 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.</p> <p>The facility policy titled Resident [NAME] of Rights, last revised 05/29/2003, documented the resident had a right to be free from mental and physical abuse. The resident had a right to be treated with consideration, respect, dignity, and individuality, including privacy and care of personal needs.</p> <p>The facility policy titled Psychosocial Needs, last reviewed 04/14/2023, documented all residents would have psychosocial needs met on a continuum of growth and development. All available services would be utilized to give the best quality of care. Residents would be assured a safe environment, both mentally and physically.</p> <p>FRI #NV00070753</p> <p>Cross Reference with tags F607, F656, and F726</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748</p> <p>Based on clinical record review, document review, and interview, the facility failed to implement the facility's Abuse policies regarding identification, investigation, protection and reporting for an allegation of verbal and physical abuse toward a resident by a Certified Nursing Assistant (CNA) for 1 of 13 sampled residents (Resident #3).</p> <p>Findings include:</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter, dysphagia, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and quadriplegia, unspecified.</p> <p>A Facility Reported Incident (FRI) dated 03/21/2024, and concluded on 03/25/2024, documented a Dietary Aid (Food Services Supervisor) had overheard a CNA tell Resident #3 I told you I would slap you if you did that again. The FRI was unsubstantiated by the facility for failure to prove Resident #3 experienced a negative psychosocial outcome.</p> <p>An Incident Progress Note dated 03/21/2024, documented Dietary staff (Food Services Supervisor) had witnessed a CNA slap Resident #3 on the hand and verbalized to the resident I told you if you did that again that I would smack you. The incident was reported to the Chief Nursing Officer (CNO) and Chief Executive Officer (CEO) and alleged after breakfast on 03/21/2024, a CNA was assisting Resident #3 with feeding the resident when the resident had brushed the hand against the staff member's breast. The resident was spoken to about the behavior and explained to the resident the touching was unwelcomed and inappropriate.</p> <p>A Care Plan initiated on 01/10/2024, and revised on 03/25/2024, documented Resident #3 was at risk for alteration in wellbeing secondary to risk of experiencing victimization of verbal/physical/emotional abuse related to cognitive impairment, communication barriers and physical limitations (paralysis).</p> <p>On 04/10/2024 at 8:24 AM, the Food Services Supervisor explained the facility had trained on abuse prior to employment with the facility and had received at least five trainings on abuse and neglect. The training covered all types of abuse, procedures on what to do if an individual suspected or witnessed abuse, who to report the abuse to and exact timeframes to report the abuse.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Food Services Supervisor verbalized on 03/21/2024, while helping to serve residents beverages, the door to the kitchen was open to the resident dining room with a view of where Resident #3 was seated. There was a CNA with Resident #3 and the CNA had an attitude. The CNAs attitude was full of frustration because Resident #3 kept moving the right arm. The resident had lifted a fist up, which was a common occurrence because the resident often gave fist bumps to staff, and the CNA slapped Resident #3's hand. The CNA told the resident you better stop or I am going to smack you and smacked his hand.</p> <p>The Food Services Supervisor demonstrated the force on the slap on the resident's hand. The slap on the hand provided some discomfort. The Food Services Supervisor retrieved the Charge Nurse and reported the verbal and physical abuse toward Resident #3. A different CNA was assigned to help Resident #3 with the rest of the breakfast. The Food Services Supervisor explained the way Resident #3 was treated was demeaning to an individual who was non-verbal and expressed the CNA knew it was abuse toward the resident, especially because the CNA had completed abuse training the day prior.</p> <p>On 04/10/2024 at 8:41 AM, CNA2 explained overhearing a CNA1 tell Resident #3 to stop touching the CNA1s breasts. CNA2 did not report the incident to any staff members.</p> <p>CNA2 verbalized Resident #3 was non-verbal and could communicate with staff by touching with the resident's right hand. CNA2 could not explain the difference between Resident #3 attempting to communicate with staff and inappropriate touching because the resident could only move the right hand with limitation.</p> <p>On 04/10/2024 at 9:45 AM, the Administrator explained there was an allegation of abuse against CNA1 on 03/21/2024, however, there was no disciplinary action toward CNA1 and the Administrator would provide the investigation the Administrator completed into the abuse allegations.</p> <p>The Investigation Packet dated 03/21/2024, documented Dietary staff's recollection of observed verbal and physical abuse toward Resident #3. The Dietary Aid (Food Services Supervisor) had overheard CNA1 tell Resident #3 I told you I was going to smack you if you did that again. An immediate assessment of the resident lacked observations of redness, bruising, signs and symptoms of pain, grimacing withdrawal, and skin integrity issues. Included in the packet were statements from staff, statements from residents, and the CNA1's trainings.</p> <p>A witness statement from the Administrator dated 03/21/2024, documented the Administrator had removed CNA1 from being in the same vicinity as Resident #3. A visual check was done on the resident and did not identify any redness to the resident's hand, arm, or face area.</p> <p>A witness statement from CNA3 dated 03/21/2024, documented CNA3 heard CNA1, who was assigned to feed Resident #3, verbalize to the resident to stop touching CNA1's breasts.</p> <p>A witness statement from the Food Services Supervisor dated 03/21/2024, documented the Food Services Supervisor was serving drinks to residents in the dining room and heard CNA1 tell Resident #3 you had better stop doing that right now or I am going to smack you next time. The Food Services Supervisor observed CNA1 smack Resident #3 and verbalized I told you I would smack you if you did it again. It appeared to the Food Services Supervisor, Resident #3 was attempting to fist bump CNA1 and CNA1 was irritated by Resident #3. The observation was reported to the Charge Nurse right away.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A witness statement from CNA4 dated 03/21/2024, documented CNA4 overheard CNA1 verbalize to Resident #3 to not touch CNA1's breasts. CNA4 observed CNA1 put Resident #3's hand down in a non-aggressive way.</p> <p>CNA1's statement dated 03/21/2024, documented CNA1 verbalized Resident #3 was touching CNA1 inappropriately and warned the resident to stop. CNA1 explained telling the resident the touching would not be tolerated. CNA1 then tapped the resident on the resident's right hand and then held the right hand to prevent the resident from moving the right hand.</p> <p>On 04/10/2024 at 10:16 AM, the Licensed Social Worker (LSW) explained the definition of abuse was non-accidental injuries, physical damage and mental anguish of a resident to include willful action and unjustified injury. Abuse did not need to leave an obvious physical injury on an individual to prove abuse occurred.</p> <p>The LSW verbalized on 03/21/2024, a report was submitted regarding a CNA1 verbally and physically abusing Resident #3. The LSW immediately went to speak to Resident #3 to determine a baseline for potential negative psychosocial outcome, behavioral changes and patterns as a result of the abuse. The resident was monitored for three days by the LSW, however, the LSW determined no further monitoring was necessary because the resident was acting normally.</p> <p>The LSW described a negative psychosocial outcome and behaviors associated would not necessarily be obvious within three days. A negative psychosocial outcome could develop a year later or even ten years after an incident had occurred.</p> <p>On 04/10/2024 at 1:35 PM, the Director of Nursing (DON) explained there were five different types of abuse and abuse was any intentional or unintentional act toward another individual whether the abuse was psychological, physical, entrapment, verbal or sexual. Furthermore, an individual would not need to have obvious signs of physical injury for abuse to occur.</p> <p>The DON verbalized on 03/21/2024, the Administrator informed the DON there was an incident in the dining room between a CNA and Resident #3. The DON arrived at the facility and escorted CNA1 off of the facility premises.</p> <p>The DON explained Resident #3 was non-verbal and was a quadriplegic. The resident could not care for themselves and relied on staff for all activities of daily living, making the resident vulnerable.</p> <p>On 04/10/2024 at 3:03 PM, the Administrator verbalized on 03/21/2024, the Food Services Supervisor notified a Charge Nurse of abuse against Resident #3 by a CNA. The CNA deflected Resident #3's hand because the resident was touching the CNA inappropriately and told the resident I told you I would slap your hand if you did that again. The Administrator defined abuse as willful injury and confinement resulting in physical harm or anguish, including deprivation.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administrator described Resident #3 as non-verbal and communicated with staff with right hand gestures to indicate a 'yes' or a 'no' to questions asked and could not demonstrate if the resident was trying to communicate to CNA1 regarding the resident needing something or if the touching was inappropriate. The Administrator verbalized CNA1 made a statement regarding the abuse. The statement documented CNA1 had asked the resident to stop touching CNA1 and had smacked the resident's hand as a result of frustration with the resident. The Administrator admitted CNA1 had completed abuse training the day prior to the incident and stated maybe the CNA1 was not paying attention to the training.</p> <p>The Administrator verbalized this was not abuse toward Resident #3 because the resident did not have any physical signs of injury, such as, a cut, scrape, red mark, or bruise. The Administrator referred to the State Operations Manual (SOM) abuse grid for pathways regarding resident-to-resident abuse and determined, based off of the grid in the SOM, abuse criteria was not met and the incident was unsubstantiated by the facility. The Administrator made no attempt to refer CNA1 to the Board of Nursing, nor investigate the allegation any further.</p> <p>The facility policy titled Abuse Prevention and Prohibition, last reviewed 08/25/2023, documented each resident had a 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.</p> <p>The facility utilized an Abuse Investigation Team consisting of Social Services, Human Resources, a department head, other than the accused employee's director supervisor, and other staff or administration as deemed necessary to assist in the investigative process. The team would interview witnesses, including residents, staff and the alleged abuser, obtain statements from all witnesses, coordinate and act as the liaison between the State Agencies and other authorities, make a recommendation based off of the information gathered to determine in the alleged abuse was substantiated and send the final report of the abuse investigation to the Quality Assurance and Performance Improvement (QAPI) Committee for review.</p> <p>Once an allegation was substantiated, based off of interviews, statements made by witnesses and the alleged perpetrator, the CNO would report the findings to the State Nurse Aide Registry, indicating the employee was unfit for service.</p> <p>FRI #NV00070753</p> <p>Cross Reference with F Tags 600, 656, and 726</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on clinical record review, interview, and document review the facility failed to ensure a care plan was developed and implemented related to 1) a resident's indwelling catheter (Resident #19), 2) a resident's end-of-life/comfort care (Resident #24), and 3) a resident's air mattress (Resident #3) for 3 of 13 sampled residents.</p> <p>Findings include:</p> <p>Resident #19</p> <p>Resident #19 was admitted to the facility on [DATE], with diagnoses including unspecified sequelae of cerebral infarction and schizoaffective disorder, unspecified.</p> <p>A physician's order dated 04/07/2024, documented indwelling catheter.</p> <p>Resident #19's clinical record lacked a care plan related to the presence or care of the resident's indwelling catheter.</p> <p>On 04/10/2024 at 3:31 PM, the Minimum Data Set (MDS) Coordinator verbalized catheters and catheter care should be included in a resident's care plan when the resident had an indwelling catheter. The MDS Coordinator explained the care plan would include interventions such as signs and symptoms to monitor for, checking the tubing for kinks and keeping the drainage bag below the level of the bladder. The MDS Coordinator confirmed Resident #19 did not have a care plan related to the indwelling catheter.</p> <p>Resident #24</p> <p>Resident #24 was admitted to the facility on [DATE], with diagnoses including arthropathy, unspecified and anemia, unspecified.</p> <p>A progress note dated 02/05/2024, documented a nurse spoke with Resident #24's family regarding comfort medications.</p> <p>A physician's order dated 02/06/2024, documented morphine sulfate oral solution 20 milligrams (mg)/milliliter (ml), give 0.5 ml by mouth every 30 minutes as needed for pain.</p> <p>A physician's order dated 02/06/2024, documented Ativan solution two mg/ml, give one ml orally every two hours as needed for agitation/anxiety.</p> <p>A progress note dated 02/06/2024, documented the Physician ordered morphine and Ativan liquid, oral solutions. Hold oral medications if the resident was not alert. The Physician would call the resident's family to discuss the ordered medications and the resident's condition.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 02/06/2024, documented the Physician spoke with Resident #24's family regarding the resident's change in condition. The end-of-life care plan was reviewed.</p> <p>A progress note dated 02/07/2024, documented Resident #24 was on comfort measures.</p> <p>Resident #24's clinical record lacked a care plan related to end-of-life/comfort care.</p> <p>On 04/15/2024 at 12:45 PM, the MDS Coordinator verbalized the MDS Coordinator did not update Resident #24's care plan to include end-of-life/comfort care. The MDS Coordinator explained the electronic medical record had a focus, goals, and interventions available to implement for residents receiving end-of-life/comfort care. The MDS Coordinator verbalized all care being provided for Resident #24 should have been added to the resident's care plan.</p> <p>30748</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter, dysphagia, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and quadriplegia, unspecified.</p> <p>On 04/08/2024 at 11:05 AM, Resident #3 was in a geri-chair next to the bed. The bed was a bariatric bed with an air mattress on the top of the bed.</p> <p>Resident #3's clinical record lacked a care plan addressing the air mattress on the top of the bariatric bed.</p> <p>A physician's order dated 06/06/2023, documented bariatric air mattress to bed to prevent skin breakdown.</p> <p>On 04/10/2024 at 2:02 PM, the MDS Coordinator explained an air mattress needed to be care planned to include the risk for entrapment, monitoring of the resident, and resident abilities. The care plan interventions would help ensure the resident's safety while in bed and confirmed the air mattress for Resident #3 was not created nor completed.</p> <p>The facility policy titled Mobility Devices and Physical Restraints, last reviewed 04/13/2023, documented all residents would be assessed for physical mobility. Every resident had the right to be free from any physical restraint and a restraint would only be used to treat a specific medical condition. A care plan would be developed.</p> <p>The facility policy titled Baseline and Comprehensive Care Plan, reviewed 04/13/2023, documented care, treatment, and services shall be planned to ensure all were individualized to the resident's needs and goals. The planning for care, treatment, and services included regularly reviewing and revising the plan and determining how the planned care, treatment, and services would be provided.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Standards of Care, reviewed 04/13/2023, documented care plans were updated at least every quarter, with a new intervention, significant change in condition, new or change in medication.</p> <p>Cross reference with tags F690, F689, and F842</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748</p> <p>Based on clinical record review, document review, and interview, the facility's Abuse Committee, to include the Director of Nursing, failed to understand and identify actual employee to resident verbal and physical abuse had occurred toward a resident for 1 of 13 sampled residents (Resident #3) and 2) the facility failed to ensure the Director of Nursing (DON) in charge of the facility's Restorative Nursing Program (RNP), had the knowledge and skills needed to manage the program.</p> <p>Findings include:</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter, dysphagia, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and quadriplegia, unspecified.</p> <p>A Facility Reported Incident (FRI) dated 03/21/2024, and concluded on 03/25/2024, documented a Dietary Aid had overheard a Certified Nursing Assistant (CNA) tell Resident #3 I told you I would slap you if you did that again. The FRI was unsubstantiated by the facility for failure to prove Resident #3 experienced a negative psychosocial outcome.</p> <p>An Incident Progress Note dated 03/21/2024, documented Dietary staff had witnessed a CNA slap Resident #3 on the hand and verbalized to the resident I told you if you did that again that I would smack you. The incident was reported to the Chief Nursing Officer (CNO) and Chief Executive Officer (CEO) and alleged after breakfast on 03/21/2024, a CNA was assisting Resident #3 with feeding the resident when the resident had brushed the hand against the staff members breast. The resident was spoken to about the behavior and explained to the resident the touching was unwelcomed and inappropriate.</p> <p>On 04/10/2024 at 8:24 AM, the Food Services Supervisor explained the facility had trained on abuse prior to employment with the facility and had received at least five trainings on abuse and neglect. The training covered all types of abuse, procedures on what to do if an individual suspected or witnessed abuse, who to report the abuse to and exact timeframes to report the abuse.</p> <p>The Food Services Supervisor verbalized on 03/21/2024, while helping to serve residents beverages, the door to the kitchen was open to the resident dining room with a view of where Resident #3 was seated. There was a CNA with Resident #3 and the CNA had an attitude. The CNAs attitude was full of frustration because Resident #3 kept moving the right arm. The resident had lifted a fist up, which was a common occurrence because the resident often gave fist bumps to staff, and the CNA slapped Resident #3's hand. The CNA told the resident you better stop or I am going to smack you and smacked his hand.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Food Services Supervisor demonstrated the force on the slap on the resident's hand. The slap on the hand provided some discomfort. The Food Services Supervisor retrieved the Charge Nurse and reported the verbal and physical abuse toward Resident #3. The CNO retrieved the CNA and assigned a different CNA to help Resident #3 with the rest of the breakfast. The Food Services Supervisor explained the way Resident #3 was treated was demeaning to an individual who was non-verbal and expressed the CNA knew it was abuse toward the resident, especially because the CNA had completed abuse training the day prior.</p> <p>On 04/10/2024 at 8:41 AM, CNA2 explained overhearing a CNA1 tell Resident #3 to stop touching the CNA1s breasts. CNA2 did not report the incident to any staff members.</p> <p>CNA2 verbalized Resident #3 was non-verbal and could communicate with staff by touching with the resident's right hand. CNA2 could not explain the difference between Resident #3 attempting to communicate with staff and inappropriate touching because the resident could only move the right hand with limitation.</p> <p>On 04/10/2024 at 9:45 AM, the Administrator explained there was an allegation of abuse against CNA1 on 03/21/2024, however, there was no disciplinary action toward CNA1 and would provide the investigation into the allegations.</p> <p>The Investigation Packet dated 03/21/2024, documented Dietary staff's (Food Services Supervisor) recollection of observed verbal and physical abuse toward Resident #3. The Dietary Aid had overheard CNA1 tell Resident #3 I told you I was going to smack you if you did that again. An immediate assessment of the resident lacked observations of redness, bruising, signs and symptoms of pain, grimacing withdrawal, and skin integrity issues. Included in the packet were statements from staff, statements from residents, and the abuse trainings completed by CNA1.</p> <p>A witness statement from the Administrator dated 03/21/2024, documented the Administrator had removed CNA1 from being in the same vicinity as Resident #3. A visual check was done on the resident and did not identify any redness to the resident's hand, arm, or face area.</p> <p>A witness statement from CNA3 dated 03/21/2024, documented CNA3 heard CNA1, who was assigned to feed Resident #3, verbalize to the resident to stop touching CNA1's breasts.</p> <p>A witness statement from the Food Services Supervisor dated 03/21/2024, documented the Food Services Supervisor was serving drinks to residents in the dining room and heard CNA1 tell Resident #3 you had better stop doing that right now or I am going to smack you next time. The Food Services Supervisor observed CNA1 smack Resident #3 and verbalized I told you I would smack you if you did it again. It appeared to the Food Services Supervisor, Resident #3 was attempting to fist bump CNA1 and CNA1 was irritated by Resident #3. The observation was reported to the Charge Nurse right away.</p> <p>A witness statement from CNA4 dated 03/21/2024, documented CNA4 overheard CNA1 verbalize to Resident #3 to not touch CNA1's breasts. CNA4 observed CNA1 put Resident #3's hand down in a non-aggressive way.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CNA1's statement dated 03/21/2024, documented CNA1 verbalized Resident #3 was touching CNA1 inappropriately and warned the resident to stop. CNA1 explained telling the resident the touching would not be tolerated. CNA1 then tapped the resident on the resident's right hand and then held the right hand to prevent the resident from moving the right hand.</p> <p>On 04/10/2024 at 10:16 AM, the Licensed Social Worker (LSW) explained the definition of abuse was non-accidental injuries, physical damage and mental anguish of a resident to include willful action and unjustified injury. Abuse did not need to leave an obvious physical injury on an individual to prove abuse occurred.</p> <p>On 04/10/2024 at 1:35 PM, the Director of Nursing (DON) explained there were five different types of abuse and abuse was any intentional or unintentional act toward another individual whether the abuse was psychological, physical, entrapment, verbal or sexual. Furthermore, an individual would not need to have obvious signs of physical injury for abuse to occur.</p> <p>The DON explained Resident #3 was non-verbal and was a quadriplegic. The resident could not care for themselves and relied on staff for all activities of daily living, making the resident vulnerable.</p> <p>On 04/10/2024 at 3:03 PM, the Administrator verbalized on 03/21/2024, the Food Services Supervisor notified a Charge Nurse of abuse against Resident #3 by a CNA. The CNA deflected Resident #3's hand because the resident was touching the CNA inappropriately and told the resident I told you I would slap your hand if you did that again. The Administrator defined abuse as willful injury and confinement resulting in physical harm or anguish, including deprivation.</p> <p>The Administrator described Resident #3 as non-verbal and communicated with staff with right hand gestures to indicate a 'yes' or a 'no' to questions asked and could not demonstrate if the resident was trying to communicate to CNA1 regarding the resident needing something or if the touching was inappropriate. The Administrator verbalized CNA1 made a statement regarding the abuse. The statement documented CNA1 had asked the resident to stop touching CNA1 and had smacked the resident's hand as a result of frustration with the resident. The Administrator admitted CNA1 had completed abuse training the day prior to the incident and stated maybe the CNA1 was not paying attention to the training.</p> <p>The Administrator explained the facility did not have an Abuse Coordinator to handle allegations of abuse but rather an Abuse Committee. The Abuse Committee consisted of the Administrator, the Chief Nursing Officer, and the Risk Manager. Whoever received an allegation of abuse, was the individual in charge of investigating and following abuse policies and procedures.</p> <p>The Administrator verbalized this was not abuse toward Resident #3 because the resident did not have any physical signs of injury, such as, a cut, scrape, red mark, or bruise. The Administrator referred to the State Operations Manual (SOM) abuse grid for pathways regarding resident-to-resident abuse and determined, based off of the grid in the SOM, abuse criteria was not met and the incident was unsubstantiated by the facility. The Administrator admitted CNA1 confessed to verbally and physically abusing Resident #3, however unsubstantiated the allegation of abuse, because the Administrator verbalized the allegation did not meet the definition of abuse. The Administrator made no attempt to refer CNA1 to the Board of Nursing, nor investigate the allegation any further.</p> <p>(continued on next page)</p>		

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 04/15/2024
NAME OF PROVIDER OR SUPPLIER Pershing General Hospital Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/10/2024 at 5:38 PM, during a joint interview with the DON and Administrator, the DON verbalized the CNA's actions against Resident #3 on 03/21/2024, did not meet the facility's definition of abuse and would have been discouraged.</p> <p>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. Assessments were to be completed to monitor for important prevention tools used to identify residents with needs and behaviors which may lead to conflict or neglect. Residents with communication disorders and those who were completely dependent on staff were at a greater risk for abuse and neglect.</p> <p>The processes for abuse investigation were as follows:</p> <ul style="list-style-type: none"> -The Caregiver would be suspended and removed from the facility pending the investigation. -The family and/or guardian would be notified. -The facility would promote protection of the resident. -An alleged abuse allegation violation would be reported to law enforcement. -The CNO or designee would report to the State Nurse Aide Registry or licensing authorities for acts of abuse. -The CNO would analyze events of abuse, neglect, mistreatment or misappropriation of resident property to determine what changes were needed, if any, to policies and procedures to prevent further occurrences. The Risk Manager would maintain a record of all abuse events. -The Abuse Team would investigate the allegation of abuse with interviews, obtaining statements, make recommendations based on the information gathered, and forward the report to QAPI for review. <p>Failure to comply with the procedures outlined would result in disciplinary action, up to and including terminating employment.</p> <p>The facility policy titled Resident [NAME] of Rights, last revised 05/29/03, documented the resident had a right to be free from mental and physical abuse. The resident had a right to be treated with consideration, respect, dignity, and individuality, including privacy and care of personal needs.</p> <p>FRI #NV00070753</p> <p>Cross Reference with Tags F600 and F607</p> <p>50210</p> <p>Restorative Nursing Program (RNP)</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/09/2024 at 3:01 PM, the Director of Nursing (DON) verbalized the Licensed Practical Nurse (LPN) providing restorative nursing care to residents changed job duties the week of 01/08/2024, due to short staffing. The DON explained the Restorative Nursing Aide (RNA) was hired on 04/08/2024, and immediately the RNA began the Walk to Dine (WTD) program. The DON confirmed from 01/08/2024, to 04/08/2024, the nursing staff did not provide restorative care to residents. The DON explained the purpose of the RNP was to prevent residents from losing their baseline physical abilities. The DON verbalized the PROM program helped to maintain and get to baseline physical functioning because the program prevented stiffness, helped blood flow, and had other muscular and psychosocial benefits. The DON described one resident who did not often walk, but since working with the RNA, was able to walk for meals. The DON verbalized the DON did not know who was expected to be on the RNP. The DON verbalized the RNA was expected to document how far residents ambulated, but the DON was not sure where the information was documented. The DON also verbalized not knowing where to access physical therapy notes related to RNP.</p> <p>On 04/09/2024 at 3:35 PM, the RNA explained the facility did not have an official list of residents participating in the RNP, but the RNA made a list of the residents the RNA planned to work with. The RNA verbalized the RNA was instructed by the PT to create a list of residents who were supposed to participate in the RNP, not active in physical therapy. The RNA then created a list of residents to work with on RNP, not active in physical therapy.</p> <p>On 04/09/2024 at 04:45 PM, the DON verbalized the DON read the restorative nursing policy and admitted the DON was mistaken as to what was considered restorative nursing. According to the policy, restorative nursing included showering, brace assistance and dressing, all of which the facility had provided.</p> <p>The clinical record of the residents who required RNP services lacked documented evidence showering, brace assistance, and dressing were related to the RNP.</p> <p>On 04/11/2024 at 2:58 PM, the RNA verbalized the RNA did provide restorative nursing to some residents active in physical therapy as the RNA tried to work with all residents if they were willing to participate.</p> <p>On 04/15/2024 at 4:18 PM, the Administrator verbalized the facility failed to execute the plan to have more than one person oversee the RNP when the LPN left the position on 01/08/2024, and it somehow got missed.</p> <p>The facility policy titled Restorative Nursing Program dated 01/10/2008, and reviewed 04/14/2023, documented the following:</p> <ul style="list-style-type: none"> -The RNP focused on restoring or compensating for skills lost, seeking to maximize and prolong abilities with individualized, progressive restorative programs. -The RNPs were expected to include a range of motion and ambulation. -Daily documentation of care delivery was to be completed on each participating resident's restorative nursing Flowsheet. <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The restorative nurse Coordinator, DON or Minimum Data Set Coordinator was obliged to document on the resident's care plan when the resident entered the program, identified resident specific goals for the program, and when the resident was discharged from the program.</p> <p>Cross Reference with Tag F688.</p>