

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/11/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure the results of a facility reported incident (FRI) abuse investigation were reported to the State Agency (SA) within five days of the initial report for 1 of 13 sampled residents (Resident #6) and an initial FRI report for potential neglect was submitted to the SA within 24 hours of facility staff becoming aware of the allegations for 1 of 13 sampled residents (Resident #5). This deficient practice had the potential to result in an allegation of abuse and/or neglect not being investigated and reported in a timely manner and one or more residents experiencing harm from late or incomplete investigations. Findings include: Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including acquired absence of left foot and acquired absence of right leg below knee. A FRI initial report for potential neglect of Resident #6, dated 03/03/2026, documented the resident had attempted to self-transfer and fell. Post fall the resident had a change in mentation. The resident was sent to the emergency room for evaluation and treatment. The initial report documented a final report with a description of the investigation would be completed when the resident returned from the Emergency Room. The FRI did not include a final report with the results of the facility investigation. On 06/11/2026 at 9:05 AM, the Director of Nursing (DON) verbalized the final investigation report had not been sent to the State Agency. The facility policy titled Abuse/Neglect Prevention and Prohibition Long Term Care, reviewed 05/12/2026, documented it was the policy of the facility to report and investigate all allegations of actual or suspected abuse or neglect. Allegations of abuse would be reported to the State Agency and the results of all investigations of alleged violations would be reported within five working days of the incident. FRI 2793790 Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including type two diabetes mellitus without complications and presence of artificial hip joint. A FRI initial report for potential neglect of Resident #5 was submitted to the SA on 03/24/2026 at 7:37 AM. The report documented Resident #5 informed a nurse the night shift Certified Nursing Assistants (CNAs) were rough with the resident and refused to take the resident's Vital Signs (VS). On 06/11/2026 at 11:26 AM, the DON, who was also the facility's Abuse Coordinator (AC), verbalized abuse was anything which was detrimental to a resident. Abuse could be physical, verbal, psychological or financial. Neglect was the act of refusing to provide care or services to a resident which the resident was required to have. The DON/AC confirmed the DON/AC was familiar with the FRI report involving Resident #5 and recalled Resident #5 informed the nurse on Saturday, 03/21/2026, the CNAs were rough and refused to check the resident's VS. The nurse emailed the DON/AC and the Assistant DON (ADON) around 3:00 AM on 03/23/2026 to report the resident's concerns. The DON/AC explained the allegations should have been reported to the DON/AC immediately and the DON/AC would have needed to submit an initial FRI to the SA within two hours of when staff became aware of the allegation. The DON/AC confirmed the initial FRI was submitted to the SA beyond the required reporting timeframe and the alleged perpetrators were not suspended immediately due to delay in staff reporting. The facility policy titled Abuse/Neglect Prevention and Prohibition Long Term Care, reviewed 05/12/2026, documented suspicions of abuse/neglect were to be reported immediately. The DON/AC was to be contacted via phone. Once a report was received and the resident's safety was verified via phone call, the AC or designee would submit a state report. If the alleged perpetrator was a staff member, the staff member would be relieved of duty, replaced with an appropriate staff member, and placed on administrative leave pending investigation. FRI 2962442		