STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295063	A. Building B. Wing	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Battle Mountain General Hospital	535 S. Humboldt Street Battle Mountain, NV 89820

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on interview, clinical record review, and document review, the facility failed to 1) ensure misappropriation of property was thoroughly investigated, 2) provide documentation of the investigation, and 3) provide a completed investigation for 1 of 2 residents investigated for FRI's (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on [DATE], with diagnoses including pseudobulbar affect, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. An initial FRI #NV00068139 with an allegation of a resident missing money from their personal bank account was submitted to the State Survey Agency on 03/10/23. A final FRI report dated 03/15/23, was submitted to the State Agency, however lacked the conclusion of the investigation and documented the facility was not sure if the incident was substantiated at that time. On 01/10/24 at 10:26 AM, the DON explained the DON did not have all of the investigative notes because the former LTC Coordinator kept the documents. The DON confirmed the LTC Coordinator's last day of employment was 10/31/23. The DON produced a timeline note from the LTC Coordiantor as the only documentation of the investigation. The DON confirmed the DON should have followed up with documentation to a complete investigation. On 01/10/24 at 10:42 AM, the Chief Nursing Officer/Director of Nursing (DON) explained the Long Term Care (LTC) Coordinator had found multiple charges on Resident #11's debit card that the resident could not have withdrawn as the resident was confined to a bed and was considered to have severe cognitive impairment. The DON confirmed the resident's son had possession of Resident #11's debit card since the resident had admtted to the facility and had only given the facility a copy of the debit card to use for the resident's liability portion. The total amount of money withdrawn by the resident's son from the months of May 2022 through March 2023 was $1285.50. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295063	A. Building B. Wing	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Battle Mountain General Hospital	535 S. Humboldt Street Battle Mountain, NV 89820

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON communicated the facility had accepted a Durable Power of Attorney (DPOA) for Healthcare Decisions the resident's son had produced upon admission and the facility notarized the document on 11/08/19. The facility later learned through another State Agency's investigation the DPOA was invalid as it was not signed by Resident #11 and had only contained the son's signature. On 01/10/24 at 10:54 AM, the DON confirmed the DON was responsible for the investigation. The DON confirmed it was the facility's responsibility to protect the resident and the only follow up to the investigation was to request the District Attorney to grant guardianship of the resident. The DON confirmed the DON was responsible for follow up to the investigation and had not provided a report to local law enforcement, investigation follow up, or a completed investigation. On 01/11/24 at 9:47 AM, the DON explained a Social Worker or LTC Coordinator would normally review the validity of the DPOA but the facility did not have either position filled when the resident admitted . The DON confirmed the DON was responsible to review the DPOA for validity and did not check the document or signatures that would authorize Resident #11's son to make decisions for the resident. The facility policy titled Freedom from Abuse/Abuse Prohibition, last reviewed 10/11/23, documented residents would be free from abuse, neglect, and exploitation by staff, volunteers, consultants, family members, and legal guardians. Misappropriation of resident property was defined as the deliberate misplacement, exploitation, or wrongful or permanent use of a resident's belongings or money without the resident's consent. Residents with communication disorders and those that require heavy nursing care and/or are totally dependent on staff could be at greater risk for abuse, neglect, or misappropriation. Identified trends that constituted abuse, neglect, or misappropriation and would determine the direction for the investigation to follow. If assault or theft was alleged or suspected, the local Sheriff's Office would be contacted for appropriate investigation. A Quality Review Report was used to communicate real or suspected abuse, neglect, or misappropriation by anyone to the LTC Supervisor, CNO, Chief Risk Officer, and Administrator. The facility would maintain a record of all incidents and reportable events. Cross referenced with F656 NV00068139

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Battle Mountain General Hospital	535 S. Humboldt Street Battle Mountain, NV 89820

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739 Based on observation, clinical record review, interview and document review, the facility failed to 1) prevent falls with injury for 1 of 2 residents investigated for Facility Reported Incident (FRI) (Resident #2), 2) assess for entrapment and restraint for residents' beds against the wall for 2 of 12 sampled residents (Resident #3 and #9) and 3) maintain a call light device for safety for 1 of 12 sampled residents (Resident #17). Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including muscle weakness, other specified disorders of bone density and structure, unspecified site, and history of falling. On 01/11/24 at 8:36 AM, Resident #2 was in bed. The bed was in the low position. All four quarter bed rails were in the up position. No fall mattresses were located in the resident's room. A walker was at the foot of the resident's bed. The bed lacked a pressure alarm device. An Incident Note dated 04/19/23, documented a nurse heard a resident yelling and found Resident #2 laying on the resident's left side on the floor by the resident's bed. X-ray orders were provided, and X-rays were taken. The X-rays determined the resident had a fracture of the left elbow. A Morse Fall Scale assessment dated [DATE], documented Resident #2 as high risk for falls. Resident #2's care plan dated 02/25/22, documented the resident as a high risk for falls related to generalized weakness. Bed in low position. Use of bed rails for sense of security. A Nurse Progress Note dated 04/21/23, documented a nurse heard screaming for help and found Resident #2 on the floor with the resident's back against the nightstand. The resident was assessed and noted a new reddish-purple bruise and skin tear approximately two centimeters by one centimeter on the resident's upper left arm. The resident also had two small skin tears below the resident's left elbow. A Nurse Progress Note dated 04/21/23, documented the resident had an X-ray taken and the resident had a fracture of the pubis. Resident #2's clinical record lacked documented evidence a physician's order was obtained for the use of or discontinuation of fall mattresses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/11/2024
NAME OF PROVIDER OR SUPPLIER Battle Mountain General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 535 S. Humboldt Street Battle Mountain, NV 89820	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/11/24 at 9:25 AM, the Chief Nursing Officer/Director of Nursing (DON) confirmed Resident #2 did fall twice within a two-day period and sustained injuries from both falls. Fall mats were in place while the resident was recovering, but since the resident's recovery, fall mats were no longer used as the resident was ambulatory with the use of a walker. The DON confirmed no other interventions were in place at the time of the falls but would consider a bed alarm if the resident continued to have falls. The facility policy titled, Falls Reduction Plan, dated 10/13/20, documented if a resident was identified as a high risk for falls, the following measures will be initiated to increase safety: provide 1 or 2 person assist for transfers and ambulation, as needed, teach resident the proper use of assistive ambulatory devices, and the use of fall mattresses on the floor and of a bed alarm if the resident demonstrated getting out bed without asking for help. FRI #NV00068420 and FRI #NV00068443 30748 Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including major depressive disorder, recurrent, unspecified, other specified anxiety disorders, developmental disorder of scholastic skills, unspecified and epilepsy, unspecified, intractable, without status epilepticus. Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including major depressive disorder, single episode, unspecified, heart failure, unspecified and chronic obstructive pulmonary disease, unspecified. On 01/08/24 at 1:27 PM, Resident #3 and Resident #9's beds were located against the wall with no spacing between the beds and the wall. Resident #3 and #9's clinical record lacked care plans addressing the beds against the wall. Resident #3 and #9's clinical record lacked documented evidence the risk and benefits were explained to the resident and the resident had been assessed for the risk of entrapment and restraint. On 01/10/24 at 11:29 AM, a Certified Nursing Assistant (CNA) confirmed the beds for Resident #3 and #9 were against the wall. On 01/10/24 at 11:43 AM, a Licensed Practical Nurse (LPN) confirmed the beds for Resident #3 and #9 were against the wall and posed an entrapment risk for both residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/11/2024
NAME OF PROVIDER OR SUPPLIER Battle Mountain General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 535 S. Humboldt Street Battle Mountain, NV 89820	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/24 at 12:01 PM, the DON explained beds located against a wall were a safety concern for residents because it was an entrapment risk. The DON explained Resident #3 needed full assistance with all Activities of Daily Living (ADL), Resident #9 needed assistance with most ADL's, and both residents could not get out of bed on their own. The DON verbalized the beds against the wall would require and evaluation to be completed, a physician's order, and risks and benefits needed to be explained and completed and confirmed the risks and benefits were not reviewed with the residents, an assessment for entrapment was not completed nor was a consent signed to be able to place the beds against the wall for Resident #3 and #9. The facility policy titled Mobility Devices & Physical Restraints, last reviewed 02/24/21, documented all residents would be assessed for physical mobility. Every resident had the right to be free from any physical restraint and a restraint would only be used to treat a specific medical condition. Prior to the using physical devises or physical restraints, an assessment would be completed, the resident would be monitored every shift, a physician's order would be obtained, consents would be obtained, and a care plan would be developed. Cross Reference with tag 656 43311 Resident #17 Resident #17 was admitted to the facility on [DATE], with diagnoses including unspecified atrial fibrillation, muscle spasm of back, and difficulty in walking, not elsewhere classified. On 01/08/24 at 3:16 PM, Resident #17's call light device was observed to have black tape loosely applied around the cord and residue from a previous tape application to the cord. Resident #17 explained the cord was broken and the facility put tape over the frayed edges to fix the cord instead of replacing the call light device and cord. On 01/11/24 at 6:53 AM, an LPN explained the Maintenance Department would be contacted via a phone call or email to request a repair or replacement of something in a resident's room. The LPN confirmed Resident #17's call light device cord had been taped with black tape and had evidence of previous taping. The LPN explained the LPN did not know who would have taped the cord and had not previously noticed the taped cord. The LPN communicated the call light device should have been replaced and not used with tape over the cord as it could present a risk of electrical shock to the resident. On 01/11/24 at 6:59 AM, Resident #17 explained the call light device had tape around the cord for months and did not know who had placed the tape on the cord. The call light device cord was observed to have new black tape wrapped tightly around the cord where the previous taping had been observed. Glue from the previous taping was visible on the cord. On 01/11/24 at 7:01 AM, a CNA explained the CNA had not noticed tape on the call light device cord and did not know who taped the cord. The CNA confirmed Maintenance would be called for a call light device replacement or the CNA could swap out the call light device with an extra call light device kept in the storage closet on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/11/2024
NAME OF PROVIDER OR SUPPLIER Battle Mountain General Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 535 S. Humboldt Street Battle Mountain, NV 89820	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/11/24 at 7:45 AM, the Maintenance Manager explained the staff usually notified the department for a repair request through a verbal conversation in the hallway. The Maintenance Manager communicated there would never be an instance a call light device would be taped rather than replaced. A maintenance log for repairs was not kept by the Maintenance Manager. The Maintenance Manager confirmed Resident #17's call light device cord was taped, had markings on it from previous taping, and was plugged into the wall. The Maintenance Manager communicated not knowing of the call light device was in need of repair and did not know who would have placed tape over the cord. The Maintenance Manager removed the tape from Resident #17's call light device cord and revealed frayed and exposed live electrical wiring on the cord. A facility policy titled Maintenance Department, dated 02/2015, documented the Maintenance Department provided the routine and emergency maintenance services to all hospital and clinic grounds, buildings, equipment, fixtures, and furniture in a safe and courteous manner. The Maintenance Manager worked under the direction of the Administrator and directed employees in proper maintenance procedures, to schedule work, train employees, and maintain proper records.