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	10/18/2024

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** 40377 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a care plan was developed to address side effects and necessary monitoring for a resident with bilateral lower extremity edema for 1 of 12 sampled residents (Resident #5). This deficient practice had the potential for the resident to suffer adverse health outcomes because of staff caring for the resident being unaware of the need to monitor for signs of leg swelling. Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of bilateral primary osteoarthritis of knee. On 10/15/2024 at 11:48 AM, Resident #5 verbalized Resident #5 had swelling in both legs. Resident #5 verbalized Resident #5 was not wearing compression stockings. Resident #5's clinical record lacked documented evidence a care plan had been developed for the resident's diagnosis of bilateral primary osteoarthritis of knee and the management of the resident's bilateral leg edema. A physician's order dated 06/06/2024, documented compression stockings to bilateral limbs as needed for occasional swelling associated with bilateral primary osteoarthritis of knee. On 10/17/2024 at 11:51 AM, the Director of Nursing (DON) confirmed Resident #5's clinical record did not include a care plan for the resident's bilateral primary osteoarthritis of knee and the management of the resident's edema. The DON verbalized the compression stockings should be care planned as an intervention for the diagnosis since the hose were being placed on the resident to provide an intervention for the bilateral leg edema. The facility policy titled Baseline and Comprehensive Care Plan, revised 04/13/2023, documented the facility shall provide an individualized, interdisciplinary plan of care for all residents appropriate to the resident's needs, strengths, rules of diagnostic testing limitations and goals. The care plan shall describe the services to be furnished to attain or maintain the resident's highest practical physical well-being.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35601 Based on interview, clinical record review, and document review, the facility failed to ensure comprehensive care plans were revised to include the physician identified behaviors for the administration of a psychotropic medication for 1 of 12 sampled residents (Resident #2) and new interventions for the prevention of falls for 2 of 12 sampled residents (Resident #23 and #25). Findings include: Resident #2 Resident #2 was admitted on [DATE], and readmitted on [DATE], with diagnoses including major depressive disorder, recurrent, unspecified and vascular dementia, moderate with mood disturbances. Resident #2's psychotropic physician's orders dated 02/15/2024, documented the following: -Seroquel Oral Tablet 25 milligrams (mg), give one tablet by mouth in the afternoon for low mood, anxiety, paranoid ideation related to major depressive disorder, recurrent, unspecified. -Cymbalta Oral Capsule Delayed Release Particles 30 mg, give one capsule by mouth two times a day for low mood, anxiety, paranoid ideation related to major depressive disorder, recurrent, unspecified. Resident #2's care plans documented the following focus areas related to psychotropic medications: -Resident #2 had a behavior history of self-isolation, sense of doom, crying/tearful episodes, anxious related to (r/t) major depressive disorder, initiated 03/05/2023 and revised 10/09/2024. -Resident #2 used psychotropic medications r/t major depressive disorder with behaviors. Resident #2 had a history of fearfulness, crying, tearfulness, anxious, self isolation, sense of doom and agitation, initiated 09/13/2023 and revised 10/09/2024. Resident #2's care plans lacked evidence of the paranoid ideation indicated in the physician ordered psychotropic medications. On 10/17/2024 at 3:45 PM, the Director of Nursing (DON) confirmed the behaviors indicated by the physician on the psychotropic medication orders did not match the behaviors documented by the nurses on the care plan for Resident #2 and the care plans lacked paranoid ideation as a behavior exhibited by the resident. The facility policy titled Baseline and Comprehensive Care Plan, last reviewed 04/13/2023, documented any resident receiving any type of psychotropic medication shall have a resident specific care plan which includes identification of resident specific targeted behaviors Cross reference F tag 758 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbances and major depressive disorder, single episode, severe without psychotic features. On 10/15/2024 at 10:50 AM, Resident #23 recalled having fell off the bed and the resident's knees hurt from the fall. On 10/16/2024 at 2:15 PM, Resident #23 stood up from the resident's bed, physically moved a wheelchair out of the way, walked around the bed from the left side to the right side while bracing self with right hand on the bed, retrieved the resident's walker and ambulated to the bathroom. Resident #23's Progress Notes documented the following: -10/08/2024 The resident was impulsive and forgetful and had poor safety awareness. The resident was on the edge of the bed, moved forward and slid from the bed with no injury . consistent reminders offered to resident to ask for assistance. -10/09/2024 Interdisciplinary Team (IDT) and Root Cause analysis, resident was in room and slid from bed, no injury, all parties notified. Root cause resident was impulsive and had intermittent confusion and was ambulatory but overestimates abilities at times. Resident was educated and verbalized understanding of call light use and safety but was non-compliant. Will attempt to discuss grip strips with maintenance as resident at times had slipper socks on but the grip did not prevent sliding, care plan would be reviewed, no injury or pain noted. On 10/18/2024 at 8:50 AM, Resident #23's room lacked grip strips on the floor as indicated in the IDT progress notes. Resident #23's comprehensive care plan initiated and revised on 09/17/2024, documented a focus area for high risk for falls r/t confusion, conditioning, gait/balance problems, poor communication/comprehension, unaware of safety needs and history of falling. On 10/18/2024 at 9:12 AM, the DON explained Resident #23 had attempted to self transfer out of bed when the resident fell . The resident had leaned forward and slipped because the grip on the resident's socks was not enough to prevent sliding. The resident had difficulty with safety awareness. The facility had not applied grip tape as indicated by the IDT as a possible intervention and confirmed the tape was not available at the facility and had not been ordered. On 10/18/2024 at 9:19 AM , the DON verbalized the facility should have updated Resident #23's care plan with new interventions or revised past interventions after the fall on 10/08/2024. The DON confirmed new interventions had not been initiated or revised on the care plan to prevent future falls. Resident #25 Resident #25 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25's Progress Notes documented the following: -09/14/2024 Post Fall Evaluation Fall Details: Date / Time of Fall: 09/14/2024 2:20 PM, Fall was not witnessed. Fall occurred in the resident's room. Activity at the time of fall: Resident cannot recall activity at time of fall. The reason for the fall was not evident .Resident was heard screaming down the hall and was found laying next to the resident's bed, on the ground, with head towards foot of the bed. Resident with no visible injuries. Denied hitting head but cannot recall how the resident fell or what the resident was doing . Bed alarm was not going off and call light was not on. New bed alarm placed. Resident returned to bed, educated and reminded to use the call light for assistance .Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall . -09/25/2024 Post Fall Evaluation Fall Details: Date / Time of Fall: 09/25/2024 2:05 PM, Fall was not witnessed. Fall occurred in the resident's room. Resident was attempting to self toilet at time of the fall. The reason for the fall was not evident .Fall Details Note: Resident with unwitnessed fall in room. Resident found face down on the ground, head towards foot of the bed. Resident was assessed by Registered Nurse (RN) and DON for injures or any deformities. No visual sign of injury. Resident assisted back into bed by RN and Certified Nursing Assistant (CNA.) Resident denied hitting head. Reported no pain. Resident attempted to self-transfer out of bed and admitted to needing to use the restroom. Vital signs within defined limits. Bed alarm in place. Contributing Factors: .Footwear at time of fall: Socks. Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall .-10/06/2024 Post Fall Evaluation Late Entry: Date / Time of Fall: 10/06/2024 6:30 PM, Fall was not witnessed. Fall occurred in the resident's room. Activity at the time of fall: Resident stated was trying to get self back to bed from sitting at side of bed eating dinner. Reason for the fall was evident. Reason for fall: Resident tried to get self back into bed. Resident denied utilizing call light for assistance . Contributing factors note: Patient denied utilizing call light for staff assistance when they were finished with meal. -10/07/2024 Fall Root cause analysis and IDT: Resident was impulsive and had poor safety awareness .The resident overestimated abilities and often became anxious and impatient during care provision .The resident denied any pain related to fall and stated the resident will attempt to be more patient and ask for assistance due to cognitive decline related to resident's condition, staff will continue to offer frequent reminders on safety past fall follow up indicated this fall was not the result of abuse or neglect. The care plan had been reviewed and updated to reflect interventions to assist in fall prevention for the resident. Resident #25's comprehensive care plan initiated on 04/30/2024 and revised on 07/02/2024, documented a focus area for high risk for falls r/t gait/balance problems and history of falling. The care plan contained one intervention post falls in September, initiated 09/17/2024: Physical Therapy/Occupational Therapy (PT/ OT) evaluate and treat as ordered or as needed (PRN.) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25's Alert Note dated 10/09/2024, documented the prior Director of Nursing initiated potential to utilize trapeze as an intervention for the resident related to falls, upon reviewing this with therapy and nursing staff and the resident, it had been determined this was an ineffective intervention and the resident would not receive any benefit related to bed mobility with a trapeze, this is an ineffective intervention. Therapy did not have a suggestion for equipment related to fall intervention, to assist in fall will have staff provide frequent checks and encourage resident to be in visual areas while awake to assist in fall prevention at this time. On 10/18/24 at 9:28 AM, the DON explained Resident #25 had impulse control problems and had quite a few falls. It was almost behavioral, the resident gets impatient and tries to get out of bed. On 10/18/2024 at 9:35 AM, the DON confirmed implementing new interventions after the 10/06/2024 fall. The previous DON wanted to do a trapeze as an intervention after one of the falls in September but did not get an evaluation from PT/OT. The current DON had a verbal meeting with PT/OT and they said no, the trapeze was not approriate and had no other interventions. The intervention for the trapeze was not on the care plan. The care plan did not reflect interventions post falls from 09/14/2024 and 09/25/2024 to prevent future falls. The PT/OT eval, post fall, did not derive new interventions. The facility policy titled Falls and Fall Prevention, last revised 05/2024, documented extra measures were to be on the care plan for fall prevention. The facility policy titled Baseline and Comprehensive Care Plan, last reviewed 04/13/2023, documented all staff using the plan of care shall be responsible for interdisciplinary collaboration to establish goals and appropriate interventions as well as ongoing evaluation and revisions. Cross reference F tag 689

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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** 35601 Based on interview, clinical record review and document review, the facility failed to ensure fall prevention interventions were initiated post-fall as a result of the root cause analysis of the falls for 2 of 12 sampled residents (Resident #23 and #25). This deficient practice had the potential for a resident to fall with serious injury. Findings include: Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbances and major depressive disorder, single episode, severe without psychotic features. On 10/15/2024 at 10:50 AM, Resident #23 recalled having fell off the bed and the resident's knees hurt from the fall. On 10/16/2024 at 2:15 PM, Resident #23 stood up from the resident's bed, physically moved a wheelchair out of the way, walked around the bed from the left side to the right side while bracing self with right hand on the bed, retrieved the resident's walker and ambulated to the bathroom. Resident #23's Progress Notes documented the following: -10/08/2024 The resident was impulsive and forgetful and had poor safety awareness. The resident was on the edge of the bed, moved forward and slid from the bed with no injury . consistent reminders offered to resident to ask for assistance. -10/09/2024 Interdisciplinary Team (IDT) and Root Cause analysis, resident was in room and slid from bed, no injury, all parties notified. Root cause resident was impulsive and had intermittent confusion and was ambulatory but overestimates abilities at times. Resident was educated and verbalized understanding of call light use and safety but was non-compliant. Will attempt to discuss grip strips with maintenance as resident at times had slipper socks on but the grip did not prevent sliding, care plan would be reviewed, no injury or pain noted. On 10/18/2024 at 8:50 AM, Resident #23's room lacked grip strips on the floor as indicated in the IDT progress notes. Resident #23's comprehensive care plan initiated and revised on 09/17/2024, documented a focus area for high risk for falls related to (r/t) confusion, conditioning, gait/balance problems, poor communication/comprehension, unaware of safety needs and history of falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/2024 at 9:12 AM, the Director of Nursing (DON) explained Resident #23 had attempted to self transfer out of bed when the resident fell . The resident had leaned forward and slipped because the grip on the resident's socks was not enough to prevent sliding. The resident had difficulty with safety awareness. The facility had not applied grip tape as indicated by the IDT as a possible intervention and confirmed the tape was not available at the facility and had not been ordered. On 10/18/2024 at 9:19 AM , the DON verbalized the facility should have updated Resident #23's care plan with new interventions or revised past interventions after the fall on 10/08/2024. The DON confirmed new interventions had not been initiated or revised on the care plan to prevent future falls. On 10/18/2024 at 9:21 AM, the DON confirmed the Morse scale evaluation had not been completed post fall for Resident #23. The DON explained the Morse scale evaluation would be used to determine if the resident had a decline and why the resident had fallen. The facility would complete another evaluation quarterly to determine if increase in functionality had occurred and to ensure no functional issue or decline had occurred. The Morse scale evaluation was required to be completed post fall. Resident #25 Resident #25 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. Resident #25's Progress Notes documented the following: -09/14/2024 Post Fall Evaluation Fall Details: Date / Time of Fall: 09/14/2024 2:20 PM, Fall was not witnessed. Fall occurred in the resident's room. Activity at the time of fall: Resident cannot recall activity at time of fall. The reason for the fall was not evident .Resident was heard screaming down the hall and was found laying next to the resident's bed, on the ground, with head towards foot of the bed. Resident with no visible injuries. Denied hitting head but cannot recall how the resident fell or what the resident was doing . Bed alarm was not going off and call light was not on. New bed alarm placed. Resident returned to bed, educated and reminded to use the call light for assistance .Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall . -09/25/2024 Post Fall Evaluation Fall Details: Date / Time of Fall: 09/25/2024 2:05 PM, Fall was not witnessed. Fall occurred in the resident's room. Resident was attempting to self toilet at time of the fall. The reason for the fall was not evident .Fall Details Note: Resident with unwitnessed fall in room. Resident found face down on the ground, head towards foot of the bed. Resident was assessed by Registered Nurse (RN) and DON for injures or any deformities. No visual sign of injury. Resident assisted back into bed by RN and Certified Nursing Assistant (CNA.) Resident denied hitting head. Reported no pain. Resident attempted to self-transfer out of bed and admitted to needing to use the restroom. Vital signs within defined limits. Bed alarm in place. Contributing Factors: .Footwear at time of fall: Socks. Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/06/2024 Post Fall Evaluation Late Entry: Date / Time of Fall: 10/06/2024 6:30 PM, Fall was not witnessed. Fall occurred in the resident's room. Activity at the time of fall: Resident stated was trying to get self back to bed from sitting at side of bed eating dinner. Reason for the fall was evident. Reason for fall: Resident tried to get self back into bed. Resident denied utilizing call light for assistance . Contributing factors note: Patient denied utilizing call light for staff assistance when they were finished with meal. -10/07/2024 Fall Root cause analysis and IDT: Resident was impulsive and had poor safety awareness .The resident overestimated abilities and often became anxious and impatient during care provision .The resident denied any pain related to fall and stated the resident will attempt to be more patient and ask for assistance due to cognitive decline related to resident's condition, staff will continue to offer frequent reminders on safety past fall follow up indicated this fall was not the result of abuse or neglect. The care plan had been reviewed and updated to reflect interventions to assist in fall prevention for the resident. Resident #25's comprehensive care plan initiated on 04/30/2024 and revised on 07/02/2024, documented a focus area for high risk for falls r/t gait/balance problems and history of falling. The care plan contained one intervention post falls in September, initiated 09/17/2024: Physical Therapy/Occupational Therapy (PT/ OT) evaluate and treat as ordered or as needed (PRN.) Resident #25's Alert Note dated 10/09/2024, documented the prior Director of Nursing initiated potential to utilize trapeze as an intervention for the resident related to falls, upon reviewing this with therapy and nursing staff and the resident, it had been determined this was an ineffective intervention and the resident would not receive any benefit related to bed mobility with a trapeze, this is an ineffective intervention. Therapy did not have a suggestion for equipment related to fall intervention, to assist in fall will have staff provide frequent checks and encourage resident to be in visual areas while awake to assist in fall prevention at this time. On 10/18/2024 at 9:28 AM, the DON explained Resident #25 had impulse control problems and had quite a few falls. It was almost behavioral, the resident gets impatient and tries to get out of bed. On 10/18/2024 at 9:35 AM, the DON confirmed implementing new interventions after the 10/06/2024 fall. The previous DON wanted to do a trapeze as an intervention after one of the falls in September but did not get an evaluation from PT/OT. The current DON had a verbal meeting with PT/OT and they said no, the trapeze was not approriate and had no other interventions. The intervention for the trapeze was not on the care plan. The care plan did not reflect interventions post falls from 09/14/2024 and 09/25/2024 to prevent future falls. The PT/OT eval, post fall, did not derive new interventions. The facility policy titled Falls and Fall Prevention, last revised 05/2024, documented extra measures were to be on the care plan for fall prevention and Morse scale completed post fall. Cross reference F tag 657

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 30748 Based on interview and personnel record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had an annual performance evaluation completed timely for 3 of 4 CNAs employed greater than one year, sampled for personnel record review (Employee #3, #8 and #9). Findings include: Employee #3 Employee #3 was hired as the Activity Director/CNA with a start date of 02/08/2018. Employee #3's personnel record documented the CNA had an annual performance evaluation last completed on 05/22/2023. Employee #3's personnel record lacked documented evidence a performance evaluation was completed in May 2024. Employee #8 Employee #8 was hired as a CNA with a start date of 07/20/2022. Employee #8's personnel record documented the CNA had an annual performance evaluation last completed on 04/28/2023. Employee #8's personnel record lacked documented evidence a performance evaluation was completed in April 2024. Employee #9 Employee #9 was hired as a CNA with a start date of 04/17/2013. Employee #9's personnel record documented the CNA had an annual performance evaluation last completed on 06/03/2023. Employee #9's personnel record lacked documented evidence a performance evaluation was completed in June 2024. On 10/16/2024 at 11:32 AM, the Human Resources Director was unable to provide evidence Employee #3, #8 and #9 had an annual performance evaluation completed for 2024 and verbalized the CNA annual performance evaluations were to be completed annually by the anniversary date of hire. The Human Resources Director confirmed the CNA annual performance evaluations were not completed for Employee #3, #8 and #9 annually for 2024. The facility policy titled Long Term Care Staff Continuing Education, last reviewed 04/13/2024, documented CNAs would receive annual evaluation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 ordered medications were available for 1 of 5 residents observed for medication administration (Resident #6) and have a procedure in place for the safe procurement of drugs and biologicals. Findings include: Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including dry eye syndrome of bilateral lacrimal glands and abnormal results of other function studies of the eye. Resident #6's October 2024 Medication Administration Record (MAR) documented Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day for cataract inflammation. The order date was 09/10/2024. The medication was documented as 9 on the following dates for the 8:00 AM medication pass: -10/11/2024 -10/16/2024 -10/17/2024 The medication was documented as 9 on the following dates for the 8:00 PM medication pass: -10/10/2024 -10/12/2024 -10/13/2024 -10/14/2024 -10/15/2024 -10/16/2024 The MAR chart code documented a 9 equated to other, see progress notes. Resident #6's Orders Administration Notes documented the following: -Effective date 10/10/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. On order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Effective date 10/11/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. Awaiting medication delivery. -Effective date 10/12/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. On order, awaiting delivery. -Effective date 10/13/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. Awaiting delivery. -Effective date 10/14/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. Still awaiting pharmacy delivery. -Effective date 10/15/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. On order. -Effective date 10/16/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. Awaiting medication delivery. -Effective date 10/17/2024, Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day. Awaiting pharmacy delivery. On 10/18/2024 at 8:30 AM, during an interview with the Director of Nursing (DON) and a Registered Nurse (RN), the DON confirmed Resident #6 had not received ordered doses of Restasis Ophthalmic Emulsion eye drops due to the medication being unavailable in the facility and on order from the pharmacy. The DON explained the DON was aware the Restasis eye drops were not available in the facility and had contacted the facility's pharmacy multiple times to request a refill of the medication. The RN reviewed Resident #6's clinical record and explained the medication had been unavailable in the facility since 10/10/2024. On 10/18/2024 at 11:40 AM, during an interview with the Administrator and the DON, the Administrator explained the facility did not have a documented policy or procedure in place for the safe procurement of drugs and biologicals for residents. The facility document titled Consultant Pharmacist Agreement, effective 10/01/2024, documented the consultant pharmacist was to assist the facility with the implementation of policies and procedures for the safe procurement of drugs and biologicals. Cross reference F tag 759

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35601 Based on interview, clinical record review, and document review, the facility failed to ensure behaviors monitored were associated with the specific condition indicated by the physician for the use of psychotropic medications for 1 of 12 sampled residents (Resident #2) and physician ordered psychotropic medications had a specific condition documented for indication of use associated with the diagnoses for 5 of 12 sampled residents (Resident #23, #25, #5, #12, and #24). Findings include: Resident #2 Resident #2 was admitted on [DATE], and readmitted on [DATE], with diagnoses including major depressive disorder, recurrent, unspecified and vascular dementia, moderate with mood disturbances. Resident #2's psychotropic physician's orders, dated 02/15/2024, documented the following: -Seroquel oral tablet 25 milligrams (mg), give one tablet by mouth in the afternoon for low mood, anxiety, paranoid ideation related to major depressive disorder, recurrent, unspecified. -Cymbalta oral capsule delayed release particles 30 mg, give one capsule by mouth two times a day for low mood, anxiety, paranoid ideation related to major depressive disorder, recurrent, unspecified. Resident #2's care plans documented the following focus areas related to psychotropic medications: -Resident #2 had a behavior history of self-isolation, sense of doom, crying/tearful episodes, anxious related to (r/t) major depressive disorder, initiated 03/05/2023 and revised 10/09/2024. -Resident #2 used psychotropic medications r/t major depressive disorder with behaviors. Resident #2 had a history of fearfulness, crying, tearfulness, anxious, self isolation, sense of doom and agitation, initiated 09/13/2023 and revised 10/09/2024. An intervention included to monitor for effectiveness by charting every shift behavior monitoring in Point of Care (POC) and/or additional behavior monitoring in progress notes of electronic Medication Administration Record (eMAR). Resident #2's behavior monitoring in the eMAR instructed the nurse to document behavior monitoring every day and night shift related to major depressive disorder, recurrent, unspecified. On 10/15/2024, the resident had behaviors twice on the day shift. The documentation was indicated with yes. On 10/17/2024 at 2:29 PM, the Director of Nursing (DON) verbalized the behavior monitoring on the eMAR was not personalized to each resident for the specific psychotropic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2024 at 3:45 PM, the DON confirmed Resident #2 did not have any documented evidence of the behaviors exhibited on 10/15/2024 or the behaviors monitored were related to the behaviors identified for the administration of the psychotropic medications. The behavior monitoring was entered by nurses in the eMAR and the physician signed after it was entered. The nurses had been using the diagnosis on the psychotropic medication as the behavior to be monitored and did not add specific behaviors related to the medication, as identified by the physician. The facility policy titled Psychotropics Medications, reviewed 04/14/2023, documented daily monitoring of psychotropic medications were to include the presence and frequency of resident-specific targeted behaviors. Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbances and major depressive disorder, single episode, severe without psychotic features. Resident #23's psychotropic physician's order dated 09/12/2024, documented the following: -Venlafaxine Hydrochloric Acid (HCl) extended release oral tablet 24 hour 75 mg, give 75 mg by mouth, one time a day related to major depressive disorder, single episode, severe without psychotic features. -Divalproex Sodium oral tablet delayed release 250 mg, give 250 mg by mouth, two times a day related to other headache syndrome and major depressive disorder, single episode, severe without psychotic features. Resident #25 Resident #25 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. Resident #25's psychotropic physician's order dated 05/01/2024, documented Citalopram Hydrobromide oral tablet 20 mg, give 20 mg by mouth, one time a day related to major depressive disorder, recurrent, unspecified. 40377 Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of depressive disorder, recurrent, unspecified. Resident #5's psychotropic physician's order dated 10/05/2024, documented Mirtazapine 15 mg oral tablet, give 15 mg by mouth at bedtime related to depressive disorder, recurrent, unspecified. Resident #12 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of unspecified psychosis not due to a substance or known physiological condition. Resident #12's psychotropic physician's order dated 07/23/2024, documented Olanzapine 2.5 mg oral tablet, give 2.5 mg by mouth at bedtime related to unspecified psychosis not due to a substance or known physiological condition. 49557 Resident #24 Resident #24 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. Resident #24's psychotropic physician's order dated 01/22/2024, documented Fluoxetine HCl oral capsule 40 mg, give 40 mg by mouth at bedtime related to major depressive disorder, recurrent, unspecified. On 10/17/2024 at 3:23 PM, the Director of Nursing (DON) explained physician orders for psychotropic medications were required to include the specific behaviors and/or symptoms the medication was ordered for. On 10/17/2024 at 3:45 PM, the DON confirmed the physician had not been identifying specific behaviors related to the administration of the psychotropic medications. Nurses were entering behaviors on care plans however, the physician had not indicated the targeted behaviors identified for the need for the specific psychotropic medications. The facility policy titled Psychotropics Medications, reviewed 04/14/2023, documented psychotropic medications were drugs effecting brain activities associated with mental processes and behavior. The interdisciplinary team would determine the lowest possible effective dose in managing identified behaviors. The provider's order would include the reason for the psychotropic being ordered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **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 medications were administered with an error rate of less than five percent (%). There were 29 opportunities and two medication errors. The medication error rate was 6.9%. Findings include: Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including heart failure, unspecified, dry eye syndrome of bilateral lacrimal glands, and abnormal results of other function studies of the eye. On 10/17/2024 at 8:08 AM, a Registered Nurse (RN) began preparing medications for Resident #6. The RN verbalized the physician ordered Restasis Ophthalmic Emulsion eye drops were not available in the facility and were on order from the pharmacy. The RN verbalized Resident #6's physician ordered medications for the morning medication pass included Metoprolol 12.5 milligrams (mg). The RN compared the bubble pack containing Metoprolol to the physician order on the Medication Administration Record (MAR) then placed the bubble pack back in the medication cart. The RN did not remove the medication from the bubble pack. On 10/17/2024 at 8:14 AM, the RN locked the medication cart, grabbed the medication cup containing Resident #6's prepared medications, and began to move toward Resident #6 to administer the medications. The RN was asked to verify the number of tablets in the medication cup. After counting the number of tablets in the medication cup, the RN verbalized Resident #6's Metoprolol was not in the cup. The RN then retrieved the Metoprolol from the medication cart, placed the medication in the medication cup and administered the medications to Resident #6. On 10/17/2024 at 8:27 AM, the RN explained the RN's usual process when administering medications to residents was to retrieve the medication from the medication cart, compare it to the order on the resident's MAR, remove the medication from the medication card, and placed the medication in a medication cup. The RN verbalized the RN forgot to place Resident #6's Metoprolol in the medication cup during the morning medication pass because the RN was nervous about being observed during medication administration. Resident #6's MAR documented the following: -Restasis Ophthalmic Emulsion, instill one drop in both eyes two times a day for cataract inflammation. The order date was 09/10/2024. -Metoprolol Tartrate oral tablet 25 milligrams (mg), give one half tablet by mouth two times a day related to heart failure, unspecified and tachycardia unspecified. The order date was 09/10/2024. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/2024 at 8:30 AM, the DON explained the DON's expectation of nursing staff when administering medications to residents was to check the physician's order, verify the medication against the order, assure the resident was within parameters if applicable, punch/remove the tablet from the medication card (bubble pack), administer the medication, and document the administration. The DON confirmed medication errors included failure to administer an ordered medication (omission). The facility policy titled Medication Error Prevention and Investigation, Adverse Drug Reactions, dated 09/27/2007, documented all medications were to be administered to residents in a safe manner, according to physician's orders. Medication errors included omitting a prescribed medication. Cross reference F tag 760

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 of 5 residents reviewed for medication administration were free from significant medication errors (Resident #6). This deficient practice had the potential to cause worsening of the resident's diagnosed heart failure. Findings include: Resident #6 Resident #6 was admitted to the facility on [DATE], with a diagnosis of heart failure, unspecified. Resident #6's MAR documented Metoprolol Tartrate oral tablet 25 milligrams (mg), give one half tablet by mouth two times a day related to heart failure, unspecified and tachycardia unspecified. Nurse to hold medication if blood pressure is lower than 90/50 and/or heart rate is lower than 50. The order date was 09/10/2024. On 10/17/2024 at 8:08 AM, during medication pass observation, a Registered Nurse (RN) began preparing medications for Resident #6. The RN verbalized Resident #6's physician ordered medications for the morning medication pass included Metoprolol 12.5 milligrams (mg). The RN compared the bubble pack containing Metoprolol to the Medication Administration Record (MAR), then placed the bubble pack back in the medication cart. The RN did not remove the medication from the bubble pack. The RN explained it was safe to administer the Metoprolol as the resident's blood pressure was 96/55 and the physician's parameters indicated to hold the medication if the resident's blood pressure was less than 90/50. On 10/17/2024 at 8:14 AM, the RN locked the medication cart, grabbed the medication cup containing Resident #6's prepared medications, and began to move toward Resident #6 to administer the medications. The RN was asked to verify the number of tablets in the medications cup. After counting the number of tablets in the medication cup, the RN verbalized Resident #6's Metoprolol was not in the cup. The RN then retrieved the Metoprolol from the medication cart, placed the medication in the medication cup and administered the medications to Resident #6. On 10/17/2024 at 8:27 AM, the RN explained the RN's usual process when administering medications to residents was to retrieve the medication from the medication cart, compare it to the order on the resident's MAR, remove the medication from the medication card, and placed the medication in a medication cup. The RN verbalized the RN forgot to place Resident #6's Metoprolol in the medication cup during the morning medication pass because the RN was nervous about being observed during medication administration. The RN explained if a resident did not receive the resident's physician ordered Metoprolol, the resident's blood pressure could elevate and the resident could suffer a cerebrovascular accident (stroke). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/2024 at 8:30 AM, the DON explained the DON's expectation of nursing staff when administering medications to residents was to check the physician's order, verify the medication against the order, punch/remove the tablet from the medication card (bubble pack), administer the medication, and document the administration. The DON explained it was important to assure the resident was within parameters if applicable, such as with blood pressure medications, to assure it was safe to administer the medication. The DON confirmed medication errors included failure to administer an ordered medication (omission). Epocrates (online drug database) - Metoprolol Tartrate, version 19.01, revised 08/09/2023, documented Metoprolol Tartrate was used to treat hypertension (high blood pressure) and to lower risk of death or needing to be hospitalized for heart failure. Anyone taking Metroprolol Tartrate was to follow all directions on the prescription label and use the medication exactly as directed. Metoprolol Tartrate should not be stopped suddenly as stopping the medication suddenly could make the condition for which it was prescribed worse. The facility policy titled Medication Error Prevention and Investigation, Adverse Drug Reactions dated 09/27/2007, documented all medications were to be administered to residents in a safe manner, according to physician's orders. Medication errors included omitting a prescribed medication. Cross reference F tag 759

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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** 50210 Based on interview, clinical record review, and document review, the facility failed to ensure psychotropic behavior monitoring was documented on the Behavioral Health (BH) Record for 6 of 12 sampled residents (Resident #2, #5, #11, #12, #24, and #25) and records were accurate for 1 of 5 residents observed during medication administration (Resident #6). Findings include: Incomplete Records Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. A physician order dated 02/18/2024, documented behavior monitoring every day and night shift related to major depressive disorder, recurrent, unspecified. Resident #2's October 2024 BH Record documented behavior monitoring every day and night shift related to major depressive disorder, recurrent, unspecified. The BH record had blank spaces for behavioral monitoring during the day shift on 10/03/2024 and 10/13/2024. Resident #2's clinical record lacked documented evidence behavioral monitoring was completed during the day shift on 10/03/2024 and 10/13/2024. Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. A physician order dated 02/04/2024, documented monitor behaviors every shift: verbal outbursts, tearfulness, social isolation, and negative statements every day and night shift for behavior monitoring. Resident #5's October 2024 BH Record documented monitor behaviors every shift: verbal outbursts, tearfulness, social isolation, and negative statements every day and night shift for behavior monitoring. The BH record had blank spaces for behavioral monitoring during the day shift on 10/13/2024. Resident #5's clinical record lacked documented evidence behavioral monitoring was completed during the day shift on 10/13/2024. Resident #11 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance. A physician order dated 09/10/2024, documented behavior monitoring every day and night shift. Resident #11's October 2024 BH Record documented behavior monitoring every day and night shift. The BH record had blank spaces for behavioral monitoring during the day shift on 10/03/2024 and 10/13/2024. Resident #11's clinical record lacked documented evidence behavioral monitoring was completed during the day shift on 10/03/2024 and 10/13/2024. Resident #12 Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of personal history of traumatic brain injury and mood disorder due to known physiological condition with mixed features. A physician order dated 09/10/2024, documented behavior monitoring every day and night shift related to personal history of traumatic brain injury and mood disorder due to known physiological condition with mixed features. Resident #12's October 2024 BH Record documented behavior monitoring every day and night shift related to personal history of traumatic brain injury and mood disorder due to known physiological condition with mixed features. The BH record had blank spaces for behavioral monitoring during the day shift on 10/03/2024 and 10/13/2024. Resident #12's clinical record lacked documented evidence behavioral monitoring was completed during the day shift on 10/03/2024 and 10/13/2024. Resident #24 Resident #24 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified, generalized anxiety disorder, and major depressive disorder, recurrent, unspecified. A physician order dated 09/10/2024, documented behavior monitoring every day and night shift related to Alzheimer's disease, unspecified, generalized anxiety disorder, and major depressive disorder. Resident #24's October 2024 BH Record documented behavior monitoring every day and night shift related to Alzheimer's disease, unspecified, generalized anxiety disorder, and major depressive disorder. The BH record had blank spaces for behavioral monitoring during the day shift on 10/03/2024 and 10/13/2024. Resident #24's clinical record lacked documented evidence behavioral monitoring was completed during the day shift on 10/03/2024 and 10/13/2024. Resident #25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. A physician order dated 04/30/2024, documented every shift behavioral monitoring. Every day and night shift related to major depressive disorder, recurrent, unspecified. Resident #25's October 2024 BH Record documented every shift behavioral monitoring. Every day and night shift related to major depressive disorder, recurrent, unspecified. The BH record had blank spaces for behavioral monitoring during the day shift on 10/03/2024 and 10/13/2024. Resident #25's clinical record lacked documented evidence behavioral monitoring was completed during the day shift on 10/03/2024 and 10/13/2024. On 10/17/2024 at 2:29 PM, the Director of Nursing (DON) confirmed spaces were left blank during the day shift on 10/03/2024 and 10/13/2024 and verbalized the nurse may have forgotten to document monitoring on 10/03/2024 and 10/13/2024. On 10/18/2024 at 11:10 AM, the DON verbalized behavior monitoring should be documented immediately after observation. 49557 Inaccurate Records Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including dry eye syndrome of bilateral lacrimal glands, and abnormal results of other function studies of the eye. Resident #6's MAR documented Restasis Ophthalmic Emulsion eyes drops were administered to Resident #6 during the 8:00 AM medication pass from 10/12/2024 through 10/15/2024. Orders Administration notes dated 10/10/2024 through 10/17/2024 documented Resident #6's Restasis Ophthalmic Emulsion eye drops were on order, awaiting delivery from the pharmacy. On 10/18/2024 at 8:30 AM, during an interview with the DON and a Registered Nurse (RN), the DON verbalized Resident #6 had not received ordered doses of Restasis Ophthalmic Emulsion eye drops due to the medication being unavailable in the facility and on order from the pharmacy. The DON explained the DON was aware the Restasis eye drops were not available in the facility and had contacted the facility's pharmacy multiple times to request a refill of the medication. The RN reviewed Resident #6's clinical record and explained the medication had been unavailable in the facility since 10/10/2024. The DON explained the DON had administered medications to Resident #6 during the 8:00 AM medication pass from 10/12/2024 through 10/14/2024. The DON verbalized the Restasis eye drops were not available, and the DON documented the medication as administered in error. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration, reviewed 04/13/2023, documented facility staff would ensure safe resident medication administration by using the seven rights for medication administration. The seven rights for medication administration included right documentation. Documentation of medication administration would be completed after administering the medication to the resident.