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	04/17/2025

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** 31739 Based on clinical record review, interview and document review, the facility failed to ensure the accuracy of Minimum Data Set 3.0 (MDS) assessments for 2 of 12 sampled residents (Resident #1 and #9). This deficient practice had the potential to deprive the residents of person-centered care plans and the associated interventions relative to their current health management needs. Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. Resident #1's quarterly MDS assessment dated [DATE], Section N0415 (Medications-High-risk Drug Classes: Use and Indication, C. Antidepressant), documented Resident #1 had been administered an antidepressant medication within the prior seven-day look-back period. A physician's order dated 04/22/2024, documented SEROquel oral tablet 25 milligrams (mg), give 25 mg by mouth at bedtime for anxiety, paranoid ideation, agitation related to major depressive disorder, recurrent, unspecified. The medication had a discontinue date of 09/10/2024. Resident #1's physician orders lacked documentation an antidepressant medication was currently ordered. Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including aphasia following cerebral infarction, unspecified intellectual disabilities, other abnormalities of gait and mobility, and a history of falling. Resident #9's quarterly MDS assessment dated [DATE], Section P0200 (Restraints and Alarms: Alarms, C. Floor mat alarm), documented a floor mat alarm had been used daily within the prior seven-day look-back period. Resident #9's physician orders lacked documentation a floor mat alarm had been ordered. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/2025 at 1:51 PM, Resident #9 was in bed with the bed in a low position. The floor and area around the bed was absent of any floor mats or floor mat alarms. On 04/16/2025 at 2:04 PM, the Director of Nursing (DON) confirmed Resident #1 had not been currently ordered or administered an antidepressant. The DON confirmed Resident #9 did not have a floor mat alarm, and verbalized the facility did not have any, nor had they every used floor mat alarms. The DON confirmed the MDS entries for each resident's last quarterly assessment had been coded incorrectly and the facility followed the Resident Assessment Instrument Manual to complete the assessment process. The facility policy titled, Comprehensive Assessment and Reassessment, reviewed 10/30/2024, documented assessments would be individualized to meet the needs of the resident and must accurately reflect the resident's status.

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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 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** 43310 Based on observation, clinical record review, interview and document review the facility failed to ensure 1) an order was obtained for the application of pressure redistribution/heel protector boots (heel boots) prior to applying heel boots and 2) failed to ensure the heel boots were correctly applied with the potential to cause a pressure injury (PI) or deep tissue injury (DTI) to the resident's heels for 1 of 12 sampled residents (Resident #14). Findings include: Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, and anxiety, foot drop, unspecified foot, and pain in left lower leg. On 04/14/2025 at 1:52 PM, Resident #14 was resting in bed with a pair of heel boots placed under the resident's feet. The heel boots were not fastened to help ensure appropriate placement and the resident's heels were resting on the inner surface of the heel boots and were not positioned over the pressure redistribution opening in the heel of the boot. On 04/16/2025 at 3:41 PM, Resident #14 was resting in bed with a pair of heel boots placed under the resident's feet. The heel boots were not fastened and the resident's heels were not aligned with the pressure redistribution opening in the heel of the boots. Resident #14's clinical record did not include an order for the use and monitoring of heel boots. The resident's Treatment Administration Record (TAR) did not include monitoring for the use of heel boots and the resident's clinical record lacked documented evidence the resident's heels had been assessed/monitored for PI/DTI related to the use of the heel boots. On 04/16/2025 at 3:44 PM, a Registered Nurse (RN) verbalized due to a past trauma Resident #14's feet were very sensitive and the resident could not tolerate anything touching the tops of the resident's feet and did not like to have the heel boots fastened. The RN explained the heel boots were used prophylactically to prevent PI/DTI due to the resident was in bed most of the time. On 04/16/2025 at 3:46 PM, The RN verbalized both nurses and Certified Nursing Assistants applied the heel boots. The RN explained to apply the boots staff raised up the resident's leg and place the heel boots under the resident's feet. The heel boots were left unstrapped because the resident did not like to have the heel boots fastened due to sensitivity in the resident's feet. The RN verbalized the use of the pressure redistribution heel boots required a physician's order and confirmed Resident #14's clinical record lacked documented evidence of an order for the use of the heel boots. On 04/16/2025 at 3:53 PM, the Director of Nursing (DON) verbalized the facility required orders for all equipment used for resident care including the heel boots. The DON confirmed Resident #14's clinical record did not include an order for the use of pressure redistribution boots and confirmed an order should have been in place prior to the application of the heel boots. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/2025 at 3:58 PM, the DON explained heel boots were generally used when residents were in bed to protect the resident's heels from skin break down including PI and DTI. The DON confirmed when heel boots were applied, the resident's heel were to be positioned over the opening in the heel of the boot. On 04/16/2025 at 4:19 PM, Resident #14 was resting in bed with heel boots placed under the resident's feet, the boots were not fastened, and the resident's heels were not resting within the opening of the heel boots. The resident's heel and foot was resting on the inner surface of the boots. The DON confirmed the heel boots were not correctly applied. On 04/16/2025 at 4:28 PM, the DON confirmed Resident #14's clinical record did not include an order for the use of heel boots and confirmed a physician's order should have been obtained prior to the use of the heel boots. The DON verbalized the correct application of the boots required the resident's heels to be placed in the opening of the heel of the boots. The DON confirmed the heel boots had not been correctly applied for Resident #14. The DON confirmed when a resident's heels were not correctly aligned within the opening of the heel of the boots, pressure was being applied to the resident's heels and had the potential to cause the resident to develop a PI or DTI. The facility policy titled Skin Integrity and Injury Prevention, dated 03/15/2022, documented pressure injury prevention included managing pressure. Pressure was managed by providing appropriate support surfaces an off-loading heels by using pillows or positioning boots. The facility policy titled Written, Verbal, Electronic Physician Orders, reviewed 10/28/2024, documented orders for resident treatment were carried out only when given by a qualified physician or other duly licensed person authorized to prescribe. All orders for treatment included the type of treatment, specific requirements, and frequency of the treatment. The healthcare professional implementing the order documented the order was implemented in the appropriate section of the resident's clinical record.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 31739 Based on personnel record review, interview and document review, the facility failed to ensure initial behavioral health care training was completed timely per facility policy for 1 of 20 sampled employees (Employee #9). This deficient practice had the potential to prevent residents with behavioral health care needs from attaining or maintaining their highest practicable physical, mental and psychosocial well-being. Findings include Employee #9 Employee #9 was hired as the Minimum Data Set 3.0 Registered Nurse on 02/25/2025. Employee #9's personnel record lacked documented evidence of behavioral health care training. On 04/16/2025 at 11:05 AM, the Human Resources Director confirmed Employee #9's start date of 02/25/2025, and Employee #9 had not yet completed behavioral health care training. The Human Resources Director verbalized all employees were to have completed the training per the facility's policy. On 04/16/2025 at 11:41 AM, the Administrator verbalized not having been aware Employee #9 was required to complete the training. The facility policy titled, Employee Compliance, revised 06/28/2023, documented new employees were required to complete behavioral health training within 40 hours of the candidate's start date.