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	02/06/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure a resident consented to a change in a psychotropic medication when the Physician increased the dose of the medication and a consent was obtained prior to administration of a new psychotropic medication for 2 of 12 sampled residents (Residents #1 and #3). This deficient practice had the potential for a resident to not have the opportunity to make an informed decision prior to receiving medications affecting the resident's mind, emotions, and behavior. Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety disorder, unspecified, and schizoaffective disorder, bipolar type. A Physician's order for Resident #1, dated 01/31/2025, documented lorazepam oral tablet 1 milligram (mg), give one tablet by mouth two times a day for anxiety. The clinical record for Resident #1 included an Informed Consent for Ativan (lorazepam) 0.5 mg by mouth twice daily. The consent was signed by the resident's representative on 12/30/2020. On 02/06/2025 at 8:38 AM, the Long-Term Care (LTC) Coordinator confirmed Resident #1 was receiving lorazepam 1 mg twice daily and Resident #1's Informed Consent for lorazepam was not for the current dose the resident was receiving. The LTC Coordinator verbalized a new consent should have been obtained when the order to increase the resident's dose of lorazepam was received and prior to administration of the medication. 40377 Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including major depressive disorder, recurrent, unspecified, insomnia, developmental disorder of scholastic skills, unspecified, and other specified anxiety disorders. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's order for Resident #3 dated 11/17/2024, documented Trazadone HCL oral tablet 100 mg, give one tablet by mouth two times a day for increased anxiety or agitation. A Physician's order for Resident #3 dated 01/11/2025, documented Belsomra oral tablet 5 mg, give one tablet by mouth at bedtime for insomnia. The clinical record for Resident #3 lacked documented evidence of an Informed Consent for Trazadone and Belsomra. On 02/05/2025 at 10:54 AM, the LTC Coordinator confirmed Resident #3 was receiving Trazadone HCL 100 mg twice daily and Belsomra 5 mg once daily and the facility lacked an Informed Consent for both medications. The facility policy titled Resident Rights, revised 05/2021, documented the resident had the right to be notified in advance about any changes in treatment decisions and the right to refuse medical treatment.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 40377 Based on interview and document review the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were transmitted timely for 3 of 11 months, starting February 2024. The deficient practice had the potential to impact resident care by also delaying the resident care plan. Findings include: September 2024: 23.1% of assessments transmitted late (3 of 13). November 2024: 45.5% of assessments transmitted late (5 of 11). December 2024: 15.7% of assessments transmitted late (1 of 3). On 02/05/2025 at 10:00 AM, the Chief Nursing Officer (CNO) verbalized the CNO was responsible to submit the MDS assessments for the facility and confirmed the CNO had filed the aforementioned MDS assessments late.

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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 0642 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure the Minimum Data Set 3.0 (MDS) assessments were certified as complete by a Registered Nurse (RN) for 13 of 13 residents reviewed for MDS completion (Residents #1, #2, #6, #12, #16, #3, #7, #13, #23, #17, #21, #14, and #5). This deficient practice had the potential for a comprehensive assessment to include inaccurate data as the result of the assessment requiring the substantial judgement, knowledge, and skill of an RN but being coordinated and completed by a Licensed Practical Nurse (LPN). Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], with diagnoses including edema, unspecified and nutritional deficiency, unspecified. A Quarterly MDS assessment for Resident #1, dated 12/09/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 12/22/2024, on section Z0500 on the line designated for the signature of the RN Assessment Coordinator to verify assessment completion. Resident #2 Resident #2 was admitted to the facility on [DATE], with diagnoses including pain, unspecified, and history of falling. A Quarterly MDS assessment for Resident #2, dated 10/25/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 10/31/2024, on section Z0500 on the line designated for the signature of the RN Assessment Coordinator to verify assessment completion. Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis and constipation, unspecified. A Quarterly MDS assessment for Resident #6, dated 11/06/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 11/19/2024, on section Z0500 on the line designated for the signature of the RN Assessment Coordinator to verify assessment completion. Resident #12 was admitted to the facility on [DATE], with diagnoses including unspecified glaucoma and nausea. (continued on next page)

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F 0642 Level of Harm - Potential for minimal harm Residents Affected - Many	An Annual MDS assessment for Resident #12, dated 01/04/2025, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 01/18/2025, on section Z0500 on the line designated for the signature of the RN Assessment Coordinator to verify assessment completion. Resident #16 was admitted to the facility on [DATE], with diagnoses including hypocalcemia and fibromyalgia. An Annual MDS assessment for Resident #16, dated 11/01/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 11/14/2024, on section Z0500 on the line designated for the signature of the RN Assessment Coordinator to verify assessment completion. 40377 Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, insomnia, and type 2 diabetes mellitus without complications. A Quarterly MDS assessment for Resident #3, dated 10/04/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 10/13/2024, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. Resident #7 Resident #7 was admitted by the facility on 04/08/2021 and readmitted on [DATE], with diagnoses including epilepsy, unspecified, intractable, with status epilepticus, type 2 diabetes mellitus without complications, and anxiety disorder. A Quarterly MDS assessment for Resident #7, dated 10/24/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 10/30/2024, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including essential (primary) hypertension, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. (continued on next page)

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F 0642 Level of Harm - Potential for minimal harm Residents Affected - Many	An Annual MDS assessment for Resident #13, dated 11/23/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 11/28/2024, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including hypothyroidism, unspecified, mild cognitive impairment of uncertain and unknown etiology. An Admission MDS assessment for Resident #23, dated 10/22/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 10/22/2024, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. 43311 Resident #17 Resident #17 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, pain in unspecified joint, and essential hypertension. A Quarterly MDS assessment for Resident #17, dated 11/03/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 11/06/2024, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. Resident #21 Resident #21 admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus without complications, polyneuropathy, and essential (primary) hypertension. A Quarterly MDS assessment for Resident #21, dated 11/11/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 11/24/2024, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. Resident #14 Resident #14 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance and anxiety disorder, unspecified. (continued on next page)

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F 0642 Level of Harm - Potential for minimal harm Residents Affected - Many	A Quarterly MDS assessment for Resident #14, dated 11/15/2024, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 11/24/2024, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. Resident #5 Resident #5 admitted to the facility on [DATE], with diagnoses including wedge compression fracture of unspecified lumbar vertebrae, essential (primary) hypertension, and gout, unspecified. A Quarterly MDS assessment for Resident #5, dated 01/01/2025, was signed by an LPN under Section Z - Assessment Administration. The section documented the signature certified the LPN had collected or coordinated collection for all sections of the MDS assessment and was signed by the LPN on 01/09/2025, on section Z0500 designated for the signature of the RN Assessment Coordinator verifying assessment completion. On 02/04/2025 at 11:22 AM, the LPN confirmed the LPN had been signing the MDS assessments as the RN Assessment Coordinator verifying assessment completion for several months. The LPN verbalized the LPN was able to complete individual assessments on the MDS assessment, but a Registered Nurse should have signed the MDS as the person completing the assessment. On 02/05/2025 at 10:41 AM, the Chief Nursing Officer (CNO) verbalized the LPN had signed all MDS assessments as the RN Assessment Coordinator for all MDS assessment completed between 10/31/2024 and 01/31/2025. The CNO verbalized the LPN could collect the data for the individual assessments, but the RN was required to sign the assessment to verify accuracy and completeness. The facility policy titled MDS (Minimum Data Set), effective 05/14/2015, documented the Registered Nurse/MDS Coordinator would complete all sections of the MDS and was responsible for the final submission of the MDS.

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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** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's Comprehensive Care Plan included 1) a care plan addressing the resident's wound for 2 of 12 sampled residents (Residents #6 and #5) and 2) a care plan addressing a resident's significant weight loss for 1 of 12 sampled residents (Resident #3). This deficient practice had the potential to result in a resident not receiving consistent care of the resident's wound and potential worsening of the wound, and consistent care addressing a resident's weight loss and potential further unplanned weight loss. Findings include: Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis and other specified nutritional deficiencies. On 02/03/2025 at 1:52 PM, Resident #6 verbalized the resident had a wound on the resident's backside. An order for Resident #6, dated 01/27/2025, documented to apply Mepilex Border (an absorbent foam dressing for treating chronic and acute wounds) sacrum dressing on Monday, Wednesday, and Friday. Cleanse the area, apply skin prep, apply SilvrStat gel (a water-based gel containing silver used to treat wounds), apply Silvercel Non-Adherent (an antimicrobial alginate dressing), and then apply dressing. A Progress Note, dated 02/03/2025, documented Resident #6's skin assessment was completed during and after the resident's shower. The resident's coccyx area was red and open. The Comprehensive Care Plan for Resident #6 lacked a care plan addressing Resident #6's wound care interventions and goals. On 02/04/2025 at 11:18 AM, the Licensed Practical Nurse (LPN) for Resident #6 verbalized wound care and dressing changes for Resident #6 were completed by the Physical Therapist (PT). The LPN explained Resident #6 did not have an open wound and PT only applied a Mepilex to the resident's coccyx to cushion the area where the resident had a wound previously. The LPN confirmed the wound care/wound prevention measures should have been care planned to ensure orders for the resident's wound care/wound prevention were communicated to all disciplines involved in the resident's care. On 02/04/2025 at 2:52 PM, the PT verbalized the PT was not providing the wound care for Resident #6. The PT verbalized the PT had assessed the wound and gave direction to the nursing staff on how to complete the wound care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2025 at 10:39 AM, the Chief Nursing Officer (CNO) verbalized the resident's wound care should have been care planned and care planning would have helped with communication across disciplines. The facility policy titled Baseline/Comprehensive Care Plan and Short-Term Care Plan, reviewed 12/08/2017, documented the planning for care, treatment, and services would include the frequency of care, services, and treatments, and the team members responsible for the care, services, and treatment. Cross reference with tag F686 43311 Resident #5 Resident #5 admitted to the facility on [DATE], with diagnoses including wedge compression fracture of unspecified lumbar vertebrae, essential (primary) hypertension, and gout, unspecified. A Skin assessment dated [DATE], documented an LPN had inspected a large slit in the left abdominal fold area for Resident #5. The LPN placed steri-strips (wound closure strips made of porous surgical tape used to close small wounds in a manner which pulls the skin on either side of the wound together) over the area instead of the Nystatin powder which was normally used and would monitor closely. A Nursing Progress Note dated 01/28/2025, documented Resident #5 was monitored closely for a large slit to the left abdominal fold, steri-strips remained intact, and would continue to monitor the resident. A Nursing Progress Note dated 01/29/2025, documented Resident #5 had a slit under the left abdominal fold which had steri-strips in place. A Nursing Progress Note dated 01/30/2025, documented Resident #5 had a slit to the left abdominal fold. The area was red in color and new steri-strips were applied. A Nursing Progress Note dated, 01/30/2025, documented the steri-strips on Resident #5's left abdominal fold were coming off and would be replaced the next morning before the resident left the facility for a couple of days to visit with family. The Comprehensive Care Plan for Resident #5 lacked a care plan addressing Resident #5's wound care treatments, interventions, and goals of the left abdominal skin tear. On 02/05/2025 at 11:31 AM, the CNO explained the Comprehensive Care Plan was used to direct the resident's care. The CNO confirmed Resident #5 had a skin tear to the left abdominal fold and lacked a care plan to identify goals and interventions to address the skin tear. The CNO explained the expectation of nursing to care plan a wound, the interventions used, and goals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2025 at 12:42 PM, the LPN/Long Term Care (LTC) Coordinator confirmed Resident #5 had a skin tear to the left abdominal fold and lacked a care plan to identify goals and interventions to address the skin tear. The LPN/LTC Coordinator explained the Comprehensive Care Plan gave nursing the whole picture of the resident and how to provide care to the resident and should have included the care and treatment of the left abdominal skin tear. The Nevada Nursing Practice Standards documented an LPN shall determine before the performance of any task that he or she has the knowledge, skill and experience to perform the task competently. An LPN shall contribute to the plan of care established for a patient by recording and reporting to the appropriate person his or her observations by conducting a focused nursing assessment. Cross referenced to F684. 40377 Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including type 2 diabetes mellitus without complications, nutritional deficiency, unspecified, developmental disorder of scholastic skills, lactose intolerance, unspecified, and gastro-esophageal reflux disease without esophagitis. Resident #3's clinical record documented Resident #3 had a -5.1% weight change from 12/13/2024 to 01/01/2025 and a -10.7% weight change from 11/04/2024 to 02/04/2025. Resident #3's Quarterly Minimum Data Set 3.0 (MDS), Section K0300 - Weight Loss, dated 01/04/2025, documented Resident #3 was not on a weight loss regimen. A Quarterly Nutritional assessment dated [DATE], documented the Registered Dietitian noted Resident #3 had a significant weight loss of 5%. A Dietary Progress Note dated 01/17/2025, documented Resident #3 had a weight change of -5.2% in the last 30 days. The resident's significant weight loss was attributed to pneumonia, medication change leading to decreased appetite and overall intake reduction. The Comprehensive Care Plan for Resident #3 dated 01/08/2025, lacked a care plan addressing Resident #3's significant weight loss interventions and goals. On 02/05/2025 at 8:13 AM, the LPN/LTC Coordinator confirmed Resident #3 had significant weight loss and lacked a care plan to identify the goals and interventions to address the weight change. On 02/05/2025 at 9:33 AM, the CNO confirmed Resident #3 had significant weight loss and lacked a care plan to identify and direct the goals and interventions to address the resident's weight change. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Baseline/Comprehensive Care Plan and Short Term Care Plan, reviewed 12/08/2017, documented the facility will provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths, results of diagnostic testing limitations and goals. The care plan shall describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being as required. Care plans will be re-evaluated with a significant change of condition.

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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** 43311 Based on interview, clinical record review, and document review, the facility failed to ensure a Licensed Practical Nurse (LPN) adhered to professional standards of nursing practice when the LPN failed to ensure 1) the physician was notified of an abdominal fold skin tear, 2) a physician's order was in place prior to administering wound care, and 3) the care and treatment of a wound was documented for 1 of 12 sampled residents (Resident #5). This deficient practice had the potential to result in a resident not receiving consistent care of the resident's wound and potential worsening of the wound. Findings include: Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including wedge compression fracture of unspecified lumbar vertebrae, essential (primary) hypertension, and gout, unspecified. A Physician Order dated 11/21/2024, documented for Resident #5 Nystatin External Powder 100000 unit/gram topical, apply to affected areas topically every 6 hours as needed for candidiasis. Start 11/21/2024. A Skin assessment dated [DATE], documented Resident #5 an LPN had inspected a large slit in the left abdominal fold area. The LPN placed steri-strips (wound closure strips made of porous surgical tape used to close small wounds in a manner which pulls the skin on either side of the wound together) over the area instead of the Nystatin powder which was normally used and would monitor closely. A Nursing Progress Note dated 01/28/2025, documented Resident #5 was monitored closely for a large slit to the left abdominal fold, steri-strips remained intact, and would continue to monitor the resident. A Nursing Progress Note dated 01/29/2025, documented Resident #5 had a slit under the left abdominal fold which had steri-strips in place. A Nursing Progress Note dated 01/30/2025, documented Resident #5 had a slit to the left abdominal fold. The area was red in color and new steri-strips were applied. A Nursing Progress Note dated, 01/30/2025, documented the steri-strips on Resident #5's left abdominal fold were coming off and would be replaced the next morning before the resident left the facility for a couple of days to visit with family. Resident #5's clinical record lacked the following documentation: -measurements of the abdominal skin tear, -physician notification of the abdominal skin tear, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a physician order to treat the abdominal skin tear, and -a care plan describing the care and interventions provided for the abdominal skin tear. On 02/05/2025 at 11:26 AM, the Chief Nursing Officer (CNO) explained Resident #5's clinical record did not contain physician notification of a new wound or an order to provide wound care related to the LPN's skin assessment findings on 01/28/2025. The CNO confirmed the LPN's description of the left abdominal fold skin tear as a large slit and did not provide measurements of length, width, or depth or staging of the site. The CNO expected the LPN to document skin assessment findings consistent with nursing practice documentation, measure and document the skin tear, contact the physician with the assessment findings, and receive an order prior to wound care provided to the resident. The CNO confirmed the facility's standard of practice followed the Nevada Nurse Practice Act and explained the LPN was not acting within the LPN's scope of practice. On 02/05/2025 at 12:42 PM, an LPN explained the LPN had assessed Resident #5 for a large skin tear of the abdominal fold after receiving a shower on 01/28/2025, and had mistakenly described the skin tear as a large slit. The LPN confirmed applying steri-strips to the left abdominal fold skin tear after the skin assessment and without a physician's order on 01/28/2025. The LPN explained the description of the skin tear as a large slit was not a properly documented wound observation, had not provided measurements of the skin tear, and had not documented physician notification of the skin tear. On 02/05/2025 at 1:12 PM, the LPN confirmed Resident #5's clinical record did not contain a physician's order for wound care and would require a physician's order prior to any wound care. The LPN confirmed the LPN did not receive a wound care order from the physician and performed wound care without an order from 01/28/2025 through 01/31/2025. The LPN explained it was not within an LPN's scope of practice to provide wound care without a physician's order. The Nevada Nursing Practice Standards documented an LPN may not independently carry out those duties which require the substantial judgment, knowledge and skill of a registered nurse. An LPN shall determine before the performance of any task that he or she has the knowledge, skill and experience to perform the task competently. An LPN shall contribute to the plan of care established for a patient by recording and reporting to the appropriate person his or her observations by conducting a focused nursing assessment. A job description titled Licensed Practical Nurse, undated, documented the LPN would: -effectively communicate with all health care members regarding resident symptoms, reactions, and progress, -demonstrate knowledge and application of job duties within the scope of practice for an LPN, -note and initiate physician orders, verifying and clarifying conflicting or questionable orders when necessary, and -perform any and all professional nursing duties within the LPN's scope of practice. Cross referenced to F656.

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	02/06/2025

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's pressure ulcer was assessed and described in the electronic health record per facility policy for 1 of 12 sampled residents (Resident #6). This deficient practice had the potential for a resident to receive inadequate wound care and complications in healing due to the inability of staff to accurately monitor the wounds progress potentially impacting the resident's safety. Findings include: Resident #6 Resident #6 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis and other specified nutritional deficiencies. On 02/03/2025 at 1:52 PM, Resident #6 verbalized the resident had a wound on the resident's backside. An order for Resident #6, dated 01/27/2025, documented to apply Mepilex Border (an absorbent foam dressing for treating chronic and acute wounds) sacrum dressing on Monday, Wednesday, and Friday. Cleanse the area, apply skin prep, apply SilvrStat gel (a water-based gel containing silver used to treat wounds), apply Silvercel Non-Adherent (an antimicrobial alginate dressing), and then apply dressing. A Physical Therapy Progress Note, dated 01/02/2025, documented the Physical Therapist (PT) was called to assess the resident's posterior pressure ulcer. Nursing would continue to monitor the pressure sore and dress with a sacral bandage. If the pressure sore worsened nursing would contact PT to further assess the wound. A Nursing Progress Note, dated 02/03/2025, documented Resident #6's skin assessment was completed during and after the resident's shower. Resident #6's coccyx area was red and open. The Skin Assessment Progress Notes for Resident #6 did not include wound measurements or documentation of the stage of the pressure ulcer. The Comprehensive Care Plan for Resident #6 did not include a care plan to address the resident's wound, interventions for wound care, or the resident's goals for the wound. On 02/04/2025 at 11:18 AM, the Licensed Practical Nurse (LPN) for Resident #6 verbalized PT completed the wound assessments but Resident #6 did not have an open wound. The LPN verbalized the resident's wound care should have been care planned and the nurse should have created the care plan when the order for wound care was received. On 02/04/2025 at 2:52 PM, the PT verbalized the PT was not responsible for the wound care for Resident #6 and only assessed the wound if the nursing staff requested the PT to look at the wound and update the wound care orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2025 at 7:32 AM, the LPN verbalized the dressing to the resident's sacrum was changed by the night shift nurse. The LPN verbalized the wound should have had measurements documented since the Progress Notes documented the wound was open. On 02/05/2025 at 10:39 AM, the Chief Nursing Officer (CNO) verbalized the wound measurements for Resident #6's wound should have been documented in the notes. The CNO explained the charting of Resident #6's wound should have included documentation of the wound size and include a good description of the wound's appearance. The CNO verbalized a care plan related to the resident's wound care would have facilitated communication between disciplines and across shifts. The facility policy titled Wound Management, reviewed 01/25/2025, documented the assessment and description of wounds would include etiology and duration of the wound, anatomical location, dimensions (length x width x depth), wound appearance, tissue type, wound edges, condition of skin surrounding the wound, exudate: amount and type, odor, pain assessment, and signs of infection, foreign bodies, debris, and dressing remnants if present. Cross reference with tag F656

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F 0731 Level of Harm - Potential for minimal harm Residents Affected - Many	Request a waiver if it can't meet the nurse staffing requirements. 41848 Based on interview and document review, the facility failed to ensure residents, resident representatives, and resident's immediate family members were notified of the facility's waiver for the seven-day Registered Nurse (RN) requirement for 22 of 22 residents residing in the facility. This deficient practice had the potential for residents to not be aware of the staffing waiver indicating the facility did not have RN coverage in the facility seven days a week. Findings include: The facility waiver for the seven-day RN requirement, dated 04/16/2021, documented the facility would notify residents of the facility (or responsible guardians or legal representatives) and members of their immediate families of the waiver. On 02/04/2025 at 11:48 AM, the Chief Nursing Officer verbalized the facility had not notified residents or their representatives and family members of the waiver. The facility policy titled Resident Rights, revised 05/2021, documented the resident had the right to be notified of all services available.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41848 Based on observation, interview, and document review, the facility failed to ensure the daily posted nurse staffing information included the actual hours worked per shift for licensed and unlicensed staff responsible for resident care for 4 of 4 dates the posting was observed. This deficient practice had the potential for residents and visitors to not be aware of the most up to date information regarding staffing in the facility. Findings include: The staff posting on the bulletin board in the long-term care hallway did not include the actual hours worked by licensed and unlicensed staff on the following dates: - 02/03/2025. - 02/04/2025. - 02/05/2025. - 02/06/2025. On 02/06/2025 at 9:08 AM, the Chief Nursing Officer confirmed the posted nurse staffing information did not include the actual hours worked by staff. The facility policy titled Resident Rights, revised 05/2021, documented the resident had the right to be notified of all services available.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40377 Based on document review and interview the facility failed to maintain the required Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) committee members to include the Infection Preventionist, Chief Nursing Officer and the Medical Director. Findings include: The facility provided a list of QAPI Committee members. The list documented the QAPI committee was comprised of the Chief Executive Officer, the Chief Nursing Officer, the Medical Director or designee, the Infection Preventionist, and two other facility staff. On 02/06/2025 at 11:03 AM, the Risk Manager verbalized the QAPI committee required at a minimum the Administrator, the Director of Nursing, Medical Director or designee, the Infection Preventionist and two other staff members. The Risk Manager provided the QAPI sign in sheets for the following dates, the following noted QAPI members were not on the QAPI meeting sign-in sheet and were not in attendance: February 14, 2024 - Medical Director (MD) March 13, 2024 - Infection Preventionist (IP), MD April 10, 2024- IP, MD May 14, 2024 - Chief Nursing Officer (CNO), MD June 19, 2024 - IP, MD July 10, 2024 - CNO, MD August 14, 2024 - CNO, MD September 11, 2024 - CNO, MD October 9, 2024 - MD November 13, 2024 - Chief Executive Officer, CNO, MD December 11, 2024 - MD On 02/06/2025 at 11:23 AM, the Risk Manager confirmed the aforementioned members of QAPI had not been in attendance at the identified meeting dates. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/06/2025 at 11:52 AM, the Chief Executive Officer confirmed the missing members of QAPI on the identified meeting dates. The facility policy titled Long Term Care Quality Assessment and Assurance Plan (QAPI), reviewed 04/10/2024, documented the Quality Assessment and Assurance Committee would consist at a minimum of the Director of Nursing Services, the Medical Director or his/her designee, at least three other members of the facility's staff, at least one who must be the Administrator, Owner, a Board member or other individual in a leadership role, and the Infection Preventionist. The QAA meetings would be held at least quarterly and with enough frequency to conduct required QAPI activities.