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	04/15/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, interview, clinical record review and document review, the facility failed to ensure a resident's Guardian gave informed consent prior to placing an air mattress on top of a resident's bariatric bed for 1 of 13 sampled residents (Resident #3). Findings include: Resident #3 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. 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. Resident #3's clinical record lacked a care plan addressing the air mattress on the top of the bariatric bed. Resident #3's clinical record lacked documented evidence the risk and benefits were explained to the resident's Guardian and the resident had been assessed for the risk of entrapment and restraint. A physician's order dated 06/06/2023, documented bariatric air mattress to bed to prevent skin breakdown. On 04/09/2024 at 2:21 PM, the air mattress had air barriers on each side of the mattress. Two Certified Nursing Assistants (CNAs) were providing care to the resident and explained Resident #3 had an air mattress on the top of the bariatric bed frame to prevent bed sores from developing or getting worse. The CNA explained the barriers would fill up with air at the same time the mattress would inflate with air. The barriers would act as a fall deterrent so as the bed would tilt to rotate the resident, the barrier would prevent the resident from falling out of the bed. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295000	A. Building B. Wing	04/15/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2024 at 1:35 PM, the Director of Nursing (DON) explained Resident #3 was a quadriplegic and needed help with all Activities of Daily Living (ADL). The facility acquired a bariatric bed for the resident. The bed tilted from side to side to help rotate the resident. The mattress on top of the bed frame was an air mattress, with air borders lining each side of the mattress. Staff were able to inflate or deflate the mattress, to include the barriers, as needed, to help prevent the resident from acquiring a pressure sore. The DON verbalized since the resident could not turn themselves, if the resident rolled into the air barriers on the mattress, the resident could suffocate. The DON verbalized the air mattress was considered a restraint for the resident. As a requirement of a potential restraint, the facility needed to attempt and document interventions attempted prior to applying the air mattress to the bed, assess the resident for risk of entrapment and review the risks and benefits with the resident's Guardian. The DON confirmed an informed consent from the resident's guardian was not obtained prior to placing the air mattress on the resident's bariatric bed. On 04/10/2024 at 2:02 PM, the Minimum Data Set (MDS) Coordinator explained the MDS Coordinator was responsible for completing assessments for risk of entrapment. A consent to use the air mattress should be obtained, a physician's order should be written and the risks and benefits should be explained to the Guardian. The MDS Coordinator confirmed an informed consent was not obtained from the resident's Guardian prior to placing the air mattress on the resident's bariatric bed. 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. Prior to the using physical devices or physical restraints, an assessment would be completed, the resident would be monitored, a physician's order would be obtained, consents would be obtained, the risks and benefits of a restraint would be obtained, and a care plan would be developed. Cross Reference Tags F656 and F689

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	04/15/2024

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 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** 49557 Based on interview, clinical record review, and document review the facility failed to ensure a fall resulting in serious bodily injury was reported the State Agency (SA) for 1of 13 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance and wandering in diseases classified elsewhere. A Post Fall Evaluation dated 01/21/2024, documented Resident #7 fell in the facility's dining area. Resident #7 fell backward and struck the back of the resident's head on a door frame. Resident #7 lost consciousness for five seconds and was transferred to the emergency room (ER) for further assessment. On 04/11/2024 at 1:10 PM, the Administrator explained falls resulting in serious bodily injury were required to be reported to the SA. The Administrator verbalized the Administrator's understanding was a fall including the resident striking the resident's head with subsequent loss of consciousness, and requiring transfer to the ER did not meet the definition of serious bodily injury. The Administrator confirmed a fall with strike to the head, subsequent loss of consciousness and transfer to the ER would not have been reported to the SA. On 04/15/2024 at 11:05 AM, the Director of Nursing (DON) explained any fall with serious injury was required to be reported to the SA. The DON confirmed loss of consciousness after a fall in which a resident struck the resident's head was a serious bodily injury. The DON confirmed Resident #7 fell on [DATE], the resident's head was struck during the fall, the resident lost consciousness and was transferred to the ER for further assessment. The DON explained the DON had the capability to report incidents to the SA. The DON confirmed the DON did not report Resident #7's fall which occurred on 01/21/2024, to the SA. The facility policy titled Falls and Fall Prevention, reviewed 04/13/2023, documented if a fall was associated with patient injury, an initial report would be filed by the nurse with the Nevada state reporting system. The facility policy titled Abuse Prevention and Prohibition, reviewed 08/25/2023, documented any falls with significant injury were required to be reported the SA. A significant injury was one which required the resident to be sent to the ER, clinic, or x-ray department for medical attention.

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	04/15/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, interview, and document review, the facility failed to provide a discharge notification to the State Long Term Care Ombudsman for 1 of 3 discharged residents (Resident #26). Findings include: Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with other specified complications and chronic obstructive pulmonary disease, unspecified. A Nurse's Note dated 03/03/2024, documented the resident was found to have slurred speech and altered mental status. The resident was transferred to the hospital for consultation. The resident was discharged from the facility on 03/04/2024. Resident #26's clinical record lacked documented evidence a notification of discharge was provided to the State Long Term Care Ombudsman's office. On 04/09/2024 at 10:08 AM, the Minimum Data Set (MDS) Registered Nurse (RN) confirmed the MDS RN was responsible for notifying the State Long Term Care Ombudsman's office of discharges. The MDS RN confirmed notification of Resident #26's discharge had not been submitted to the State Long Term Care Ombudsman's office but should have been as the resident was discharged after having been transferred to the hospital. The facility policy titled, Transfer of Resident, reviewed 04/13/2023, documented the facility was to send a copy of the discharge notice to the State Long Term Care Ombudsman's office.

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	04/15/2024

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review, and document review the facility failed to ensure a Minimum Data Set 3.0 (MDS) assessment was transmitted timely and at any point in the subsequent five months for one discharged resident reviewed for resident assessment (Resident #22). Findings include: Resident #22 Resident #22 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy and major depressive disorder, recurrent, unspecified. A Transfer/Discharge Report documented Resident #22 was discharged from the facility on 11/20/2023. Resident #22's clinical record lacked a discharge MDS assessment. On 04/09/2024 at 9:26 AM, the MDS Coordinator verbalized the facility was required to complete MDS assessments upon a resident's entry to the facility, with any changes in condition, and upon discharge from the facility. The MDS Coordinator explained the MDS Coordinator was required to submit a final validation report to the Centers for Medicare and Medicaid Services (CMS) within two weeks of a resident's discharge from the facility. The MDS Coordinator verbalized the validation report for Resident #22's discharge was due to be submitted by 12/04/2023, was not submitted, and was over 120 days late. On 04/09/2024 at 2:07 PM, the facility lacked a policy related to MDS final validation reporting. The facility policy titled Comprehensive Assessment and Reassessment, reviewed 04/13/2023, documented the facility must be capable of transmitting MDS data to the Internet Quality Improvement and Evaluation System within seven days of a discharge event (the date of death or discharge). Cross reference with tag F842

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	04/15/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on clinical record review, interview, and document review the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 3 of 13 sampled residents (Resident #2, #15 and #17). Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure with hypoxia and vascular dementia, moderate, with mood disturbance. On 04/08/2024 at 1:06 PM, Resident #2 denied having an indwelling catheter in place currently or recently. Resident #2's MDS Section H - Bowel and Bladder, dated 03/11/2024, documented Resident #2 had an indwelling catheter. Resident #2's clinical record lacked any other documented evidence of the presence of an indwelling catheter. On 04/10/2024 at 3:35 PM, the MDS Coordinator confirmed Resident #2 did not have an indwelling catheter in place at the time the MDS dated [DATE], was completed and the indwelling catheter was marked in error. 50210 Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including other sequelae of cerebral infarction and vascular dementia, moderate, with other behavioral disturbance. Resident #15's last quarterly MDS assessment dated [DATE], section N0415 (Medications - High-Risk Drug Classes: Use and Indication) documented the resident was taking an antipsychotic and the indication was noted. Section N0450 (Medications - Antipsychotic Medication Review) documented antipsychotics were received on a routine basis. Resident #15's clinical record lacked documentation the resident was receiving an antipsychotic. A physician's order dated 03/27/2024, and started 03/29/2024, documented Depakote oral tablet delayed release 250 milligrams (mg). Give one tablet by mouth two times a day for irritable/disruptive behaviors related to vascular dementia, moderate, with other behavioral disturbance. (continued on next page)

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	04/15/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2024 at 12:14 PM, the MDS Coordinator verbalized the resident received Depakote as a response to the resident's behavior related to vascular dementia. The MDS Coordinator explained Depakote was classified as an anticonvulsant but was used as an antipsychotic. The MDS Coordinator admitted the medication should not have been documented as an antipsychotic on the MDS assessment. Resident #15's last quarterly MDS assessment dated [DATE], section P0100 (Restraints and Alarms - Physical Restraints) documented the resident used bed rails daily as a physical restraint that could not be removed easily which restricts freedom of movement or normal access to one's body. On 04/08/2024 at 10:01 AM, Resident #15 had half bed rails up, one on each side of the upper part of the bed. On 04/08/2024 at 1:11 PM, the resident verbalized the resident felt safer with bed rails up. Resident #15's comprehensive care plan initiated 09/26/2022, and revised 10/05/2022, documented a focus on the utilization of left and right upper bed rails with a goal of utilization for safety, transfers, bed mobility, and to maintain current level of independence, and an intervention bed rails were not used as a restraint. A physician's order dated 04/09/2024, documented upper left and right side rail - continuous usage - other sequelae of cerebral infarction. Side rail utilization was for safety, transfers, bed mobility, and to maintain current level of independence. Resident #15's clinical record lacked documentation the resident used bed rails as a restraint. On 04/11/2024 at 12:23 PM, the MDS Coordinator verbalized Resident #15 used bed rails for mobility and to self-transfer, so the bed rails were not used as a restraint. On 04/15/2024 at 10:44 AM, the MDS Coordinator admitted the bed rails for Resident #15 should not have been documented as restraints on the MDS assessment. Resident #17 Resident #17 was admitted to the facility on [DATE], with a diagnosis of other sequelae of cerebral infarction. Resident #17's last quarterly MDS assessment dated [DATE], section N0415 (Medications - High-Risk Drug Classes: Use and Indication) documented the resident was taking an anticoagulant and the indication was noted. A physician's order dated 05/24/2023, and started 05/25/2023, documented Clopidogrel Bisulfate (Clopidogrel) oral tablet 75 milligrams (mg) give one tablet by mouth one time a day related to unspecified sequelae of cerebral infarction; other sequelae of cerebral infarction. Resident #17's clinical record lacked documentation the resident was receiving an anticoagulant. (continued on next page)

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	04/15/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/2024 at 10:50 AM, the MDS Coordinator verbalized Resident #17 was on Clopidogrel. The MDS Coordinator admitted Clopidogrel was classified as a hematological agent, not an anticoagulant, and should have been documented as an antiplatelet on the MDS assessment according to the Resident Assessment Instrument (RAI) Manual. The facility policy titled Comprehensive Assessment and Reassessment, last reviewed 04/13/2023, documented an individualized assessment of the care or treatment required to meet resident needs would be completed throughout the resident's stay. The assessment would accurately document the care needs of each resident, to include any devices used by the resident based on ability to perform Activities of Daily Living (ADL) care.

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	04/15/2024

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 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** 49557 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. Findings include: Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including unspecified sequelae of cerebral infarction and schizoaffective disorder, unspecified. A physician's order dated 04/07/2024, documented indwelling catheter. Resident #19's clinical record lacked a care plan related to the presence or care of the resident's indwelling catheter. 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. Resident #24 Resident #24 was admitted to the facility on [DATE], with diagnoses including arthropathy, unspecified and anemia, unspecified. A progress note dated 02/05/2024, documented a nurse spoke with Resident #24's family regarding comfort medications. 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. 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. 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. (continued on next page)

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	04/15/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. A progress note dated 02/07/2024, documented Resident #24 was on comfort measures. Resident #24's clinical record lacked a care plan related to end-of-life/comfort care. 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. 30748 Resident #3 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. 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. Resident #3's clinical record lacked a care plan addressing the air mattress on the top of the bariatric bed. A physician's order dated 06/06/2023, documented bariatric air mattress to bed to prevent skin breakdown. 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, montoring 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. 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. 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. (continued on next page)

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	04/15/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Cross reference with tags F690, F689, and F842

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	04/15/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on clinical record review, interview, and document review, the facility failed to follow physician's orders for insulin therapy for 2 of 13 sampled residents (Resident #9 and #13). Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with unspecified complications. A physician's order dated 10/10/2023, documented NovoLOG Insulin FlexPen subcutaneous solution pen-injector 100 unit/milliliters (ml), (Insulin Aspart). Inject as per sliding scale subcutaneously before meals and at bedtime related to type II diabetes mellitus with unspecified complications: - if blood sugar was between 150 - 200, inject two units; - 201 - 250 = four units; - 251 - 300 = six units; - 301 - 350 = eight units; - 351 - 400 = ten units; - 401 - 450 = 12 units. Give insulin as directed and call provider. Resident #9's Medication Administration Record (MAR) dated February 2024, documented the resident's blood sugar was over 400 on the following dates: -02/03/2024 at 8:00 PM, the resident's blood sugar was 446 and 12 units of insulin was administered. -02/08/2024 at 8:00 PM, the resident's blood sugar was 413 and 12 units of insulin was administered. The resident's clinical record lacked documented evidence the physician was notified of the resident's blood sugar level over 400 on 02/03/2024 and 02/08/2024. Resident #13 Resident #13 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with hyperglycemia. (continued on next page)

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	04/15/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 09/16/2023, documented HumaLOG Insulin KwikPen subcutaneous solution pen-injector 100 unit/ml, (Insulin Lispro). Inject as per sliding scale subcutaneously before meals related to type II diabetes mellitus with hyperglycemia: - if blood sugar was between 0 - 250, inject zero units; - 251 - 300 = two units; - 300 - 350 = four units; - 351 - 400 = six units; - 401 - 450 = eight units; - 451 and over = ten units. Give insulin and notify provider with any blood sugar levels above 400. The order was discontinued on 02/27/2024. Resident #13's MAR dated January 2024, and February 2024, documented the resident's blood sugar was over 400 on the following dates: -01/28/2024 at 11:30 AM, the resident's blood sugar was 411 and eight units of insulin was administered. -01/30/2024 at 11:30 AM, the resident's blood sugar was 481 and ten units of insulin was administered. -02/06/2024 at 11:30 AM, the resident's blood sugar was 483 and ten units of insulin was administered. -02/15/2024 at 11:30 AM, the resident's blood sugar was 439 and eight units of insulin was administered. -02/16/2024 at 11:30 AM, the resident's blood sugar was 434 and eight units of insulin was administered. -02/16/2024 at 4:30 PM, the resident's blood sugar was 454 and ten units of insulin was administered. -02/17/2024 at 11:30 AM, the resident's blood sugar was 458 and ten units of insulin was administered. -02/23/2024 at 4:30 PM, the resident's blood sugar was 495 and ten units of insulin was administered. -02/24/2024 at 11:30 AM, the resident's blood sugar was 403 and eight units of insulin was administered. (continued on next page)

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	04/15/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-02/24/2024 at 4:30 PM, the resident's blood sugar was 454 and ten units of insulin was administered. -02/27/2024 at 11:30 AM, the resident's blood sugar was 404 and eight units of insulin was administered. A physician's order dated 02/27/2024, documented HumaLOG Insulin KwikPen subcutaneous solution pen-injector 100 unit/ml, (Insulin Lispro). Inject as per sliding scale subcutaneously before meals related to type II diabetes mellitus with hyperglycemia: - if blood sugar was between 0 - 200, inject zero units; - 201 - 250 = two units; - 251 - 300 = four units; - 301 - 350 = six units; - 351 - 400 = eight units; - 401 - 450 = ten units. Give insulin and advise provider of blood sugar levels above 400. The order was discontinued on 03/05/2024. Resident #13's MAR dated February 2024, and March 2024, documented the resident's blood sugar was over 400 on the following dates: -02/28/2024 at 11:30 AM, the resident's blood sugar was 432 and ten units of insulin was administered. -03/01/2024 at 11:30 AM, the resident's blood sugar was 403 and ten units of insulin was administered. A physician's order dated 03/05/2024, documented HumaLOG Insulin KwikPen subcutaneous solution pen-injector 100 unit/ml, (Insulin Lispro). Inject as per sliding scale subcutaneously before meals related to type II diabetes mellitus with hyperglycemia: - if blood sugar was between 0 - 200, inject zero units; - 201 - 250 = three units; - 251 - 300 = four units; - 301 - 350 = five units; - 351 - 400 = six units; - 401 - 450 = seven units; (continued on next page)

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	04/15/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 451 - 500 = eight units; - 500 and over = nine units. Give insulin and advise provider of blood sugar levels above 400. Resident #13's MAR dated March 2024, documented the resident's blood sugar was over 400 on the following dates: -03/22/2024 at 11:30 AM, the resident's blood sugar was 464 and eight units of insulin was administered. -03/22/2024 at 4:30 PM, the resident's blood sugar was 441 and seven units of insulin was administered. The resident's clinical record lacked documented evidence the physician had been notified of the resident's blood sugar level over 400 on 01/28/2024, 01/30/2024, 02/06/2024, 02/15/2024, 02/16/2024, 02/17/2024, 02/23/2024, 02/24/2024, 02/27/2024, 02/28/2024, 03/01/2024, and 03/22/2024. On 4/15/2024 at 12:00 PM, the Director of Nursing (DON) confirmed Resident #9 and #13's clinical records lacked documented evidence the physician had been notified of Resident #9's blood sugar level over 400 on 02/03/2024 and 02/08/2024, and Resident #13's blood sugar level over 400 on 01/28/2024, 01/30/2024, 02/06/2024, 02/15/2024, 02/16/2024, 02/17/2024, 02/23/2024, 02/24/2024, 02/27/2024, 02/28/2024, 03/01/2024, and 03/22/2024. The DON verbalized it was the DON's expectation for the nurse to notify the physician if the resident's blood sugar was over 400, per the physician's orders, and to have documented the notification in the resident's record. The DON verbalized the importance of notifying the physician as the resident could have been experiencing diabetic ketoacidosis or if a consistent [NAME] emerged, as to allow the physician to make changes or provide additional directions as needed. The facility policy titled, Standing Protocol for Treatment of Hypo and Hyper-Glycemia, reviewed 05/11/2023, documented if the resident had orders for sliding scale insulin, the nurse would notify the physician per the physician's order.

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	04/15/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on observation, interview, clinical record review, and document review the facility failed to ensure the Restorative Nursing Program (RNP) was provided to 13 of 13 residents in need of restorative nursing services (Resident #1, #2, #3, #7, #10, #11, #12, #15, #16, #17, #20, #21, and #23). Findings include: On 04/09/2024 at 2:48 PM, the Restorative Nursing Aide (RNA) verbalized the facility's RNP had not been active since January 2024, when the Licensed Practical Nurse (LPN) providing restorative nursing care changed job duties due to short staffing. The RNA explained the RNP started back up when the RNA was hired on 04/08/2024. The RNA verbalized the RNA briefly spoke with the Physical Therapist (PT) on 04/08/2024, and referred to the restorative nursing binder for activities to do with the residents. The RNA verbalized the RNA was supposed to document RNP after working with the residents but had not had the opportunity to do so. On 04/09/2024 at 3:01 PM, the Director of Nursing (DON) verbalized the LPN providing restorative nursing care to residents changed job duties the week of 01/08/2024, due to short staffing. The DON explained the 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 Passive Range of Motion (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 RNA was expected to document how far residents ambulated, but the DON was not sure where the information was documented. Resident #1 Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including generalized anxiety disorder, contracture of muscle, unspecified lower leg, feeding difficulties, unspecified, and other specified congenital deformities of hip. Resident #1's Minimum Data Set 3.0 (MDS) Assessment, Section O0500, dated 02/26/2024, lacked documented evidence the resident was participating in a RNP. On 04/09/2024 at 3:35 PM, a RNA explained the facility did not have an official list of residents participating in the RNP, but the RNA made a (handwritten) list of the residents the RNA planned to work with. Resident #1 was listed as a PROM resident. An email from the DON to the PT and edited by the PT dated 04/10/2024 at 7:49 AM, documented Resident #1 was a PROM resident. Resident #1's comprehensive care plan lacked documented evidence of a RNP to include PROM. (continued on next page)

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	04/15/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of chronic respiratory failure with hypoxia. Resident #2's MDS, Section O0500, dated 03/11/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #2 was listed as a WTD resident. An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #2 as a WTD resident. An email from the DON to the PT and edited by the PT dated 04/10/2024 at 7:49 AM, documented Resident #2 as a PROM resident. Resident #2's comprehensive care plan initiated 02/20/2021, and revised 09/12/2023, documented the resident was evaluated for the RNP with recommendations and plan of care from physical therapy. Suggestions initiated on 12/11/2023 were as follows: -ADL locomotion off unit. -ADL transferring. -ADL walk in corridor. -ADL walk in room. Resident #3 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 and contracture of muscle, unspecified lower leg. 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. Resident #3 was listed as a PROM resident. An email from the DON to the PT and edited by the PT dated 04/10/2024 at 7:49 AM, documented Resident #3 as a PROM resident. Resident #3's comprehensive care plan initiated 07/27/2011, and revised 07/19/2023, documented an intervention for RNP to maintain range of motion. Resident #7 (continued on next page)

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	04/15/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral, wandering in diseases classified elsewhere and scoliosis, unspecified. Resident #7's MDS, Section O0500, dated 01/15/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #7 was listed as a WTD resident. An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #7 as a WTD resident. Resident #7's comprehensive care plan lacked documented evidence of a RNP to include WTD. Resident #10 Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis including unspecified intellectual disabilities, muscle weakness, contracture of muscle, right hand, and other abnormalities of gait and mobility. Resident #10's MDS, Section O0500, dated 02/26/2024, lacked documented evidence the resident was participating in a RNP. On 04/09/24 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. Resident #10 was listed as a WTD resident. An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #10 as a WTD resident. An email from the DON to the PT and edited by the PT dated 04/10/2024 at 7:49 AM, documented Resident #10 as a PROM resident. Resident #10's comprehensive care plan lacked documented evidence of a RNP to include WTD and PROM. Resident #11 Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of dementia in other diseases classified elsewhere, severe, with other behavioral disturbance. Resident #11's MDS, Section O0500, dated 03/04/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #11 was not on the list for the RNP. (continued on next page)

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	04/15/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #11 as a WTD resident. Resident #11's comprehensive care plan lacked documented evidence of a RNP to include WTD. Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including personal history of traumatic brain injury, history of falling, scoliosis unspecified, and weakness. Resident #12's MDS, Section O0500, dated 02/26/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #12 was not on the list for the RNP. An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #12 as a WTD resident. An email from the DON to the PT and edited by the PT dated 04/10/2024 at 7:49 AM, documented Resident #12 as a PROM resident. Resident #12's comprehensive care plan lacked documented evidence of a RNP to include Walk to Dine and PROM. Resident #15 Resident #15 was admitted to the facility on [DATE], with diagnoses including primary osteoarthritis, right shoulder, other sequelae of cerebral infarction, primary osteoarthritis, left shoulder, and low back pain, unspecified. Resident #15's MDS, Section O0500, dated 02/26/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #15 was listed as a WTD resident. An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #15 as a WTD resident. Resident #15's comprehensive care plan lacked documented evidence of a RNP to include WTD. Resident #16 (continued on next page)

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	04/15/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #16 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery and hemiplegia and hemiparesis after a stroke affecting the right side of the brain. Resident #16's MDS, Section O0500, dated 02/05/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #16 was listed as a WTD resident. An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #16 as a WTD resident. Resident #16's comprehensive care plan initiated 02/26/2023, documented an intervention of restorative care walking program for staff to assist the resident in ambulation around the unit a minimum of one time per day on days off from physical therapy treatment or as needed. There was no documented evidence of a RNP to include WTD. Resident #17 Resident #17 was admitted to the facility on [DATE], with diagnoses including other sequelae of cerebral infarction, contracture of muscle multiple sites, and pain in unspecified knee. On 04/08/2024 at 10:16 AM, Resident #17 verbalized the resident used to receive restorative nursing care until a Licensed Practical Nurse (LPN) who provided restorative nursing care changed job duties. Resident #17's MDS, Section O0500, dated 03/11/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #17 was listed as a PROM resident. Resident #17's comprehensive care plan lacked documented evidence of a RNP to include PROM. Resident #20 Resident #20 was admitted to the facility on [DATE], with diagnoses including cerebral palsy unspecified, and history of falling. Resident #20's MDS, Section O0500, dated 02/12/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #20 was listed as a WTD resident. (continued on next page)

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	04/15/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #20 as a WTD resident. Resident #20's comprehensive care plan lacked documented evidence of a RNP to include WTD. Resident #21 Resident #21 was admitted to the facility on [DATE], with a diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance. Resident #21's MDS, Section O0500, dated 03/04/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #21 was listed as a WTD resident. Resident #21's comprehensive care plan lacked documented evidence of a RNP to include WTD. Resident #23 Resident #23 was admitted to the facility on [DATE], with a diagnosis of Alzheimer's disease, unspecified. Resident #23's MDS, Section O0500, dated 01/29/2024, lacked documented evidence the resident was participating in a RNP. 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. Resident #23 was listed as a WTD resident. An email from the PT to the DON dated 03/12/2024 at 12:54 PM, documented Resident #23 as a WTD resident. Resident #23's comprehensive care plan lacked documented evidence of a RNP to include WTD. 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. On 04/09/2024 at 4:45 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. (continued on next page)

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	04/15/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record of the residents who required RNP services lacked documented evidence showering, brace assistance, and dressing were related to the RNP. 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. 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. The facility policy titled Restorative Nursing Program dated 01/10/2008, and reviewed 04/14/2023, documented the following: -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. -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. Cross Reference with Tag F726.

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	04/15/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on observation, clinical record review, interview and document review, the facility failed to assess an air mattress for entrapment and restraint for 1 of 13 sampled residents (Resident #3). Findings include: Resident #3 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. 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. Resident #3's clinical record lacked a care plan addressing the air mattress on the top of the bariatric bed. Resident #3's clinical record lacked documented evidence the risk and benefits were explained to the resident's Guardian and the resident had been assessed for the risk of entrapment and restraint. A physician's order dated 06/06/2023, documented bariatric air mattress to bed to prevent skin breakdown. On 04/09/2024 at 2:21 PM, the air mattress had air barriers on each side of the mattress. Two Certified Nursing Assistants (CNAs) were providing care to the resident and explained Resident #3 had an air mattress on the top of the bariatric bed frame to prevent bed sores from developing or getting worse. The CNA explained the barriers would fill up with air at the same time the mattress would inflate with air. The barriers would act as a fall deterrent when the bed would tilt to rotate the resident; the barrier would prevent the resident from falling out of the bed. On 04/10/2024 at 1:35 PM, the Director of Nursing (DON) explained Resident #3 was a quadriplegic and needed help with all Activities of Daily Living (ADL). The facility acquired a bariatric bed for the resident that would tilt from side to side to help rotate the resident. The mattress on top of the bed frame was an air mattress, with air borders lining each side of the mattress. Staff were able to inflate or deflate the mattress, to include the barriers, as needed, to help prevent the resident from acquiring a pressure sore. The DON verbalized since the resident could not turn themself, if the resident rolled into the air barriers on the mattress, the resident could suffocate. (continued on next page)

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	04/15/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON verbalized the air mattress was considered a restraint for the resident. As a requirement of a potential restraint, the facility needed to attempt and document interventions attempted prior to applying the air mattress to the bed, assess the resident for risk of entrapment and review the risks and benefits with the resident's guardian. The DON confirmed the risks and benefits were not reviewed with the resident's guardian, an assessment was not completed nor was a consent signed to be able to utilize an air mattress on top of the residents bariatric bed. On 04/10/2024 at 2:02 PM, the Minimum Data Set (MDS) Coordinator explained the MDS Coordinator was responsible to complete assessments for risk of entrapment and if a resident had an air mattress. A consent to use the air mattress would be obtained, a physician's order would be written and the risks and benefits would be explained to the Guardian. The MDS Coordinator verbalized Resident #3 would require a head to toe assessment be completed, consents would be obtained for the air mattress and all factors included to explain the risks and benefits to the resident's Guardian to be completed. It was important for Resident #3 to have all components in place because the air mattress would be over inflated or underinflated, creating a cradle situation, which could suffocate the resident. The MDS Coordinator confirmed the risks and benefits were not reviewed with the resident's guardian, an assessment was not completed for the air mattress, nor was a consent signed to be able to utilize the air mattress on top of Resident #3's bariatric bed. 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. Prior to using physical devises or physical restraints, an assessment would be completed, the resident would be monitored, a physician's order would be obtained, consents would be obtained, the risks and benefits of a restraint would be obtained, and a care plan would be developed. Cross Reference with tag F656

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	04/15/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review the facility failed to ensure 1) a resident with an indwelling catheter had orders in place for ongoing care of the catheter, 2) catheter care provided to a resident was documented in the resident's clinical record, and 3) a care plan was developed and implemented related to an indwelling catheter for 1 of 13 sampled residents (Resident #19). Findings include: Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including unspecified sequelae of cerebral infarction and schizoaffective disorder, unspecified. Resident #19's Admission Record documented on 04/04/2024, the onset of the diagnoses of other symptoms and signs involving the genitourinary system and retention of urine, unspecified. A physician's order dated 04/07/2024, documented indwelling catheter. On 04/10/2024 at 3:11 PM, a Certified Nursing Assistant (CNA) verbalized the catheter care CNAs provided to residents included emptying the catheter bag, recording urinary output, cleansing of the catheter and cleansing around the insertion site. The CNA explained the CNA knew care needed to be provided for residents' catheters when the electronic medical record informed staff catheter care was needed and when the information was shared during shift change. The CNA confirmed Resident #19 had an indwelling catheter. The CNA verbalized the CNA did not believe Resident #19 had a catheter care task to be completed in the resident's clinical record. On 04/10/2024 at 3:23 PM, a Registered Nurse (RN) verbalized nurses and CNAs were responsible for catheter care. The RN explained nurses were alerted of the need for catheter care by a task on the Treatment Administration Record (TAR) and the TAR was populated by physician orders. The RN confirmed Resident #19 did not have physician orders for catheter care. Resident #19's clinical record lacked documented evidence of physician orders for catheter care or a care plan related to the resident's indwelling catheter. (continued on next page)

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	04/15/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2024 at 3:31 PM, the Minimum Data Set (MDS) Coordinator explained staff knew a resident required catheter care by verbally reporting at shift change and later by physician orders placed in the resident's electronic medical record. The MDS Coordinator verbalized orders would include the placement of the catheter, when the catheter was to be changed, and catheter care. Catheter care included checking the leg strap, cleansing of the catheter and cleansing of the insertion site. The MDS coordinator explained physician orders triggered tasks to appear on the TAR so nurses or CNAs would know to complete the tasks daily. The MDS Coordinator verbalized it was discovered in the afternoon of 04/10/2024, Resident #19 had not had physician orders for catheter care. The MDS Coordinator verbalized the orders should have been placed when the catheter was ordered and inserted on 04/07/2024. The 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. On 04/11/2024 at 12:01 PM, an RN confirmed the RN provided catheter care to Resident #19 on 04/10/2024. The RN verbalized any catheter care provided to Resident #19 prior to 04/11/2024, was not documented due to the task not populating on the TAR until the morning of 04/11/2024. The facility policy titled Indwelling Urinary Catheter and Maintenance, reviewed 04/13/2023, documented maintenance of indwelling catheters included emptying of urine drainage bags at least once per shift. Perineal and catheter care included: cleansing of the catheter and perineum at least once per shift and as needed with incontinence of stool, cleansing of the perineum and meatus at least once per day. Daily documentation included: time of catheter care and perineal care and nursing assessment of catheter and meatus. 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. Each shift documentation would include care, treatment, and interventions provided. Cross reference with Tag F656 and F842.

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	04/15/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 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. Findings include: Resident #3 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. 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. 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. 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. 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. (continued on next page)

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	04/15/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	04/15/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	04/15/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. The processes for abuse investigation were as follows: -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. Failure to comply with the procedures outlined would result in disciplinary action, up to and including terminating employment. 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. FRI #NV00070753 Cross Reference with Tags F600 and F607 50210 Restorative Nursing Program (RNP) (continued on next page)

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	04/15/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. The clinical record of the residents who required RNP services lacked documented evidence showering, brace assistance, and dressing were related to the RNP. 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. 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. The facility policy titled Restorative Nursing Program dated 01/10/2008, and reviewed 04/14/2023, documented the following: -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. (continued on next page)

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	04/15/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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. Cross Reference with Tag F688.

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	04/15/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure 1) a multidose vial was discarded by the use by date, 2) discontinued medications were disposed of timely and 3) the temperature of a refrigerator containing medications was logged daily for 1 of 1 sampled medication rooms. Findings include: Multidose Vial On [DATE] at 4:23 PM, during an inspection of the medication storage room in the presence of a Registered Nurse (RN), a vial of tuberculin purified protein derivative, diluted aplisol 5 tuberculin units (TU)/0.1 milliliters (ml) was located in a refrigerator. The vial was inside the manufacturer box, ,d+[DATE] was written on the box. The box contained the following instruction: Once entered, vial should be discarded after 30 days. The RN confirmed the date written on the box was ,d+[DATE] and the vial should have been discarded prior to [DATE]. On [DATE] at 10:05 AM, the Director of Nursing (DON) explained the expectation of nursing staff when a multidose vial was opened was to write the date opened on the vial. The vial was to be discarded on or before 28 days after the open date. The DON confirmed a multidose vial with an open date of ,d+[DATE] should have been discarded prior to [DATE]. The DON explained potential outcomes from the use of a multidose vial past the use by date were adverse reactions and infection. The facility policy titled Medication Storage, reviewed [DATE], documented multidose vials of injectable medications were to be dated and initialed when opened. The vial would be destroyed within 28 days of opening. Medication Disposal On [DATE] at 4:23 PM, during an inspection of the medication storage room in the presence of an RN, an unopened box containing a suprep bowel preparation kit was located in a cabinet. The box had a resident label attached, indicating the medication belonged to Resident #24. The RN verbalized the medication should have been destroyed due to the resident no longer residing in the facility. A physician's order dated [DATE], documented suprep bowel preparation kit oral solution 15XXX, d+[DATE]XXX,d+[DATE].6 grams (GM)/177 ml (sodium sulfate - potassium sulfate - magnesium sulfate). Give six ounces (oz) by mouth one time only related to gastrointestinal hemorrhage. Discontinue date [DATE], resident refused procedure, procedure cancelled per resident request. (continued on next page)

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	04/15/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:05 AM, the DON explained the process when a resident expired or was discharged from the facility was to place the resident's medications in a bin in the medication storage room, remove any resident labels and shred the labels, then use a prescription (rx) destroyer to destroy the medication. The DON verbalized the destruction/disposal of medications should be completed at the time of discharge or on the date the resident expired. The DON confirmed Resident #24 expired on [DATE], and the bowel preparation kit should have been destroyed. The facility policy titled Disposal of Drugs, reviewed [DATE], documented discontinued drugs should be returned to the pharmacy for proper disposition. Refrigerator Temperatures On [DATE] at 4:23 PM, during an inspection of the medication storage room in the presence of a Registered Nurse (RN), the log titled Refrigerator Temperature Log for Medications was reviewed and lacked documented evidence the temperature was monitored and recorded as follows: -The Refrigerator Temperature Log for Medications (Temperature Log) for [DATE], did not document a temperature for 2 of 31 days. -The Temperature Log for [DATE], did not document a temperature for 1 of 31 days. The Temperature Log instructions documented in case of abnormal temperature values: -Remove and discard all foods or biologicals. -Do incremental adjustments to the refrigerator temperature to correct the temperature. -Recheck temperature in two hours, if no changes call maintenance or the individual on call. -Complete QRR (incident report). On [DATE] at 4:37 PM, the RN verbalized refrigerator temperatures were to be checked once daily. The RN confirmed the Temperature Logs lacked documentation of a temperature reading on [DATE], [DATE], and [DATE]. On [DATE] at 10:05 AM, the DON verbalized medications were stored in the refrigerator in the medication storage room. The DON verbalized the floor nurse was responsible to check the temperature of the medication refrigerator each day and write the temperature on the log. The DON confirmed the Temperature Logs for the refrigerator in the medication storage room lacked documented evidence the temperature was monitored on [DATE], [DATE], and [DATE]. The DON explained the importance of monitoring medication refrigerator temperatures was if the temperature was out of range medications could go bad. The facility policy titled Medication Storage, reviewed [DATE], documented all drugs and biologicals would be stored in a way to ensure safety of all medications. Refrigerators containing drugs were maintained between two degrees Celsius (36 degrees Fahrenheit) and eight degrees Celsius (46 degrees Fahrenheit). A daily log of temperatures would be kept.

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	04/15/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review and document review the facility failed to assist a resident in obtaining dental services after a resident experienced bleeding gums for 1 of 13 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of cerebellar stroke syndrome. On 04/08/2024 at 2:36 PM, Resident #10's Guardian explained the resident had dental issues in the past and there was supposed to be a follow-up appointment but the Guardian did not know if a dental appointment was made. A physician's order dated 11/22/2021, documented the facility may arrange for podiatry, dental, psychiatric, audiology and vision consultations as needed. A care plan initiated 04/07/2023, and revised 10/12/2023, documented the resident had oral/dental health problems related to poor oral hygiene, needing supervision with oral care, and history of cavities. The care plan documented an intervention to coordinate arrangements for dental care and dental care transportation as needed. Resident #10's progress notes documented the following: -Effective date 01/10/2024, Certified Nursing Assistant (CNA) entered resident's room and observed the resident was uncomfortable. The resident indicated the resident was experiencing oral pain. -Effective date 01/10/2024, an attempt was made to inform the Guardian of the resident's wishes to schedule a dentist appointment. An email dated 01/10/2024 to the Guardian by the Unit Secretary requested an appointment. -Effective date 02/20/2024, the resident was given oral care due to a large amount of plaque noted. While cleaning, the resident had a large amount of blood from gums. On 04/10/2024 at 2:35 PM, a CNA verbalized the CNA provided oral care to Resident #10 every morning but a few months prior, the resident had a gum bleeding issue causing the resident pain. The CNA verbalized the CNA hoped there was a dentist appointment made to address the dental issues experienced by the resident. On 04/10/2024 at 3:15 PM, the Social Worker (SW) verbalized the last known attempt made to notify the Guardian of a request for a dentist appointment was on 01/10/2024, but the Guardian did not respond. (continued on next page)

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	04/15/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2024 at 03:28 PM, a Registered Nurse (RN) explained the Guardian returned the phone call to the facility on [DATE], and asked for the resident to receive a follow-up dentist appointment. Following the guardian's failure to respond to the last known contact attempt on 01/10/2024 until 04/10/2024, no further documented attempts were made to schedule a dentist appointment. The facility policy titled Dental Services in LTC (Long Term Care) & (and) Swing Bed dated 11/28/2007, and reviewed 04/13/2023, documented the facility would assist residents on obtaining routine and emergency dental care.

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	04/15/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210 Based on interview, clinical record review and document review the facility failed to ensure a resident's allergy restrictions were accommodated related to lactose intolerance for 1 of 13 sampled residents (Resident #17). Findings include: Resident #17 Resident #17 was admitted to the facility on [DATE], with a diagnosis of lactose intolerance, unspecified. On 04/08/2024 at 10:28 AM, Resident #17 verbalized the resident could not eat cheese because the resident was lactose intolerant. The resident explained the resident sometimes received cheese with the resident's meals and the resident was served eggs with cheese on top for the resident's breakfast on the morning of 04/08/2024. Resident #17's physician's orders documented the following: -Order date 05/31/2023, resident to dairy-free products as a replacement for whole milk. -Order date 02/18/2024, regular diet, regular texture, thin consistency, related to lactose intolerance, unspecified. Resident #17's comprehensive care plan initiated 08/10/2023, documented the resident had episodes of diarrhea related to lactose intolerance. A diet order and communication form dated 04/01/2024, documented a food allergy to milk. A diet type report dated 04/10/2024, documented a regular diet type, regular texture, thin consistency. There were no additional directions for Resident #17. On 04/10/2024 at 3:40 PM, the Dietary Manager (DM) verbalized the breakfast menu for 04/08/2024, documented an egg and sausage bake with cheese. The DM recalled speaking with Resident #17 after breakfast on 04/08/2024 and the resident informed the DM the resident received cheese on the resident's egg and sausage bake. The DM explained the diet type report the kitchen used to ensure therapeutic diets and preferences were adhered to did not document the resident's allergies. The DM confirmed the DM had a diet order and communication form documenting milk as an allergy for the resident. (continued on next page)

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	04/15/2024

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/2024 at 1:36 PM, the Minimum Data Set (MDS) Coordinator confirmed Resident #17 was lactose intolerant and verbalized the diet order and communication form was inaccurate. The MDS Coordinator explained the diet order and communication form indicated no milk when the form should have indicated no milk products to accurately reflect the resident's diagnosis and physician's orders.

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	04/15/2024

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 31739 Based on clinical record review, interview and document review, the Administrator failed to ensure a Restorative Nursing Program (RNP) was maintained for residents with the potential to participate in the program and failed to ensure the Abuse Committee investigated allegations of employee to resident abuse by applying the current definition of abuse as per 42 CFR Chapter IV, Part 483, Section 12, Freedom from Abuse, Neglect, and Exploitation. Findings include: Restorative Nursing Program On 04/09/2024 at 2:48 PM, the Restorative Nursing Aide (RNA) verbalized the facility's RNP had not been active since January of 2024, when the Licensed Practical Nurse (LPN) providing restorative nursing care changed job duties due to short staffing. On 04/09/2024 at 3:01 PM, the Director of Nursing (DON) verbalized the LPN providing restorative nursing care changed job duties the week of 01/08/2024, due to short staffing. The DON confirmed from 01/08/2024, to 04/08/2024, nursing staff did not provide restorative care. 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 and it somehow got missed. Abuse Committee The Facility Reported Incident (FRI) NV00070753, with the allegation an employee verbally and physically abused a resident was investigated by the facility and was unsubstantiated. The FRI's final report dated 03/25/2024, documented the investigation included reports of witnesses, the employee of concern's documented statements regarding the incident and the employee of concern admitting responsibility to the allegations. The report documented the facility unsubstantiated the incident due to the resident not having shown signs of any psychosocial impact. On 04/11/2024 at 2:34 PM, the Administrator verbalized the Administrator was a part of the Abuse Committee. The Administrator verbalized an employee hitting a resident or telling a resident they would hit the resident was only considered abuse if resulting in injury, harm, pain or mental anguish to the resident. On 04/15/2024 at 4:38 PM, the Administrator verbalized the Abuse Committee's understanding of the definition of abuse by an employee to a resident, at the time of the investigation, was only substantiated as abuse if the resident experienced injury, harm, pain or mental anguish from the abuse. The Administrator confirmed employee to resident abuse allegations had not been investigated appropriately as the definition of abuse had not been applied correctly. Cross Reference Tags F600, F607 and F688

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	04/15/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30748 Based on interview, clinical record review and document review, the facility failed to ensure a resident's clinical record was complete when an Minimum Data Set 3.0 (MDS) assessment was not completed for a resident upon discharge from the facility for 1 of 1 resident selected for Resident Assessment (Resident #22) and care provided related to a resident's indwelling catheter was documented in the resident's clinical record for 1 of 13 sampled residents (Resident #19). Findings include: Resident #22 Resident #22 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy and major depressive disorder, recurrent, unspecified. A Transfer/Discharge Report documented Resident #22 was discharged from the facility on 11/20/2023. Resident #22's clinical record lacked a discharge MDS assessment. On 04/09/2024 at 9:26 AM, the MDS Coordinator verbalized the facility was required to complete MDS assessments upon a resident's entry to the facility, with any changes in condition, and upon discharge from the facility. The MDS Coordinator explained the MDS Coordinator was required to submit a final validation report to the Centers for Medicare and Medicaid Services (CMS) within two weeks of a resident's discharge from the facility. The MDS Coordinator verbalized the validation report for Resident #22's discharge was due to CMS by 12/04/2023, was not submitted, and was over 120 days late. The MDS Coordinator confirmed Resident #22's clinical record was incomplete and inaccurate due to the lack of a discharge MDS assessment. On 04/09/2024 at 2:07 PM, facility staff verbalized the facility lacked a policy related to MDS final validation reporting. 49557 Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including unspecified sequelae of cerebral infarction and schizoaffective disorder, unspecified. A physician's order dated 04/07/2024, documented indwelling catheter. Resident #19's clinical record lacked documented evidence of catheter care being provided or ordered. (continued on next page)

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	04/15/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/2024 at 3:11 PM, a Certified Nursing Assistant (CNA) verbalized the catheter care CNAs provided to residents included emptying of the catheter bag, recording urinary output, cleansing of the catheter and cleansing around the insertion site. The CNA explained the CNA knew care needed to be provided for residents' catheters when the electronic medical record informed staff catheter care was needed and when the information was shared during shift change. On 04/10/2024 at 3:23 PM, a Registered Nurse (RN) verbalized nurses and CNAs were responsible for catheter care. The RN explained the task indicating the need for catheter care was populated for nurses on the Treatment Administration Record (TAR). On 04/10/2024 at 3:31 PM, the MDS Coordinator explained staff knew a resident required catheter care by verbally reporting at shift change and later by physician orders placed in the resident's electronic medical record. The MDS Coordinator verbalized physician orders would include the placement of the catheter, when the catheter was to be changed, and catheter care. Catheter care included checking the leg strap, cleansing the catheter and cleansing the insertion site. The MDS coordinator explained physician orders triggered tasks to appear on the TAR so nurses or CNAs would know to complete the tasks daily. The MDS coordinator verbalized physician orders for catheter care for Resident #19 were placed in the afternoon of 04/10/2024, and should have been placed when the catheter was ordered. On 04/11/2024 at 12:01 PM, the RN verbalized the task indicating the need for catheter care for Resident #19 did not populate on the TAR until the morning of 04/11/2024. The RN confirmed the RN provided catheter care for Resident #19 on 04/10/2024. The RN verbalized any catheter care provided to Resident #19 prior to 04/11/2024, was not documented due to the task not populating on the TAR until the morning of 04/11/2024. The facility policy titled Indwelling Urinary Catheter and Maintenance, reviewed 04/13/2023, documented required daily documentation included: time of catheter care and perineal care, nursing assessment of catheter and meatus, and urinary output. The facility policy titled Standards of Care, reviewed 04/13/2023, documented each shift documentation would include care, treatment, and interventions provided. The facility policy titled Comprehensive Assessment and Reassessment, reviewed 04/13/2023, documented the facility must be capable of transmitting MDS data to the Internet Quality Improvement and Evaluation System within seven days of a discharge event (the date of death or discharge). All resident assessments completed in the previous 15 months would be maintained in the resident's record including discharge records. The facility policy titled Medical Records - Content of Health Record, reviewed 03/14/2024, documented the medical record must be completed within 30 days post patient discharge from the facility. Cross reference with F Tags 640, 656 and 690.

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	04/15/2024

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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 31739 Based on personnel record review, interview and document review, the facility failed to ensure 10 of 20 facility staff received training on the facility's Quality Assurance and Performance Improvement (QAPI) program. Findings include: The following employee records lacked documented evidence QAPI training had been completed: -Employee #2, with a title of Director of Nursing and a start date of 12/05/2023. -Employee #4, with a title of Registered Dietitian and a start date of 06/28/2017. -Employee #8, with a title of Certified Nursing Assistant and a start date of 06/03/2003. -Employee #16, with a title of Certified Nursing Assistant and a start date of 01/23/2024. -Employee #13, with a title of Registered Nurse and a start date of 12/13/2023. -Employee #15, with a title of Licensed Practical Nurse and a start date of 12/20/2021. -Employee #18, with a title of Dietary Aide/Cook and a start date of 11/20/2023. -Employee #19, with a title of Dietary Aide/Cook and a start date of 06/16/2017. -Employee #20, with a title of Housekeeper and a start date of 01/24/2023. -Employee #21, with a title of Certified Nursing Assistant and a start date of 01/19/2015. On 04/15/2024 at 2:41 PM, the Administrator verbalized the issue with QAPI training had been identified, a couple of surveys ago, and staff were assigned but some had not yet completed the training. The Administrator verbalized the facility had not previously made it part of their onboarding employee orientation but would do so moving forward. On 04/15/2024 at 4:27 PM, the Risk Manager confirmed it was the Risk Manager's responsibility to ensure QAPI training had been completed. The Risk Manager confirmed the 10 of 20 sampled employees had not yet completed the required training. The facility policy titled, Quality Assurance and Performance Improvement Plan (QAPI) for Pershing General Hospital Long-Term Care Facility, reviewed 10/11/2023, documented facility-wide training would be conducted to inform all employees in the facility about the QAPI plan.

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	04/15/2024

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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 49557 Based on interview, personnel record review and document review, the facility failed to ensure infection control training was provided timely to 1 of 20 sampled employees (Employee #9). Findings include: Employee #9 Employee #9 was hired as the Minimum Data Set (MDS) Coordinator on 08/16/2021. Employee #9's personnel record documented infection control training was last completed on 01/25/2023. The employee's personnel record lacked documented evidence infection control training had been completed for 2024. On 04/15/2024 at 3:17 PM, the Human Resources (HR) Generalist verbalized infection control training was required to be completed upon hire and annually. The HR Generalist confirmed Employee #9 had not completed infection control training timely. The facility policy titled Long-Term Care Staff Continuing Education, reviewed 04/13/2023, documented all permanent nursing department employees shall receive infection control educational programs yearly.