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	04/23/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure residents who received psychotropic medications had adequate monitoring for side effects, appropriate indication for usage, and required gradual dose reductions (GDR) for 2 of 5 residents selected for unnecessary medication review (Resident #5 and #22). This deficient practice had the potential to result in unnecessary medication use and adverse drug reactions.Findings include:Resident #5 Resident #5 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, insomnia, unspecified, and anxiety disorder, unspecified. A physician order dated 07/12/2025, documented doxepin hydrochloride (HCl) oral tablet, 6 milligrams (mg), give one tablet by mouth at bedtime for insomnia. A physician order dated 07/27/2025, documented Rexulti oral tablet 2 mg (brexpiprazole), give one tablet by mouth in the morning for hallucinations. Side effects include sleepiness. A physician order dated 02/18/2026, documented Sertraline HCl oral tablet 25 MG, give one tablet by mouth in the morning for depression. Side effects include sleepiness, fatigue, and or drowsiness. A physician order dated 08/25/2025 documented hydroxyzine HCl oral tablet 25 MG, give one tablet by mouth two times a day for agitation, yelling, and/or screaming. Side effects include sedation, drowsiness, and fatigue. A Providers Progress note dated 03/26/2026, documented a gradual dose reduction (GDR) was not indicated at this time because Resident #5 continued to have episodes of not sleeping for many days at a time and had improved with doxepin. On 04/21/2026 at 7:45 AM, Resident #5 was asleep in bed, and a Certified Nursing Assistant (CNA) was attempting to feed the resident while the resident slept. On 04/21/2026 at 1:57 PM, Resident #5 was asleep in bed. On 04/21/2026 at 3:45 PM, a fire drill was conducted and alarms sounded loudly throughout the facility. Resident #5 was in bed asleep and slept through the fire drill. On 04/22/2026 at 3:00 PM, Resident #5 was in bed asleep. On 04/22/2026 at 3:00 PM, a CNA confirmed Resident #5 had been sleeping all day for approximately (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the last two weeks. The CNA verbalized the CNA had not reported the resident was sleeping throughout the day. On 04/23/2026 at 11:23 AM, the Chief Nursing Officer (CNO) confirmed Resident #5's condition should have been reported to a Physician/Provider when the resident was noted to have been sleeping throughout each day for approximately two weeks. Resident #22 Resident #22 was admitted to the facility on [DATE], with diagnoses including Parkinsons, unspecified, dementia unspecified, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and insomnia unspecified. The physician's order dated 12/19/2025, documented Aricept oral tablet 10 mg (Donepezil Hydrochloride (HCl)), give one tablet by mouth in the morning for hallucinations due to Parkinson's. The physician's order dated 01/23/2026, documented Namenda oral tablet 5 mg (Memantine HCl), give one tablet by mouth in the morning for hallucinations. Resident #22's Side Effect Monthly Flow Sheet for April 2026 documented monitoring for Trazodone side effects during each shift. The Side Effect Monthly Flow Sheet for April 2026 lacked any documentation of Namenda and Aricept side effect monitoring. On 04/21/2026 at 3:36 PM, the Registered Nurse (RN) explained behavior and side effect monitoring were completed during each shift. Behavior monitoring was completed in the resident electronic health record (EHR), and side effect monitoring was completed on a paper document titled Side Effect Monthly Flow Sheet. The RN verbalized Resident #22 had frequent hallucinations and Resident #22 received Namenda and Aricept for hallucinations. The RN explained the Side Effect Monthly Flow Sheet was created by the Director of Nursing by running a report to determine psychotropic medications prescribed for each resident. The RN confirmed only Trazodone side effects were monitored for Resident #22 and confirmed side effect monitoring should have been completed for Namenda and Aricept. On 04/21/2026 at 4:21 PM, the CNO explained side effects and behavior monitoring were required for all psychotropic medications. The CNO confirmed Resident #22's Namenda and Aricept side effects were not being monitored for April 2026. The CNO explained Namenda was used for hallucinations, which could represent a diagnosis or behavior; however, this was not an appropriate indication for usage because Resident #22 did not have a diagnosis of hallucinations. The facility's policy titled Psychotropic Medication Use, reviewed 04/18/2025, documented each resident's drug regimen would be free from unnecessary drugs. Psychotropic drugs may be ordered by a physician when medically necessary, when indicated by assessment of the resident, after non-pharmaceutical interventions had been tried and at the lowest possible dose. Residents who were prescribed antipsychotic medication would receive gradual dose reduction unless clinically contraindicated in an effort to discontinue these drugs. Licensed nurses would be aware of potential side effects of psychotropic medications and report any side effects to the resident's attending physician.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and document review, the facility failed to ensure accurate and complete submission of required staffing information to the Centers for Medicare & Medicaid Services (CMS). This deficient practice resulted in inaccurate federal reporting of staffing levels.Findings include:The Payroll-Based Journal (PBJ) Staffing Data Report 1705D October through December 2025 documented the following dates with no Registered Nurse (RN) coverage reported:10/01; 10/02; 10/03; 10/06; 10/08; 10/09; 10/14; 10/15; 10/20; 10/21; 10/23; 10/27; 10/28; 10/29; 10/30.11/03; 11/05; 11/06; 11/08; 11/12; 11/13; 11/14; 11/19; 11/20; 11/21; 11/26; 11/28; 11/29; 11/30.12/03; 12/04; 12/05; 12/06; 12/10; 12/11; 12/12; 12/13; 12/18; 12/19; 12/20; 12/21; 12/23; 12/25; 12/29; 12/31.A review of the Long-Term Care Staffing Hours Sheets dated October through December 2025 documented RN coverage on multiple dates CMS reported as having no RN hours, including:10/01; 10/03; 10/06; 10/08; 10/09; 10/14; 10/15; 10/16; 10/20; 10/21; 10/23; 10/30.11/05; 11/06; 11/12; 11/13; 11/14; 11/19; 11/20; 11/21; 11/26; 11/28.12/03; 12/04; 12/05; 12/10; 12/11; 12/12; 12/18; 12/19.On 04/23/2026 at 7:40 AM, the Human Resources Director provided the Certification and Survey Provider Enhanced Reports (CASPER) 1702S, Staffing Summary for Quarter 1 (October through December 2025). The Human Resources Director verbalized this report was the only document available showing how many staffing hours were reported. The Human Resources Director explained being unable to pull a report showing what specific staffing hours and staff were reported to CMS for each day worked.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review the facility failed to ensure 4 of 5 residents sampled for pneumococcal vaccinations (Resident #2, #4, #16, and #17) were screened for eligibility to receive a pneumococcal vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the indicated pneumococcal vaccine was offered and either administered or declined. This deficient practice had the potential to place residents at increased risk for preventable illness and complications associated with pneumococcal disease. Findings include:Resident #2 Resident #2 was admitted to the facility on [DATE], with a diagnosis of active primary progressive multiple sclerosis. Resident #2's State Immunization Record (SIR) did not document the resident had ever received vaccination with a pneumococcal vaccine. Resident #2's clinical record documented the resident declined administration of a pneumococcal vaccine when admitted to the facility in 2015, and did not include documentation the resident had been screened for eligibility to receive a pneumococcal vaccine, education regarding the vaccine was provided to the resident and/or the resident representative, and the vaccine was offered and either was administered or declined. On 04/22/2026 at 10:56 AM, the Infection Preventionist (IP) explained when Resident #2 was admitted to the facility in 2015, the resident was not screened for eligibility to receive a pneumococcal vaccine due to the resident was under [AGE] years of age. The IP confirmed Resident #2's clinical record lacked documented evidence the resident was screened for eligibility to receive a pneumococcal vaccine, education regarding the Centers for Disease Control and Prevention's (CDC) recommended vaccines, pneumococcal conjugate vaccine (PCV) 13 or pneumococcal polysaccharide vaccine 23 (PPSV23) were provided to the resident and/or the resident's representative, and a vaccine was offered as indicated and either administered or declined. The IP confirmed Resident #2 had not been screened for eligibility to receive a pneumococcal vaccine since the resident was admitted to the facility in 2015. Resident #4Resident #4 was admitted to the facility on [DATE], with a diagnosis of major depressive disorder, recurrent, unspecified. A diagnosis of chronic obstructive pulmonary disease, unspecified, was added on 10/27/2020.Resident #4's SIR documented the resident was administered one dose of PCV13 on 12/27/2021 and was administered one dose of PPSV23 on 06/21/2023.On 04/22/2026 at 11:00 AM, the IP confirmed Resident #4's clinical record lacked documented evidence the resident was screened after 06/21/2023 for eligibility to receive a pneumococcal vaccine, education regarding the CDC's recommended vaccines, PCV-15 or PCV-21, was provided to the resident and/or the resident's representative, and a vaccine was offered as indicated and either administered or declined.Resident #16Resident #16 was admitted to the facility on [DATE], with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #16's SIR documented the resident was administered one dose of PCV-13 on 09/29/2016 and one dose of PPSV23 on 05/08/2019. On 04/22/2026 at 11:28 AM, the IP confirmed Resident #16's clinical record lacked documented evidence the resident was screened after 01/28/2020 for eligibility to receive a pneumococcal vaccine, education regarding the CDC's recommended vaccines, PCV-20 or PCV-21, was provided to the resident and/or the resident's representative, and a vaccine was offered as indicated and either administered or declined.Resident #17Resident #17 was admitted to the facility on [DATE], with a diagnosis of Rheumatoid Arthritis. Resident #17's SIR documented the resident was administered one dose of PCV-13 on 12/27/2021. On 04/22/2026 at 11:28 AM, the IP confirmed Resident #16's clinical record lacked documented evidence the resident was screened after 01/28/2020 for eligibility to receive a pneumococcal vaccine, education regarding the CDC's recommended vaccines, PCV-20 or PCV-21, was provided to the resident and/or the resident's representative, and a vaccine was offered as indicated and either administered or declined.The CDC guideline titled Pneumococcal Vaccine Recommendations, dated 02/25/2026, documented adults 50 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	years or older had the following options to complete a pneumococcal vaccine schedule:For Adults 50 years or older: - Those with no prior vaccine or those who had an unknown vaccination history, had the option to receive either PCV15, PCV20 or PCV21. -For those who had previously received PCV15, the recommendation was to administer a dose of PPSV23 one year later. If the individual was previously administered PCV15 and PPSV23, no additional vaccine was required.-For those who had previously received PCV20 or PCV21, an additional vaccination was not recommended.Adults 65 years or older:-Based on shared clinical decision-making, individuals 65 years or older had the option to receive PCV20 or PCV21 or could choose not to get any additional vaccines.-PCV20 OR PCV21 could be administered if the individual had received both of the following: -PCV13 (but not PCV15, PCV20, OR PCV21) at any age AND -PPSV23 at or after the age of 65.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview, and document review the facility failed to ensure a Registered Nurse (RN) was screened annually for eligibility to receive a COVID-19 (COVID) vaccine, education regarding the vaccine was provided, and the vaccine was offered and either administered or declined. This deficient practice had the potential to affect compliance with vaccination requirements and increase the risk of disease transmission. Findings include:Employee #1 was hired as an RN on 02/28/2022. A facility document titled 2023-2024 COVID Vaccine Consent/Declination form dated 09/2023, documented Employee #1 declined COVID vaccines on 10/13/2023. The form included questions to be answered by the employee and this portion of the form was not completed. The questions to be answered included the following: -Is the person sick today, is moderately or severely ill without fever?-Have you ever received a COVID-19 vaccine?-Do you have a severe allergic reaction to any component of the vaccine?-Do you have a bleeding disorder or are you taking a blood thinner? -Are you currently pregnant or breastfeeding? On 04/23/2026 at 11:41 AM, the facility was not able to provide documented evidence Employee #1 was screened for eligibility to receive a COVID vaccine, provided education regarding the vaccine, and if a COVID vaccine was offered and administered or declined from 10/14/2023 - 04/23/2026. On 04/23/2026 at 11:42 AM, the Infection Preventionist (IP) confirmed Employee #1 had not been screened for eligibility to receive a COVID Vaccine, provided education regarding the vaccines, and was not offered an opportunity to receive or decline vaccination. The IP confirmed none of the facility staff had been offered a COVID vaccine, provided education regarding the vaccine, and/or provided an opportunity to receive or decline the vaccine between 01/01/2024 and 04/23/2026. A Centers for Disease Control and Prevention (CDC) document titled COVID-19 Vaccination for Long-term Care Residents dated 06/11/2025, documented most adults ages 18 years and older, including people who work in long-term care (LTC) settings, should receive one dose of an updated COVID-19 vaccine. The CDC recommended two doses of an updated COVID-19 vaccine for everyone ages 65 and older, including those who work in LTC settings.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to ensure 1 of 12 sampled residents (Resident #5) maintained a dignified existence when the resident's bedroom door was left open and the resident's uncovered catheter bag containing urine was visible from the hallway. This deficient practice had the potential to compromise the resident's privacy and dignity. Findings include:Resident # 5 Resident # 5 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, chronic kidney disease, and diabetes mellitus type II without complications.On 04/20/2026 at 11:30 AM, Resident #5 was in the resident's room asleep. The resident's catheter bag was attached to the side of resident's bed and was not covered with a dignity bag. The resident's bedroom door was left open and the catheter bag containing urine was visible from the hallway. On 04/20/2026 at 2:36 PM, Resident #5 was in the resident's room asleep. The resident's catheter bag was attached to the side of resident's bed and was not covered with a dignity bag. The resident's bedroom door was left open and the catheter bag containing urine was visible from the hallway. On 4/21/2026 10:34 AM, Resident #5 was in the resident's room asleep. The resident's catheter bag was attached to the side of resident's bed and was not covered with a dignity bag. The resident's bedroom door was left open and the catheter bag containing urine was visible from the hallway. On 04/21/2026 at 1:57 PM, Resident #5 was in the resident's room asleep. The resident's catheter bag was attached to the side of resident's bed and was not covered with a dignity bag. The resident's bedroom door was left open and the catheter bag containing urine was visible from the hallway. On 04/22/2026 at 9:04 AM, Resident #5 was in the resident's room asleep. The resident's catheter bag was attached to the side of resident's bed and was not covered with a dignity bag. The resident's bedroom door was left open and the catheter bag containing urine was visible from the hallway. On 04/22/2026 at 3:00 PM, a Certified Nursing Assistant (CNA) confirmed Resident #5's catheter bag was not covered with a dignity bag and urine was visible from the hallway. On 4/23/2026 at 8:45 AM, Resident #5 was in the resident's room asleep. The resident's catheter bag was attached to the side of resident's bed and was not covered with a dignity bag. The resident's bedroom door was left open and the catheter bag containing urine was visible from the hallway. On 04/23/2026 at 11:25 AM, The Chief Nursing Officer (CNO) confirmed CNAs were provided training related to placing catheter collection devices inside of a dignity bag. The expectation was each resident with a urinary catheter would have the catheter's urinary collection bag placed inside of a dignity bag at all times when the bag was visible to others. The facility policy titled, Resident Rights last updated 03/03/2026, documented residents were to be treated with consideration and respect with full recognition of the resident's dignity and individuality.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a required Minimum Data Set 3.0 (MDS) assessment when a resident passed away in the facility for 1 of 1 residents reviewed (Resident #20). This deficient practice had the potential to affect the accuracy of federally required reporting and compliance with MDS submission requirements.Findings include:Resident #20Resident #20 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, and nutritional deficiency. Resident #20 expired on [DATE].On [DATE] at 11:18 AM, the Chief Executive Officer (CEO) verbalized being the MDS Coordinator.On [DATE] at 1:54 PM, the CEO verbalized being notified MDS assessments needed to be completed when the electronic health record (EHR) assigned assessments. The Administrator explained all residents required admission, quarterly, annual, change of condition, death, and reentry MDS assessments. The Administrator confirmed the MDS assessment for Resident #20, who passed away on [DATE], was not completed.The facility policy titled MDS (Minimum Data Set), reviewed [DATE], documented the nursing home was to maintain compliance with all state and federal mandate for data collection and transmission of the MDS.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set 3.0 (MDS) assessments were completed accurately for residents receiving antipsychotic medications for 1 of 12 sampled residents (Resident #22). This deficient practice had the potential to result in inaccurate federal reporting, missed required monitoring, and incorrect classification of psychotropic medication use.Findings include:Resident #22Resident #22 was admitted to the facility on [DATE], with diagnoses including Parkinson's, unspecified, dementia unspecified, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and insomnia unspecified.The physician's order dated 12/19/2025, documented Aricept oral tablet 10 milligrams (mg) (Donepezil Hydrochloride (HCl)), give one tablet by mouth in the morning for hallucinations due to Parkinson's.The physician's order dated 01/23/2026, documented Namenda oral tablet 5 mg (Memantine HCl), give one tablet by mouth in the morning for hallucinations.The MDS assessment dated [DATE], section N - Medication, N0415 - High Risk Drug Classes: Use and Indication documented zero antipsychotic medications.On 04/21/2026 at 3:01 PM, the Chief Executive Officer reported currently completing MDS assessments and explained MDS assessments were previously completed by the former Director of Nursing. The CEO explained when completing the MDS assessment, reviewing medication orders, the Medication Administration Record (MAR), and asked nursing staff questions when needed. The CEO verbalized the MDS assessment included all antipsychotic medications and accurate identification of antipsychotic medications was important for tracking, ensuring residents received gradual dose reductions (GDR), monitoring behaviors, and tracking side effects. The CEO verbalized antipsychotic medications were dangerous medications requiring strict monitoring.The CEO confirmed the MDS assessment was inaccurate and did not classify Namenda and Donepezil as antipsychotics because they were ordered for treatment of Parkinson's-related hallucinations. The CEO verbalized not realizing the medications should have been classified as antipsychotics due to drug classification requirements.The facility policy titled MDS (Minimum Data Set), reviewed 04/02/2025, documented the nursing home was to maintain compliance with all state and federal mandates for data collection and transmission of the MDS. Comprehensive and Quarterly assessment errors inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care were considered Significant Errors.

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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** Based on interview, clinical record review, and document review, the facility failed to ensure prescribed chemotherapeutic medications were care planned for 1 of 12 sampled residents (Resident #17). This deficient practice had the potential to result in the resident not receiving the services and protections needed to keep the immunocompromised resident safe from infections, and ensure the resident was kept comfortable, medications administered correctly and safely, diagnostic labs were done timely, and the resident was monitored for signs and symptoms of adverse reactions to the chemotherapeutic medication. Findings include:Resident #17 was admitted to the facility on [DATE], with a diagnosis of rheumatoid arthritis, unspecified. Resident #17 had a diagnosis of myelodysplastic syndrome (MDS) and the diagnosis was not documented on the resident's list of diagnoses. A physician order dated 01/26/2026, documented Inqovi oral tablet 35-100 milligrams (mg) (decitabine- cedazuridine) give one tablet by mouth, one time a day, for 5 days on and 23 days off for MDS. Resident #17's Medication Administration Records (MAR) documented Inqovi was administered daily at breakfast from 01/26/2026 - 04/23/2026. On 04/21/2026 at 1:54 PM, the Chief Executive Officer (CEO) verbalized when writing care plans the facility followed the Resident Assessment Instrument (RAI) manual. On 04/23/2026 at 11:24 AM, the Chief Nursing Officer (CNO) confirmed Resident #17's Comprehensive Care Plan lacked a care plan related to Inqovi including administration of the medication, precautions to take when administering the medication, side effects of the medication, monitoring of side effects, protective isolation needs for the resident, and handling of bodily fluids/excretions. A facility email regarding Resident #17, titled Chemotherapy dated 01/22/2026, documented the oncologist recommendations regarding the treatment, plan of care, and side effects of Inqovi, a chemotherapeutic medication. The recommendations included the following: -The medication was to be taken on an empty stomach, two hours before eating or two hours after eating. The medication would be given at 6:00 AM and could be taken with other medications.-The medication could not be touched with skin, and nurses would need to double glove prior to popping the medication out of the blister pack and wash their hands with soap and water afterwards.-The medication could not be crushed or dissolved and had to be given whole.-The medication was to be kept in the bottom locked drawer of the medication cart for safety.-The medication treatment was ongoing and would likely need to be administered for the remainder of the resident's life, as long as the resident's body could tolerate the medication and/or as long as the resident chose to take the medication.-Every Wednesday a blood draw was completed for a Complete Blood Count (CBC) and a Comprehensive Metabolic Panel (CMP). The results were to be faxed to the resident's provider and the oncologist.-For the resident's safety staff were to wear a mask while in the resident's room and the resident was to wear a mask when leaving the room. The rationale was the chemo-therapeutic medication would further decrease the resident's already suppressed immune system.-The resident was to be administered one unit of packed red blood cells (PRBC) if the resident's hemoglobin (Hgb) was below eight, and two units if the resident's Hgb was below seven. Transfusions could be completed at the facility when needed.-The resident was to receive a platelet transfusion if the resident's platelets fell below 10. Transfusion could be completed at the facility when needed. The potential side effects of Inqovi and what to do if identified included:-Fatigue: maintain the resident's current level of activity even when it hurts to do so, in order to prevent further debilitation.-Increased cough and/or shortness of breath (SOB): notify Oncology.-Constipation: encourage drinking as much water as possible each day, initiate bowel protocol as indicated.-Muscle and joint pain: if not well managed with Oxycodone 10 mg every six hours, notify the provider and Oncologist to request to increase frequency to every four hours.-Nausea and/or vomiting: if Zofran was not effective, give Compazine every six hours as needed. If Zofran and Compazine were not effective notify (continued on next page)

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	295063	A. Building B. Wing	04/23/2026

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oncology.-Diarrhea: Give Imodium for two -three loose bowel movements in a 12-hour period.-For Nausea/Vomiting/Diarrhea: at the same time, monitor for fluid loss. Administer a bolus of fluids as indicated to prevent dehydration.-Rash/itchy skin: keep skin moisturized with lotion, avoid direct sun exposure and use sunscreen when going outside.-Fluid retention and or swelling in lower extremities: elevate lower extremities, weight daily on days 1-14 of the course of medication and notify provider and oncology for a weight gain of more than five pounds in one week.-Headache: give Tylenol (acetaminophen), do not give non-steroidal anti-inflammatory drugs (NSAID)-Liver: monitor for yellowing of the eyes and skin, dark urine, or excessive bleeding.-Monitor lab values: glucose, albumin, sodium, and calcium. The most important one which would require everyone involved was the chemo would be excreted in the resident's urine and stool. The interventions included: -Place red trash bags in the resident's bathroom for the disposal of all dry wipes, green wipes, and paper towels.-The red bags were to be disposed of in the biohazard trash can in the dirty utility room.-Clean the resident's bathroom with bleach.-No one other than the resident was to use the resident's toilet.-Place a sign on the door to the resident's bathroom stating no one was to use the resident's bathroom to be safe.-The measures were to be taken for a total of seven days starting with days 1-5 and for 48 hours afterwards. The Oncologist would send a calendar indicating the days the red trash bags were to be used. The calendar was to be placed in the resident's bathroom to assist staff to know when the red trash bags should be used. The Resident Assessment Instrument (RAI) 3.0 manual, Chapter 2, The Care Area Assessment (CAA) Process and Care Plan Completion dated 10/2023, documented the residents' plan of care would be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The resident's care plan would be revised based on changing goals, preferences, and needs of the resident and in response to current interventions. The RAI 3.0 manual, Chapter 4, CAA Process and Care Planning, dated 10/2023, documented the care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident was receiving.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise and update the comprehensive personˆcentered care plan for 1 of 12 sampled residents (Resident #4) after the initiation of a new anticoagulant medication for a new diagnosis of atrial fibrillation. This deficient practice had the potential to result in unmet care needs, inadequate monitoring, and increased risk of adverse effects related to anticoagulant therapy. Findings include: Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted from hospital on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, insomnia, and atrial fibrillation. Resident #4's medication regimen was updated, and Xarelto oral tablet 20 milligrams (mg) (Rivaroxaban). Give 1 tablet by mouth in the morning for atrial fibrillation was added to the Medication Administration Report (MAR) and MDS as an anti-coagulant medication for atrial fibrillation. Resident #4's clinical record lacked documented evidence the care plan was revised following the new medication being prescribed and administered. No updates were found in the resident's care plan to address anticoagulant therapy needs, such as bleeding risk assessments, or medication education. Resident #4's MAR for February, March, and April 2026 indicated Xarelto 20mg was administered daily as prescribed. On 04/22/2026 at 2:31 PM, a Licensed Practical Nurse (LPN) explained the care plan should be reviewed and updated following a resident's change in high-risk medications. The LPN confirmed no revisions were completed to Resident #4's care plan following the return of the resident to the facility with a new high-risk medication. The LPN confirmed Resident #4 was administered Xarelto 20 mg daily for two months with no revisions completed to Resident #4's care plan. On 04/22/2026 at 3:06 PM, the Chief Nursing Officer (CNO) explained care plans were initiated and updated right away when a significant change in condition occurred for a resident. The CNO verbalized care plans were updated to ensure resident safety and ensure interventions to meet the resident's needs. The CNO expected care plans to be updated when a high-risk medication was prescribed, to include prevention interventions, and risk for side effects of a medication. The CNO confirmed Resident #4's care plan was initiated on 02/18/2026 with no indication an anticoagulant was prescribed or monitored in the care plan. The CNO confirmed a high-risk medication was expected to be care planned right away for a resident. The Resident Assessment Instrument (RAI) 3.0 manual, Chapter 2, The Care Area Assessment (CAA) Process and Care Plan Completion dated 10/2025, documented the residents' plan of care would be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The resident's care plan would be revised based on changing goals, preferences, and needs of the resident and in response to current interventions.The RAI 3.0 manual, Chapter 4, CAA Process and Care Planning, dated 10/2025, documented the care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident was receiving.

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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** Based on observation, interview, clinical records review, and document review the facility failed to ensure care was provided in accordance with professional standards of practice when staff provided feeding assistance to a sleeping resident. This deficient practice had the potential to result in physical and psychosocial harm to include aspiration, and an undignified existence. Findings include:Resident #5Resident #5 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, insomnia, unspecified, and anxiety disorder, unspecified.On 04/21/2026 at 8:00 AM, Resident #5 was lying flat on the resident's bed. The resident's eyes were closed, and the mouth was slightly ajar. A Certified Nursing Assistant (CNA) sat on the right side of the resident's bed and scooped scrambled eggs from the plate into the resident's mouth. The resident did not respond, and the eggs fell out of the left side of the resident's mouth onto Resident #5's face and clothing. The CNA asked if the resident wanted more food and the resident moaned in response. The CNA placed the spoon in resident mouth and the resident stirred.On 04/22/2026 at 3:00 PM, the CNA verbalized for approximately two weeks, Resident #5 had begun sleeping throughout the night and day. The CNA stated sleeping residents were to be woken up for meals. If the resident was unable to be awoken, the food tray would be left at the resident's bedside for a couple of hours to see if they will eat.On 04/23/2026 at 8:40 AM, Resident #5 was asleep when the resident was asked what was for breakfast and if the resident ate. The resident responded the resident was asleep and did not eat anything for breakfast. There were crumbs of food on Resident #5's face and shirt.On 04/23/2026 at 11:25 PM, the Chief Nursing Officer (CNO) confirmed residents should be awake and positioned at a 30-to-45-degree angle when assisted with eating. The CNO verbalized residents fed while asleep could be at risk of aspiration.Resident #5's comprehensive care plan focus, revised 04/18/2022, documented Resident #5 had activities of daily living (ADL) self-care performance deficit related to weakness on the right side. An intervention, revised 04/18/2022, documented Resident #5 was able to eat independently with supervision and tray set up and clean up assistance.A nurse progress note, dated 03/26/2026, documented Resident #5 had been more lethargic lately and needed to be fed by staff because the resident was too tired to eat.The Minimum Data Set (MDS) 3.0 Assessment, dated 04/17/2026, Section GG, Self-Care Assessment, documented the resident was independent for eating and could feed themself. The resident, however, did require staff set up and clean up assistance.The facility policy titled, Feeding the patient with dysphagia last updated 04/29/2015, directed staff to place the resident in an upright sitting position for about twenty minutes before feeding and twenty minutes after feeding. When one mouthful was swallowed, staff should remove the spoon immediately. If a resident drools, staff were expected to wipe the resident's mouth before the next mouthful.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, and interview, the facility failed to ensure 1) the administration of intravenous (IV) medications was documented by the nurses who administered the IV medications and 2) the diagnoses of myelodysplastic syndrome and leukemia were not included on a residents Active Medical Diagnosis Record for 1 of 12 sampled residents (Resident #17). This deficient practice had the potential for the resident to not receive appropriate care and/or medications.Findings include: Resident #17 Resident #17 was admitted to the facility on [DATE], with diagnoses including rheumatoid arthritis, scoliosis, and fibromyalgia. Resident #17's physician's order dated 04/19/2026, documented: Piperacillin Sodium-Tazobactam Solution Reconstituted 3-0.375 milligrams (mg). Use 3.375 mg IV every six hours for pneumonia until 04/24/2026 at 4:00 AM. On 04/23/2026 at 9:07 AM, an emergency room (ER) nurse went to Resident #17's Long Term Care unit (LTC) room to transport the resident to the ER for administration of the IV antibiotic. The Licensed Practical Nurse (LPN) explained the ER nurses were trained in administering IV medications. On 04/23/2026 at 12:50 PM, the ER nurse returned to the LTC with Resident #17. The ER nurse informed the LPN the resident's IV antibiotics were administered and the resident would need an IV site change as the present site was sore. An LTC Medication Administration Record (MAR) dated 04/01/2026-04/30/2026, documented Resident #17 was administered the medication at 9:49 AM on 04/23/2026. The MAR documentation lacked an indication the IV medication was administered by the ER nurse and was instead signed as administered by the LTC LPN, who did not administer the medication. Nevada State Board of Nursing NAC 632.220, retrieved on 04/28/2026, documented Licensed Practical Nurses (LPNs) with a course in intravenous therapy approved by the Board could administer IV fluids under specific conditions. LPNs were required to act under the supervision of a physician, physician assistant, or registered nurse and follow the procedures outlined in the Nevada Administrative Code. This included the ability to start peripheral intravenous therapy, introduce electrolytes, nutrients, or vitamins, and administer intravenous fluids and medications from commercially prepared or premixed containers. The nurse must establish and/or document the intervention in a patient record, that minimally includes the patient's medical information, the practitioner and nurse's assessments/notes and orders. Resident #17's Active Medical Diagnosis record did not include the resident's diagnoses of myelodysplastic syndrome (a group of blood cancers) or leukemia (a cancer involving blood forming tissues. Dysfunctional white blood cells are produced by bone marrow and crowd out healthy white blood cells). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17's last Quarterly [NAME] Data Set 3.0 (MDS) assessment, dated 02/02/2026 Section I Active Diagnoses in the last seven days, item (10100), Cancer with and without metastasis was not marked to indicate the resident had a diagnosis of cancer, and item (18000) Additional active diagnoses did not include the diagnoses of myelodysplastic syndrome or leukemia. A physician order dated 01/26/2026, documented Inqovi oral tablet, 35-100 milligram (mg) (Decitabine-Cedazuridine) give one tablet by mouth one time a day for five days on, followed by 23 days off, for myelodysplastic syndrome. Resident 's #17 Comprehensive Care Plan dated 01/26/2026 documented the focus was about chemotherapy for the disease process leukemia). On 04/23/2026 at 11:25 AM, the Chief Nursing Officer (CNO) confirmed Resident #17's current Active Medical Diagnosis List and Quarterly MDS assessment dated [DATE] did not include the resident's diagnoses of myelodysplastic syndrome and leukemia.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure 1 of 12 sampled residents had the appropriate isolation precautions in place. This lapse in infection control protocols jeopardized the safety of the immunocompromised resident by creating an unnecessary risk of infection Resident #17 Resident#17 was admitted to the facility on [DATE], with diagnoses including rheumatoid arthritis, unspecified. Resident #17's Active Medical Diagnosis record did not include the resident's diagnoses of myelodysplastic syndrome (a group of blood cancers) or leukemia (a cancer involving blood forming tissues. Dysfunctional white blood cells are produced by bone marrow and crowd out healthy white blood cells). On 04/21/2026 at 11:01 AM, an Enhanced Barrier Precaution (EBP) was posted on the door outside of Resident #17's room. The sign did not include instructions for staff and/or visitors to wear a mask when entering the resident's room. Certified Nursing Assistants entered the resident's room and did not wear a mask. A facility email regarding Resident #17, titled Chemotherapy dated 01/22/2026, documented the oncologist recommendations regarding the treatment, plan of care, and side effects of Inqovi, a chemotherapeutic medication. The recommendations included the following: - For the resident's safety staff were to a wear mask while in the resident's room and the resident was to wear a mask when leaving the room. The rationale was the chemo-therapeutic medication would further decrease the resident's already suppressed immune system.-Place red trash bags in the resident's bathroom for the disposal of all dry wipes, green wipes, and paper towels.-Dispose of red bags in the biohazard trash can in the dirty utility room.-Clean the resident's bathroom with bleach.-No one other than the resident was to use the resident's toilet.-Place a sign on the door to the resident's bathroom stating no one was to use the resident's bathroom to be safe.-These measures were to be taken for a total of seven days starting with days 1-5 and for 48 hours afterwards.-A calendar indicating the days red trash bags were to be used was to be placed in the resident's bathroom. The Calendar was to assist staff to know when the red trash bags should be used. On 04/23/2026 at 11:25 PM, the Chief Nursing Officer (CNO) verbalized the CNO was not aware of the email regarding the recommendations from the Oncologist, including infection control measures. The CNO confirmed Resident #17 was immunocompromised and EBP were not the correct level of isolation precautions for an immunocompromised person. The CNO confirmed the resident should have been placed on reverse isolation precautions which required staff and visitors to wear mask when entering the resident's room and for the resident to wear a mask when leaving the resident's room. The CNO confirmed the expectation was recommendations from the Oncologist office would be followed. A Centers for Disease Prevention and Control (CDC) document titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions (EBP) in Nursing Homes dated 06/28/2024, documented EBPs were to be used when a resident had wounds and/or indwelling devices during care of the device or when providing wound care. Gowns and gloves were the recommended personal protective equipment (PPE). EBPs did not include wearing a mask when entering the resident's room or when providing care. The recommendation for EBPs did not include the protection of immunocompromised residents including residents with cancer diagnoses and/or orders for chemotherapeutic medications.

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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 interview, personnel record review, and document review, the facility failed to ensure elder abuse prevention training was completed timely for 1 of 20 sampled employees (Employee #7). This deficient practice had the potential to place all residents at risk for abuse and neglect. Findings include:Employee #7Employee #7 was hired as a Certified Nursing Assistant with a start date of 10/15/2023.Employee #7's personnel record documented annual abuse training completed on 01/17/2025 and 03/10/2026. The 2026 annual abuse training was completed late.On 04/23/2026 at 8:35 AM, the Human Resources (HR) Director explained all staff in the facility were required to complete abuse training upon hire and annually thereafter. The HR Director verbalized annual training was defined as completion every 12 months. The HR Director confirmed Employee #7 had not completed annual abuse training timely.The facility policy titled Training and Education, reviewed 01/05/2026, documented all employees were trained and competent to perform their assigned duties. All personnel would receive training on the prevention, identification and reporting of abuse, neglect, exploitation and misappropriation of resident property upon hire and annually thereafter.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to maintain a complete and current facility assessment. This deficient practice had the potential to result in staffing levels and facility resources not matching resident needs.Findings include:The facility's assessment dated [DATE] documented an average number of nine nurses and twentyˆone nurse aides.On 04/21/2026 at 3:55 PM, the Chief Executive Officer (CEO) verbalized the facility assessment was not reviewed when the change in administration occurred and did not include the amount of required staffing. The CEO confirmed the average number of nine nurses and twentyˆone nurse aides documented in the facility assessment was not accurate and was not updated to reflect operational needs and current staffing resources, including changes in administration staff; such as, the CEO and the Chief Nursing Officer.The facility assessment dated [DATE], documented nursing facility would conduct, document and annually review a facility-wide assessment, which included both their resident population and the resources the facility needs to care for their residents. The intent of the facility assessment was for the facility to evaluate the resident population and identify the resources needed to provide the necessary person-centered care and services the residents required.