STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review the facility failed to protect a resident from neglect after a fall in the facility for 1 of 19 sampled residents (Resident #60). This deficient practice placed the resident at risk for changes in condition to go unnoticed by staff and a delay in transfer to the hospital. Findings include: Resident #60 Resident #60 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including nontraumatic chronic subdural hemorrhage, hepatic encephalopathy, and alcohol dependence with alcohol-induced persisting dementia. A Progress Note dated 11/20/2024 at 4:30 PM, documented Resident #60 was found by a nurse on the floor, face down in the resident's room. The resident had no signs or symptoms of head injury, equal hand grips and denied pain. The resident had frequent falls. The resident was assisted to the shower and a skin assessment was performed. The resident had a large red scrape to the right chest, a skin tear on the lower right arm and the left middle finger and thumb appeared purple and swollen. Per physician, continue checking neurological (neuro) signs as the fall was unwitnessed. The Director of Nursing (DON) and the oncoming nurse were made aware. The nurse did not see any head trauma, resident was alert, pleasant, and cooperative. A Progress Note dated 11/20/2024 at 10:46 PM, documented upon arrival to the unit, outgoing staff reported Resident #60 fell around 4:30 PM. The resident was on neuro checks. Noted resident's systolic blood pressure (SBP) from the time of the fall until the start of night shift were all high, as high as 193/74. Redness to the resident's forehead was noted. Staff reported to the night shift nurse the resident was found in the resident's bathroom with the resident's forehead touching the floor. At 6:22 PM, the night shift nurse notified the physician of a possible head strike and high SBP. The physician ordered to resident to be sent out for further treatment due to head strike. At approximately 7:00 PM, Resident #60 was sent to the emergency room via emergency medical services. A Neurological Assessment flowsheet dated 11/20/2024, included assessments for Resident #60 from 4:30 PM through 6:15 PM. The assessment items to be performed included vital signs (VS) and the flowsheet documented the following blood pressure (BP) readings: (continued on next page)

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
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4:30 PM, BP 193/74. -4:45 PM, BP 191/69. -5:00 PM, BP 193/65. -5:15 PM, BP 195/79. -5:45 PM, BP 187/67. -6:15 PM, BP 187/81. On 03/12/2025 at 4:02 PM, a Licensed Practical Nurse (LPN) verbalized the LPN had received training from the facility related to abuse and neglect. Neglect included not providing care to residents and not performing expected job functions. The LPN confirmed the LPN was familiar with Resident #60 and verbalized Resident #60 was confused at baseline, was unable to accurately recall recent events, was a fall risk, and fell frequently. The LPN recalled Resident #60 had a fall in November 2024. The resident was sent to the hospital for a few days prior to being transferred back to the facility. The LPN recalled the LPN found Resident #60 on the ground in the resident's room. The resident was lying face down on the floor, with the resident's head touching the ground. The LPN and Certified Nursing Assistants (CNAs) assisted the resident into the shower due to a large amount of bowel movement on the resident. The LPN recalled when the resident was assisted off the ground, a red spot in the middle of the resident's forehead was present. The LPN checked Resident #60's vital signs and performed a neuro check and everything seemed ok. The LPN explained neuro checks were documented on a flowsheet. The LPN verbalized the night shift nurse sent Resident #60 to the hospital after seeing the resident's vital signs, noting the resident's BP was high, and the nurse felt the resident seemed more confused. The LPN recalled the LPN initially checked the resident's blood pressure with the LPN's wrist cuff after the fall and the LPN did not notice anything wrong. The LPN denied the LPN documented the BP reading. The LPN reviewed the Neurological Assessment flowsheet dated 11/20/2024 and confirmed the initials at the bottom of the columns for assessments completed from 4:30 PM through 5:45 PM belonged to the LPN. The LPN verbalized the blood pressure readings documented on the flowsheet were documented by the CNA. The LPN verbalized the LPN had been busy with two resident falls, was focused on the residents' eyes and handgrips, and never saw the vital signs. The LPN denied the LPN followed up with the CNA to ask what the vital signs were following Resident #60's fall and denied the LPN reviewed the vital signs documented by the CNA prior to initialing the bottom of each column on the flowsheet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/2025 at 8:59 AM, a CNA confirmed the CNA was familiar with Resident #60 and recalled the resident fell on [DATE]. The CNA recalled the resident was found flat on the floor, face down. The LPN stayed with the resident while the CNA retrieved a VS machine. When the CNA returned to the room, the resident was lying on the resident's back and had a red bump on the resident's forehead. The CNA and LPN assisted the resident with a shower, then assisted the resident to the dining room. The CNA recalled the CNA continued to check Resident #60's vital signs every 15 minutes for one hour, then every 30 minutes, and notified the LPN the resident's blood pressure was really high. The CNA verbalized the CNA had concerns related to the LPN's response to Resident #60's fall and the resident not being sent to the hospital despite the resident's vital signs and the bump on the resident's forehead. The CNA recalled the CNA voiced the CNA's concerns to the night shift nurse at change of shift. On 03/13/2025 at 10:19 AM, a Physician confirmed the Physician was familiar with Resident #60. The Physician verbalized the Physician was aware Resident #60 had fallen in the facility however could not recall specific details related to a fall on 11/20/2024. The Physician verbalized for unwitnessed falls in the facility with head strike the Physician had a low threshold for sending the resident to the hospital. The Physician explained if a resident fell, the Physician would want to know if the fall was witnessed or unwitnessed, if the fall was ground level, if the resident lost consciousness, the results of the nurse's head to toe assessment, and the resident's VS. VS after a fall were important and nursing assessment was key. The Physician affirmed a SBP reading in the 190's after an unwitnessed fall with possible head strike would be concerning and would likely prompt transfer of the resident to the hospital. On 03/13/2025 at 11:00 AM, a Registered Nurse (RN) verbalized the RN was familiar with Resident #60. The RN recalled Resident #60 had many falls in the facility and confirmed the RN was familiar with the fall on 11/20/2024. The RN recalled the RN came on shift, was informed the resident had fallen during the day shift and was on neuro checks. The RN noted Resident #60's SBP documented on the neuro check form was high, and verbalized the RN knew something was wrong. The day shift CNA informed the RN the resident had an indentation on the resident's head and asked the RN to reassess the resident. The RN recalled Resident #60 was alert and appropriate in responses during the assessment and the RN had a concern with an injury on the resident's forehead which prompted the RN to call the Physician. The RN explained it was the facility's protocol to send residents to the hospital after a fall if the resident struck the resident's head, especially if the resident was on a blood thinner or the resident had a bump. On 03/13/2025 at 11:35 AM, the Regional Director of Quality and Clinical Services (RDQCS) verbalized neglect was failure to provide care for a resident. If a resident sustained a serious bodily injury and the facility didn't know how the injury occurred or if it could have been preventable, the facility needed to rule out neglect. The RDQCS explained the facility's expectation of staff after a resident fell was for the nurse to assess the resident, get a set of VS, do a neuro check, and check range of motion. Based on the findings of the assessment and VS, staff were to contact the doctor. The RDQCS verbalized monitoring of VS after an unwitnessed fall was very important and neuro checks were to be done every 15 minutes. Increased blood pressure after a fall could indicate an injury or a subdural hematoma (a collection of blood between the outmost layer of the meninges and the surface of the brain). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RDQCS reviewed Resident #60's clinical record and explained after the Physician was notified of elevated SBP and redness to the resident's forehead, the resident was transferred to the hospital on [DATE] due to possible head strike during a fall. The RDQCS verbalized the RDQCS would expect a nurse to review and be aware of the resident's VS documented on the neuro flowsheet. The RDQCS verbalized if a CNA checked the VS and the nurse did not review the VS, did not recheck the VS, did not notify the physician of the VS, or did not look in the record to see if there were any as needed medications available to treat blood pressure then it would be considered neglect. If the nurse saw the VS and did not intervene it could be considered neglect. The State of Nevada Administrative Code 632 - Nursing, revised August 2019, documented a Practical Nurse may supervise other personnel in the provision of care (NAC 632.228, 3). Unprofessional conduct by a licensee or certificate holder included: failing to supervise a person to whom functions of nursing are delegated or assigned, if responsible for supervising that person (NAC 632.890, 7), failing to collaborate with other members of a health care team as necessary to meet the health needs of a patient (632.890, 24), and failing to observe the conditions, signs and symptoms of a patient, to record the information or to report significant changes to the appropriate persons (632.890, 25). The Nevada State Board of Nursing Decision Tree for Delegation by Advanced Practice Registered Nurse (APRN), RN, LPN to Assistive Personnel (AP), undated and viewed on the Nevada State Board of Nursing website on 03/18/2025, documented steps in the delegation of tasks to AP included supervision and monitoring. An LPN was to assure tasks had been performed as delegated. The nurse maintained accountability for nursing tasks/activities delegated and performed by the AP, monitored the outcomes of the delegated task/s, and recognized subtle signs and symptoms with appropriate intervention when the client's condition changed. AP included CNAs. The facility policy titled Accidents/Falls, reviewed 11/2024, documented if a fall occurred, nursing/emergency care was to be provided per the facility's policy/standard of practice. Neurological observations (neuros) would be conducted following any observation of a resident hitting their head during a fall or if it was unknown/not observed whether a resident hit their head or not during a fall. Even if a resident reported the head was not hit and the fall was not observed, neuros were required to be completed. The facility policy titled Freedom from Abuse, Neglect, and Exploitation, dated 09/13/2022, documented neglect occurred when the facility was aware of, or should have been aware of, goods or services a resident required but the facility failed to provide them to the resident. Neglect included cases where the facility's indifference or disregard for resident care, comfort or safety resulted or could result in physical harm, pain, mental anguish, or emotional distress. Neglect may have been the result of a pattern of failures or may have been the result of one or more failures involving one resident and one staff person. Cross reference tag F609 and F610. CPT #NV00072985

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review the facility failed to ensure an allegation of neglect and a fall resulting in serious bodily injury was reported to the State Agency (SA) for 1 of 19 sampled residents (Resident #60). This deficient practice had the potential for allegations of neglect to not be investigated by the facility and/or the SA. Findings include: Resident #60 Resident #60 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including nontraumatic chronic subdural hemorrhage, hepatic encephalopathy, and alcohol dependence with alcohol-induced persisting dementia. A Progress Note dated 11/20/2024 at 4:30 PM, documented Resident #60 was found by a nurse on the floor, face down in the resident's room. The resident had no signs or symptoms of head injury, equal hand grips and denied pain. The resident had frequent falls. The resident was assisted to the shower and a skin assessment was performed. The resident had a large red scrape to the right chest, a skin tear on the lower right arm and the left middle finger and thumb appeared purple and swollen. Per physician, continue checking neurological (neuro) signs as the fall was unwitnessed. The Director of Nursing (DON) and the oncoming nurse were made aware. The nurse did not see any head trauma, resident was alert, pleasant, and cooperative. A Progress Note dated 11/20/2024 at 10:46 PM, documented upon arrival to the unit, outgoing staff reported Resident #60 fell around 4:30 PM. Resident was on neurological checks. Noted resident's systolic blood pressure (SBP) from the time of the fall until the start of night shift were all high, as high as 193/74. Redness to the resident's forehead was noted. Staff reported to the night shift nurse the resident was found in resident's bathroom with the resident's forehead touching the floor. At 6:22 PM, the night shift nurse notified the physician of a possible head strike and high SBP. The physician ordered to resident to be sent out for further treatment due to head strike. At approximately 7:00 PM, Resident #60 was sent to the emergency room via emergency medical services. A Progress Note dated 11/20/2024 at 11:13 PM, documented a call was received by the facility at 10:15 PM from the emergency room (ER). The ER nurse reported the resident was being transferred to another hospital for further treatment due to computed tomography (CT) scan results showing a subdural hematoma. An acute care History and Physical dated 11/20/2024, documented Resident #60 was injured in a mechanical, ground-level fall with probable brief loss of consciousness. The resident was initially evaluated at an alternate hospital and transferred for a neurosurgical evaluation. Review of the resident's transfer CT imaging demonstrated a new acute left frontotemporal extra-axial hemorrhage with mild mass effect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Issue Brief Form initiated by the facility on 11/21/2024, documented Resident #60 was found on the floor in the resident's bathroom with the resident's forehead touching the floor. The resident was sent to the emergency room for further evaluation, report received indicating the resident had a subdural hematoma. The facility's action steps following the incident included: -Medical evaluation and further management of the resident's subdural hematoma. The action step had a documented completion date of 11/20/2024. -Reassess if the subdural hematoma was acute or chronic. The action step included a note indicating acute on chronic and had a task completed date of 11/25/2024. The Issue Brief was signed by the Executive Director (ED). On 03/13/2025 at 11:35 AM, the Regional Director of Quality and Clinical Services (RDQCS) verbalized neglect was failure to provide care for a resident. Serious bodily injuries were injuries requiring further medical attention, if the resident had to be transferred to the hospital, if the resident needed a CT scan, if there was a closed head injury, or if the resident had altered mental status. The RDQCS confirmed a subdural hematoma was considered a serious bodily injury. All allegations of abuse, neglect, mistreatment, misappropriation of resident property, elopements, and injuries of unknown origin were required to be reported to the SA. If a resident sustained a serious bodily injury and the facility was unsure how the injury occurred or if it could have been preventable, the facility needed to rule out neglect and needed to be reported. On 03/13/2025 at 12:29 PM, the RDQCS denied the facility had received any concerns, complaints, or allegations regarding the failure of staff to follow post-fall policy or delay/refusal to transfer Resident #60 to the hospital after the fall on 11/20/2024 aside from a report filed against the facility's former Director of Nursing (DON). The RDQCS verbalized the facility had received a subpoena for records from the Nevada State Board of Nursing. The RDQCS explained the subpoena received did not include any allegations against the former DON however the former DON contacted the RDQCS via phone and informed the RDQCS the allegations included the former DON telling staff not to send Resident #60 to the hospital or the emergency room and not to care for Resident #60. The RDQCS believed the allegations were communicated to the RDQCS in January 2025. On 03/13/2025 at 2:53 PM, via phone call with the ED and with the RDQCS present, the ED denied Resident #60's fall on 11/20/2024 was reported to the SA. On 03/13/2025 at 2:54 PM, the RDQCS denied the allegations against the facility's former DON were thoroughly investigated or reported to the SA. It was the RDQCS's belief the allegations were not neglect and were allegations of the former DON working outside the former DON's scope of practice. The RDQCS explained the facility did not thoroughly investigate or report the allegations because the RDQCS had looked in the resident's record at the time the allegations were communicated to the RDQCS and did not believe the allegations had any merit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Freedom from Abuse, Neglect and Exploitation - Abuse Reporting and Responsibilities of Covered Individuals, revised 09/13/2022, documented the facility would report alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property and results of investigations of the allegations according to regulatory guidelines and in accordance with state law within the required timeframes. Serious bodily injury was defined as an injury involving extreme physical pain, substantial risk of death, protracted loss or impairment of the function of a bodily member, organ, or mental faculty or requiring medical intervention such as surgery or hospitalization. Each covered individual was to report immediately, but not later than two hours after forming the suspicion, if the events resulted in serious bodily injury or not later than 24 hours if the events did not result in serious bodily injury. Cross reference tag F600 and F610. CPT #NV00072985

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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** Based on clinical record review, interview, and document review the facility failed to ensure an allegation of neglect was thoroughly investigated for 1 of 19 sampled residents (Resident #60). This deficient practice had the potential for physical and/or emotional harm to residents due to allegations of neglect not being investigated and protections put in place to prevent future neglect. Findings include: Resident #60 Resident #60 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including nontraumatic chronic subdural hemorrhage, hepatic encephalopathy, and alcohol dependence with alcohol-induced persisting dementia. A Progress Note dated 11/20/2024 at 4:30 PM, documented Resident #60 was found by a nurse on the floor, face down in the resident's room. The resident had no signs or symptoms of head injury, equal hand grips and denied pain. The resident had frequent falls. The resident was assisted to the shower and a skin assessment was performed. The resident had a large red scrape to the right chest, a skin tear on the lower right arm and the left middle finger and thumb appeared purple and swollen. Per physician, continue checking neurological (neuro) signs as the fall was unwitnessed. The Director of Nursing (DON) and the oncoming nurse were made aware. The nurse did not see any head trauma, resident was alert, pleasant, and cooperative. A Progress Note dated 11/20/2024 at 10:46 PM, documented upon arrival to the unit, outgoing staff reported Resident #60 fell around 4:30 PM. Resident was on neurological checks. Noted resident's systolic blood pressure (SBP) from the time of the fall until the start of night shift were all high, as high as 193/74. Redness to the resident's forehead was noted. Staff reported to the night shift nurse the resident was found in resident's bathroom with the resident's forehead touching the floor. At 6:22 PM, the night shift nurse notified the physician of a possible head strike and high SBP. The physician ordered to resident to be sent out for further treatment due to head strike. At approximately 7:00 PM, Resident #60 was sent to the emergency room via emergency medical services. A Progress Note dated 11/20/2024 at 11:13 PM, documented a call was received by the facility at 10:15 PM from the emergency room (ER). The ER nurse reported the resident was being transferred to another hospital for further treatment due to computed tomography (CT) scan results showing a subdural hematoma. An acute care History and Physical dated 11/20/2024, documented Resident #60 was injured in a mechanical, ground-level fall with probable brief loss of consciousness. The resident was initially evaluated at an alternate hospital and transferred for a neurosurgical evaluation. Review of the resident's transfer CT imaging demonstrated a new acute left frontotemporal extra-axial hemorrhage with mild mass effect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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	An Issue Brief Form initiated by the facility on 11/21/2024, documented Resident #60 was found on the floor in the resident's bathroom with the resident's forehead touching the floor. The resident was sent to the emergency room for further evaluation, report received indicating the resident had a subdural hematoma. The facility's action steps following the incident included: -Medical evaluation and further management of the resident's subdural hematoma. The action step had a documented completion date of 11/20/2024. -Reassess if the subdural hematoma was acute or chronic. The action step included a note indicating acute on chronic and had a task completed date of 11/25/2024. The Issue Brief was signed by the Executive Director (ED). On 03/13/2025 at 11:35 AM, the Regional Director of Quality and Clinical Services (RDQCS) verbalized neglect was failure to provide care for a resident. All allegations of abuse, neglect, mistreatment, misappropriation of resident property, elopements, and injuries of unknown origin were required to be reported to the SA. On 03/13/2025 at 12:29 PM, the RDQCS denied the facility had received any concerns, complaints, or allegations regarding the failure of staff to follow post-fall policy or delay/refusal to transfer Resident #60 to hospital after the fall on 11/20/2024 aside from a report filed against the facility's former Director of Nursing (DON). The RDQCS verbalized the facility had received a subpoena for records from the Nevada State Board of Nursing. The RDQCS explained the subpoena received did not include any allegations against the former DON however the former DON contacted the RDQCS via phone and informed the RDQCS the allegations included the former DON telling staff not to send Resident #60 to the hospital or the emergency room and not to care for Resident #60. The RDQCS believed the allegations were communicated to the RDQCS in January 2025. On 03/13/2025 at 2:54 PM, the RDQCS denied the allegations against the facility's former DON were thoroughly investigated or reported to the SA. It was the RDQCS's belief the allegations were not neglect and were allegations of the former DON working outside the former DON's scope of practice. The RDQCS explained the facility did not thoroughly investigate or report the allegations because the RDQCS had looked in the resident's record at the time the allegations were communicated to the RDQCS and did not believe the allegations had any merit. The facility policy titled Freedom from Abuse, Neglect and Exploitation - Abuse Reporting and Responsibilities of Covered Individuals, revised 09/13/2022, documented the facility would report alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property and results of investigations of the allegations according to regulatory guidelines and in accordance with state law and within the required timeframes. The facility policy titled Freedom from Abuse, Neglect, and Exploitation, reviewed 11/2024, documented allegations of abuse, neglect, or exploitation would be thoroughly investigated, and the investigation would be initiated upon receipt of the allegation. The investigation could include but was not limited to: the names of the resident/s involved, the date and time of the incident, the circumstances surrounding the incident, where the incident took place, the names of any witnesses, and the name of the person alleged to have committed the act. The results of all investigations were to be reported to the Administrator and the SA within five working days of the alleged violation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295105	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Nevada State Veterans Home	36 Battleborn Way Sparks, NV 89431

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	Cross reference tag F600 and F609. CPT #NV00072985