

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Pershing General Hospital Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 855 6th Street Lovelock, NV 89419	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to remove a personal food item stored in a refrigerator designated for resident food, ensure a cook on tray line was not wearing a dangling earring, ensure hair coverings fully covered all hair and facial hair, and ensure a kitchen aide performed hand hygiene before returning to tray line. These deficient practices had the potential to affect the entire facility census due to improper food storage, possible cross-contamination, and an increased likelihood of foodborne illness. Findings include: Personal Food Item On 06/08/2026 at 10:12 AM, an 8.4 ounce unopened can of Red Bull original, was located in the refrigerator by the three-compartment sink. The can was undated and unlabeled. On 06/08/2026 at 10:13 AM, the Dietary Manager confirmed the Red Bull was not dated or labeled and belonged to a facility employee. The Dietary Manager verbalized having been unaware employee personal food items were not to be stored with resident food items. The facility policy titled, Nutrition Room Refrigerators, reviewed 02/25/2026, documented resident refrigerators located in Long Term Care and in nutrition rooms were reserved for resident food only and no employee food was to be stored in resident refrigerators. Earring On 06/09/2026 at 11:17 AM, the [NAME] had a black lightning bolt earring dangling below the right earlobe. The earring was approximately one inch in length. On 06/09/2026 at 12:08 PM, the Dietary Manager confirmed the [NAME] was wearing a dangling lightning bolt earring in the right earlobe while on tray line. The Dietary Manager verbalized all jewelry over a quarter of an inch should not be worn in the kitchen. The facility policy titled, Dress Code and Personnel Appearance, dated 04/01/2026, documented jewelry shall not pose a safety risk and dangling jewelry shall not be worn. Hair Coverings On 06/09/2026 at 11:18 AM, the Cook's left and right sideburn hair was uncovered and down the sides of the Cook's cheeks approximately two inches. On 06/09/2026 at 11:20 AM, the Dietary Aide/Cook had an uncovered moustache and goatee. The goatee hung approximately one inch from the Dietary Aide/Cook's chin. On 06/09/2026 at 11:23 AM, the Dietary Aide/Cook was on the tray line and prepared a cheese quesadilla for a resident. The Dietary Aide/Cook's moustache and goatee were uncovered. On 06/09/2026 at 11:24 AM, Dietary Aide #1's left and right sideburn hair was uncovered and down the sides of the Dietary Aide's cheeks approximately three inches. The sideburn hair was thick and curly. On 06/09/2026 at 12:09 PM, the Dietary Manager confirmed the Cook, the Dietary Aide/Cook and Dietary Aide #1 all had uncovered sideburns or facial hair. The Dietary Manager confirmed all hair including sideburns and facial hair should have been covered while in the kitchen. The facility policy titled, Maintenance of Sanitary Conditions, reviewed 02/25/2026, documented employees engaged in meal preparation or handling food products were to use hair nets, covering the hair line at all times. The facility policy lacked language on the use of hair nets or hair coverings for facial hair. Hand Hygiene On 06/09/2026 at 11:28 AM, Dietary Aide #2 returned to the kitchen after delivering food trays and entered the tray line prior to washing hands. On 06/09/2026 at (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11:29 AM, the Dietary Manager confirmed Dietary Aide #2 returned to the tray line without washing hands and instructed Dietary Aide #2 to wash hands before returning to the tray line. On 06/09/2026 at 12:10 PM, the Dietary Manager confirmed kitchen staff were to wash hands each time before returning to the tray line. The facility policy titled, Hand Hygiene, reviewed 03/21/2026, documented all staff were to perform effective hand hygiene by washing hands with soap and water before, during and after preparing food.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) hand hygiene was performed per facility policy during a dressing change on a gastric tube insertion site for 1 of 13 sampled residents (Resident #4), 2) a staff member's personal belongings were not stored in a drawer of the medication cart on top of tissues for resident use for 1 of 1 medication carts, and 3) personal protective equipment (PPE) was worn when touching a soiled mop pad and hand hygiene was performed prior to touching a housekeeping cart and a nutrition room door handle. This deficient practice had the potential to result in a resident developing a health care associated infection from poor hand hygiene during a dressing change and the transmission of infection from staff and environmental surfaces to residents with weakened immune systems with the potential for actual harm to residents such as sepsis or death. Findings include: Gastric Tube Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dysphagia following cerebral infarction and cerebellar stroke syndrome. An Order Summary Report for Resident #4 documented the following: Complete tube site care every day. The start date for the order was 12/05/2025. On 06/09/2026 at 2:36 PM, the Registered Nurse (RN) for Resident #5 removed the dressing from the resident's gastric tube insertion site. The RN cleaned the area around the insertion site, dried the area with dry gauze, and applied a new dressing. The RN did not perform hand hygiene or change gloves in between removing the old dressing and applying the clean dressing. The RN confirmed the RN should have performed hand hygiene and changed gloves in between removing the old dressing and applying a clean dressing. The RN confirmed the RN had not performed hand hygiene or changed gloves. On 06/09/2026 at 4:17 PM, the Director of Nursing (DON) verbalized the correct process for changing a dressing was to remove the dressing, perform hand hygiene and don new gloves and then apply the clean dressing to avoid contaminating the insertion site with bacteria from the old dressing. The facility policy titled Enteral Feeding Tube Exit Site Care, Gastrostomy and Jejunostomy, revised 12/14/2025, documented because the tube exited through the abdominal wall it required careful skin care to prevent infection. Site care included performing the following steps: Remove old dressing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Remove and discard gloves. Perform hand hygiene. Put on gloves. Medication Cart On 06/11/2026 at 9:40 AM, during a medication cart observation with the DON, the top drawer of the medication cart had a tissue box for resident use and use with dispensing medications. A staff member's cell phone and lip balm were laying on top of the tissues. The DON confirmed the items should not have been stored in the medication cart or near any items intended for resident use. The DON verbalized the personal items in the medication cart had the potential to spread bacteria or infection to residents. The Licensed Practical Nurse (LPN) confirmed the cell phone and lip balm in the top drawer of the medication cart were on top of a box of tissue for resident use and the personal items belonged to the LPN. The facility policy titled Medication Storage, reviewed 10/28/2024, documented all areas where drugs were stored would be kept dry, clean, and neat at all times. Housekeeping On 06/11/2026 at 8:29 AM, a Housekeeper was mopping the floor in room [ROOM NUMBER], the Housekeeper was not wearing gloves. The Housekeeper finished mopping floor around the resident bed closest to the door, exited the room, removed the mop pad from the mop handle, placed the pad in a plastic bag on a housekeeping cart, grabbed the cart handle, opened a binder located on top of the cart, grabbed the handle on the door to the nutrition room and opened the door. The Housekeeper did not perform hand hygiene after touching the soiled mop pad and prior to touching the cart, binder, or nutrition room door handle. On 06/11/2026 at approximately 8:35 AM, the Housekeeper verbalized the Housekeeper usually wore gloves when touching soiled mop pads and would perform hand hygiene after removing the gloves. The Housekeeper confirmed the Housekeeper was not wearing gloves when the Housekeeper removed the soiled mop pad from the mop handle and did not perform hand hygiene prior to touching the housekeeping cart, binder on the cart, and the nutrition room door handle. On 06/11/2026 at 10:19 AM, the Infection Preventionist (IP) and the DON verbalized hand hygiene was required to be performed when going in and out of resident rooms, before performing a task, after performing a task, and any time staff came in contact with a resident or object in the resident's environment. The IP's expectation of housekeeping staff when mopping floors in resident rooms included switching the mop pad between resident areas and performing hand hygiene. The IP confirmed a Housekeeper would be expected to wear gloves when removing a soiled mop pad from the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mop handle and would be expected to perform hand hygiene after touching a soiled mop pad with bare hands, prior to touching any other surface. The IP explained if staff did not wear gloves when touching soiled mop pads and did not perform hand hygiene afterward, infectious organisms could be transmitted to other people and surfaces. The facility policy titled Hand Hygiene, reviewed 03/21/2026, documented all staff who came into contact either directly with patients, or indirectly through equipment or the environment, would perform effective hand hygiene practices to minimize the risk of cross-infection to other patients, staff and visitors. Hand hygiene was the single most important activity for preventing the spread of infection. Circumstances indicating or recommended to perform hand hygiene included but were not limited to before and after exiting resident rooms and after contact with patient's surroundings.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and document review, the facility failed to ensure staff followed the facility's policy related to inventorying of residents' personal belongings and a resident was allowed to retain and use personal possessions when a fish tank was removed from the resident's room without the resident's permission and placed in a common area of the facility for 1 of 13 sampled residents (Resident #12). This deficient practice had the potential to result in emotional distress and psychosocial harm to the resident. Findings include: Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including rheumatoid arthritis, unspecified and major depressive disorder, recurrent, unspecified. Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbances, major depressive disorder, recurrent, unspecified, and age-related physical debility. Resident #26 was discharged from the facility on 09/25/2025. On 06/08/2026 in the afternoon, Resident #12 verbalized a facility staff member had removed an aquarium from the resident's room without the resident's permission. On 06/09/2026 at 11:01 AM, Resident #12 pointed to a large cylindrical fish tank in the activities room. The fish tank contained several small faux fish, was secured to the wall, and was unplugged. Resident #12 verbalized the fish tank had been removed from the resident's room a few months prior when the Activity Director (AD) had maintenance take it out and the resident wanted the fish tank back. The resident explained the fish tank previously belonged to the resident's roommate (Resident #26) and was kept in the residents' room. When the former roommate passed away, the roommate's family member gave the fish tank to Resident #12 because Resident #12 loved it. Resident #12 verbalized the fish tank was typically turned off because the noise bothered other residents. An Activity Participation Note dated 04/21/2026, documented Resident #12 was upset about the fish tank. The AD explained to Resident #12 the facility set the rules, and the resident had too many belongings in the room to fit the fish tank. It was placed in the common area for everyone to enjoy. Resident #12 was refusing to participate in activities because of this. On 06/10/2026 at 2:25 PM, the Social Worker (SW) verbalized tracking and inventorying of residents' personal items was a shared responsibility. Activities staff typically would help residents place orders for new items and once items arrived at the facility, the SW would take the items to the Unit Secretary (US) who would log the items. The SW confirmed the SW was familiar with Resident #12. The SW recalled there was a fish tank in the resident's room which originally belonged to Resident #26, who had passed away. Resident #12 asked Resident #26's family member if the resident could keep the fish tank and the family member agreed. When Resident #12 got a new roommate, facility staff let the resident know if the resident was able to find space for the fish tank and it remained safe for the resident to get in and out of bed, the fish tank could remain in the room. The SW recalled the fish tank remained in Resident #12's room from the time Resident #26 passed away in September 2025, until a new roommate moved in in April 2026. On 06/10/2026 at 2:37 PM, the US verbalized resident belongings were tracked on inventory sheets. The US confirmed the US was familiar with Resident #12 and verbalized there was a lot of debate about the fish tank. The US confirmed Resident #12 asked Resident #26's family member for the fish tank after Resident #26 passed away. The US denied having any documentation of Resident #12 taking possession of the fish tank and denied having any documentation of the disposition of Resident #26's belongings after the resident passed. On 06/11/2026 at 11:58 AM, the Director of Nursing (DON) verbalized staff tried to (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make the facility feel as close to home as possible. Residents deserved respect and were allowed to keep personal items, however; the facility could not accommodate all items. If there was a safety risk staff would explain this to the resident, explain why the facility could not accommodate the item, ask the resident if there was something else the facility could get for the resident or something else the facility could do to try to accommodate the request. The DON explained the facility would usually document the conversation if an item was not safe and had to be removed. The DON confirmed the DON was familiar with Resident #12 and verbalized the DON had previously spoken to Resident #12 about the fish tank. The fish tank belonged to Resident #12's former roommate who had passed away and was given to Resident #12 by the roommate's family member. There was concern due to some residents who wandered, and staff were afraid the fish tank would get knocked over. The DON recalled the fish tank remained in Resident #12's room for a while and the DON did not know who had removed it or when it had been removed. On 06/11/2026 at 12:15 PM, during an interview with the AD and the DON, the AD verbalized maintenance had removed the fish tank from Resident #12's room at the AD's request. The AD verbalized staff provided Resident #12 with some boxes in order to remove some items from the resident's room to make room for the fish tank. The AD denied being present for a conversation with Resident #12 or having any knowledge of the resident agreeing to have any items removed from the room. The AD confirmed the fish tank was in the activities room and verbalized it was unplugged due to it making a lot of noise. On 06/11/2026 at 12:42 PM, the DON, the AD and two Certified Nursing Assistants (CNAs) denied having any documentation related to the disposition of the fish tank when Resident #26 passed away, the conversation with Resident #12 regarding the safety concerns related to the fish tank, removing the fish tank from Resident #12's room, and any offers of alternatives such as a different tank or removal of other items to make room for the tank. The DON, the AD, and the CNAs confirmed the resident brought up the fish tank in conversation and voiced being upset about the fish tank being removed every few weeks. The DON acknowledged Resident #12 and Resident #26 were close and verbalized the DON thought the fish tank may have reminded Resident #12 of Resident #26. The facility document titled Resident's [NAME] of Rights, undated, documented residents had the right to be treated with consideration, respect, and dignity, to have security of possessions, and to reasonable accommodation of one's needs and preferences. The facility policy titled Patient Belongings and Property, reviewed 04/20/2026, documented upon admission, nursing staff were to complete a resident property inventory form. Residents could retain and use personal items unless the item presented a safety risk, created an infection control concern, was prohibited by law, or interfered with care or treatment. Upon a resident's death, two staff members were to inventory belongings. The property would be secured and be released only to the legally authorized individual.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record review, interview and document review the facility failed to ensure a Minimum Data Set 3.0 (MDS) assessment was transmitted timely for one discharged resident reviewed for resident assessment (Resident #26). This deficient practice had the potential to result in delayed submission of resident assessment data affecting the accuracy of the facility's quality measures and reimbursements. Findings include: Resident #26 Resident #26 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbances, major depressive disorder, recurrent, unspecified, and age-related physical debility. A progress note dated [DATE] at 4:40 PM, documented Resident #26 passed away while in the facility. Resident #26's MDS assessment dated [DATE], Section A, documented the resident passed away while in the facility. The MDS assessment documented having been completed by the MDS Registered Nurse (RN) on [DATE] at 7:15 AM. The MDS assessment submission validation report for Resident #26, documented the MDS assessment dated [DATE] was submitted to the Centers for Medicare and Medicaid (CMS) on [DATE] at 10:17 AM. The report documented the record had been submitted late and should have been submitted within 14 days of the resident's death. On [DATE] at 8:50 AM, the MDS RN confirmed having completed the MDS assessment after Resident #26's death on [DATE], but had not submitted the assessment until [DATE], more than a month after the resident's death. The MDS RN confirmed the record should have been submitted within 14 days of the resident's passing. On [DATE] at 8:52 AM, the MDS RN verbalized the facility did not have a policy related to MDS submission validation reporting and only used the Resident Assessment Instrument 3.0 (RAI) Manual for instructions and guidance. The Long-Term Care RAI 3.0 Manual, version 1.20.1, effective [DATE], documented assessment records related to deaths in the facility were to be transmitted to CMS no later than 14 calendar days after the date of death .		

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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** Based on observation, interview, clinical record review and document review, the facility failed to ensure a controlled medication was documented in the controlled drug record at the time the medication was administered for 1 of 13 sampled residents (Resident #5). This deficient practice had the potential to result in inaccurate record keeping of the administration of controlled substances with the potential to result in misappropriation of a resident's medications and a resident's symptoms not being managed effectively. Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including anxiety disorder, unspecified and borderline personality disorder. A medication order and the June 2026 Medication Administration Record for Resident #5 documented the following: Ativan oral tablet 1 milligram (mg). Give 1 mg by mouth three times a day for fidgeting, agitation, restlessness related to anxiety disorder, unspecified. On 06/11/2026 at 9:39 AM, during an observation of the narcotic drawer in the medication cart with the Director of Nursing (DON), a Licensed Practical Nurse (LPN) retrieved the controlled substance log from the medication cart and verbalized the LPN needed to document in the log. On 06/11/2026 at 9:40 AM, the LPN confirmed the LPN had administered Ativan to Resident #5 at 9:31 AM but had not documented the administration and current count for the medication in the controlled substance log. On 06/11/2026 at 9:41 AM, the DON verbalized a controlled substance, such as Ativan, should have been documented in the controlled substance log at the time the medication was administered so the medication count was accurate, and the nurse administering could ensure the current medication count was accurate prior to administration. The facility policy titled, Medication Administration, reviewed 05/01/2026, documented documentation of medication administration would be completed after administering the medication to the resident.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review, the facility failed to provide documented evidence residents and/or residents' representatives were provided opportunity to change their decision regarding acceptance or declination of the influenza (flu) vaccine prior to administration of the vaccine for 2 of 5 residents sampled for vaccinations (Residents #4 and #23). This deficient practice had the potential to result in residents and their representatives not being given the opportunity to make informed decisions before accepting or declining the vaccination. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of aphasia following cerebral infarction. A Record of Vaccination Acceptance and Declination Form signed by Resident #4's representative on 07/24/2025, documented the resident's provider notified the resident and/or responsible party the Centers for Disease Control and Prevention (CDC) recommended vaccinations for the resident and the resident was to be informed when the vaccination was due. The provider had offered risk versus benefits of receiving the recommended vaccinations. The flu vaccine was documented as accepted on 07/24/2025 with an administration due date of 2025. Additionally, the form documented the resident and/or representative understood the resident and/or representative had the right to change their mind and accept or decline any of the recommended vaccinations at any time. An Influenza Vaccination Consent and Documentation form documented the flu vaccine was administered to Resident #4 on 09/29/2025. The form included vaccination contraindication screening questions, a statement indicating the resident/representative had been given the opportunity to decline the vaccine and had consented to the vaccine being administered to the resident. The patient signature line and the parent/guardian signature lines were left blank. The form lacked documented evidence the screening was completed with the resident/representative and consent was obtained at the time of administration. Resident #23 Resident #23 was admitted to the facility on [DATE], with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Record of Vaccination Acceptance and Declination Form signed by Resident #23's representative on 06/04/2025, documented the resident's provider notified the resident and/or responsible party the CDC recommended vaccinations for the resident and the resident was to be informed when the vaccination was due. The provider had offered risk versus benefits of receiving the recommended vaccinations. The flu vaccine was documented as accepted on 06/04/2025 with an administration due date of 2025. Additionally, the form documented the resident and/or representative understood the resident and/or representative had the right to change their mind and accept or decline any of the recommended vaccinations at any time. An Influenza Vaccination Consent and Documentation form documented the flu vaccine was administered to Resident #23 on 10/12/2025. The form included vaccination contraindication screening questions, a statement indicating the resident/representative had been given the opportunity to decline the vaccine and had consented to the vaccine being administered to the resident. The patient signature line and the parent/guardian signature lines were left blank. The form lacked documented evidence the screening was completed with the resident/representative and consent was obtained at the time of administration. On 06/11/2026 at 10:19 AM, during an interview with the Director of Nursing (DON) and the Infection Preventionist (IP), the DON verbalized the facility followed CDC guidelines and would review WebIZ (an online, statewide immunization information system) to determine if residents were eligible for vaccines offered by the facility. Eligibility for vaccines was reviewed upon admission and at least annually for all residents. The facility Record of (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vaccination Acceptance or Declination Form was intended for residents and/or resident representatives to say which vaccines the resident was interested in. The DON verbalized people could change their mind, and staff were to ask the resident and/or representative if the resident/representative still wanted the vaccine at the time it was due. A separate form was to be filled out at the time of administration. The DON and IP acknowledged the Influenza Vaccination Consent and Documentation Forms for Residents #4 and #23 lacked documented evidence consent was obtained at the time of administration and the resident and/or representative were given the opportunity to change their mind regarding receipt of the vaccine. The DON verbalized both residents were not their own responsible parties. The DON and IP explained when a resident was not their own responsible party, staff usually administered vaccines based on the Record of Vaccination Acceptance or Declination Form as staff did not often get a response from the representative/Power of Attorney (POA). The DON confirmed the DON's expectation was staff would obtain informed consent and complete an individual consent form prior to administration of each vaccine. If the resident had a representative and/or POA, the representative/POA could sign the vaccine-specific consent form, or two nurses could obtain verbal consent over the phone. If verbal consent over the phone was obtained, both nurses were to document on the consent form. The DON acknowledged failure to obtain consent at the time of administration denied the resident/representative the opportunity to decline the vaccine. The facility policy titled Influenza Vaccination Program, reviewed 12/01/2025, documented the facility would provide, promote, and document annual influenza vaccination for all eligible healthcare personnel and residents in compliance with regulations. The facility policy titled Standards of Care, reviewed 08/06/2025, documented each shift documentation would include but was not limited to: care, treatment, and interventions provided, notifications of guardian or family, and any resident or caregiver education including level of understanding.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Pershing General Hospital Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 855 6th Street Lovelock, NV 89419	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review, the facility failed to provide documented evidence residents and/or residents' representatives were provided opportunity to change their decision regarding acceptance or declination of the Covid-19 vaccine prior to administration of the vaccine for 2 of 5 residents sampled for vaccinations (Residents #24 and #4). This deficient practice had the potential to result in residents and their representatives not being given the opportunity to make informed decisions before accepting or declining the vaccination. Findings include: Resident #24 Resident #24 was admitted to the facility on [DATE], with diagnoses including other sequelae of cerebral infarction and vascular dementia, severe, with anxiety. A Record of Vaccination Acceptance and Declination Form signed by Resident #24 on 06/04/2025, documented the resident's provider notified the resident and/or responsible party the Centers for Disease Control and Prevention (CDC) recommended vaccinations for the resident and the resident was to be informed when the vaccination was due. The provider had offered risk versus benefits of receiving the recommended vaccinations. The Covid-19 vaccine was documented as accepted on 06/04/2025 with an administration due date of Fall 2025. Additionally, the form documented the resident and/or representative understood the resident and/or representative had the right to change their mind and accept or decline any of the recommended vaccinations at any time. Two facility Vaccination Administration Forms documented the Covid-19 vaccine was administered to Resident #24 on 01/17/2026 and 04/22/2026. The form lacked documented evidence consent was obtained from the resident and/or resident representative at the time of administration, and staff verified if the resident and/or representative had changed their mind regarding acceptance or declination of the vaccine prior to administration. Resident #4 Resident #4 was admitted to the facility on [DATE], with a diagnosis of aphasia following cerebral infarction. A Record of Vaccination Acceptance and Declination Form signed by Resident #4's representative on 07/24/2025, documented the resident's provider notified the resident and/or responsible party the CDC recommended vaccinations for the resident and the resident was to be informed when the vaccination was due. The provider had offered risk versus benefits of receiving the recommended vaccinations. The Covid-19 vaccine was documented as accepted on 07/24/2025 with an administration due date of Fall 2025. Additionally, the form documented the resident and/or representative understood the resident and/or representative had the right to change their mind and accept or decline any of the recommended vaccinations at any time. A facility Vaccination Administration Form documented the Covid-19 vaccine was administered to Resident #4 on 01/16/2026. The form lacked documented evidence consent was obtained from the resident and/or resident representative at the time of administration, and staff verified if the resident and/or representative had changed their mind regarding acceptance or declination of the vaccine prior to administration. On 06/11/2026 at 10:19 AM, during an interview with the Director of Nursing (DON) and the Infection Preventionist (IP), the DON verbalized the facility followed CDC guidelines and would review WebIZ (an online, statewide immunization information system) to determine if residents were eligible for vaccines offered by the facility. Eligibility for vaccines was reviewed upon admission and at least annually for all residents. The facility Record of Vaccination Acceptance or Declination Form was intended for residents and/or resident representatives to say which vaccines the resident was interested in. The DON verbalized people could change their mind, and staff were to ask the (continued on next page)		

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and/or representative if the resident/representative still wanted the vaccine at the time it was due. A separate form was to be filled out at the time of administration. The DON and IP acknowledged the Vaccine Administration Forms for Residents #4 and #24 lacked documented evidence consent was obtained at the time of administration and the resident and/or representative were given the opportunity to change their mind regarding receipt of the vaccine. The DON verbalized both residents were not their own responsible parties. The DON and IP explained when a resident was not their own responsible party, staff usually administered vaccines based on the Record of Vaccination Acceptance or Declination Form as staff did not often get a response from the representative/Power of Attorney (POA). The DON confirmed the DON's expectation was staff would obtain informed consent and complete an individual consent form prior to administration of each vaccine. If the resident had a representative and/or POA, the representative/POA could sign the vaccine-specific consent form, or two nurses could obtain verbal consent over the phone. If verbal consent over the phone was obtained, both nurses were to document on the consent form. The DON acknowledged failure to obtain consent at the time of administration denied the resident/representative the opportunity to decline the vaccine. The facility policy titled COVID-19 Vaccination Policy - Long Term Care, reviewed 05/2026, documented the facility would maintain a COVID-19 vaccination program to include vaccine education, vaccine offering or assistance with access, documentation of acceptance/refusal/contraindication, and required reporting. The facility would provide each resident or resident representative education regarding COVID-19 vaccination and offer the vaccination when available unless the resident was up to date or the vaccination was medically contraindicated. The resident or representative may accept, refuse, or later change vaccination decision. Documentation was to be maintained in residents' medical records, vaccine administration records, and declination or contraindication forms.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on personnel record review, interview and document review, the facility failed to ensure elder abuse prevention training was completed timely for 1 of 20 sampled employees (Employee #10). This deficient practice had the potential for the employee to be unprepared to recognize, prevent and report abuse thereby placing residents at risk for abuse and neglect. Findings include:Employee #10 Employee #10 was hired by the facility on 05/24/2018, as a Speech Therapist Contractor. Employee #10's personnel record documented elder abuse training had been completed on 01/20/2025. Employee #10's personnel record lacked documentation of annual elder abuse prevention training having been completed in 2026. On 06/11/2026 at 7:52 AM, the Administrator confirmed Employee #10 had not completed annual elder abuse prevention training for 2026, but should have. The facility policy titled, Abuse/Neglect Prevention and Prohibition Long Term Care, reviewed 05/12/2026, documented employees were to have completed abuse and neglect prevention training upon employment and annually thereafter.		

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure the posted nurse staffing data included the actual hours worked per shift for licensed and unlicensed staff responsible for resident care for 4 of 4 days observed. This deficient practice had the potential to result in residents and visitors to the facility not being able to view accurate and complete staffing data. Findings include: On 06/08/2026, 06/09/2026, 06/10/2026, and 06/11/2026, the posted nurse staffing data did not include the actual hours worked per shift by licensed and unlicensed nursing staff directly responsible for resident care. On 06/11/2026 at 9:19 AM, the Director of Nursing (DON) verbalized the DON was unaware of the requirement to include actual hours worked on the posted nurse staffing data and confirmed the actual hours worked were not included in the facility's posting.		