STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295075	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pahrump Health and Rehabilitation Center	4501 N Blagg Road Pahrump, NV 89060

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on interview, record review and document review, the facility failed to ensure a resident with a full code status was provided basic life support (BLS) after having been found unresponsive for 1 of 9 sampled residents (Resident 1). The deficient practice deprived the resident of life-saving measures, specifically cardiopulmonary resuscitation (CPR) which may have potentially increased the resident's chances of recovery and survival. Findings include: Resident 1 (R1) R1 was admitted on [DATE] and readmitted on [DATE], with diagnoses including Alzheimer's disease with late onset, nutritional deficiency, and urinary tract infection (UTI). A provider order for life-sustaining treatment (POLST) dated [DATE], revealed R1 was evaluated by the physician assistant to have decisional capacity and the resident elected to be a full code (attempt CPR in the event of cardiopulmonary arrest). A quarterly social services assessment dated [DATE], revealed R1 expressed wanting to remain full code. A nursing progress note dated [DATE], revealed a Certified Nursing Assistant (CNA) reported to the nurse R1 had expired. The Licensed Practical Nurse (LPN) assessed the resident to be unresponsive, no respirations noted with absent pulse. The LPN notified the Director of Nursing Services (DNS) and Sheriff. A nursing progress note dated [DATE], documented the DNS notified the physician R1 had expired, and the Sheriff was at the building to pronounce death. The medical record lacked documented evidence the nurse or CNA initiated CPR, called a Code Blue (response to a resident who was found without vital signs), or called 911 (emergency services) when the resident was found unresponsive without pulse or respirations. (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility report submitted to the state agency on [DATE], revealed an allegation of neglect was verified by the facility concerning an LPN who did not initiate CPR on a full code resident who was found unresponsive with no pulse or respirations on [DATE]. Based on the report, the LPN reasoned not performing CPR on the resident because, the resident really looked dead. The LPN was suspended during the investigation with intention to terminate. On [DATE], two attempts to contact the LPN of concern (LPN 1) for a telephone interview were made at 8:19 AM and 12:20 PM, both attempts were unsuccessful. On [DATE] at 9:19 AM, an LPN (LPN 2) indicated working alongside LPN 1 on [DATE] with LPN 1 being assigned to the 600-Hall and LPN 2 assigned to the 500-Hall. LPN 2 explained a Code Blue was typically announced using the overhead paging system, but according to LPN 2 there was no Code Blue incident during the shift on [DATE]. LPN 2 recalled conversing with LPN 1 at the nurse's station towards end of shift when LPN 1 casually verbalized R1 had expired. On [DATE] at 1:05 PM, an attempt was made to contact the CNA assigned to R1 on [DATE]. The attempt was unsuccessful. The DNS indicated the CNA was on vacation leave and may not be reachable. On [DATE] at 1:48 PM, another CNA recounted not being assigned to R1 on [DATE] but assisted with R1's bed bath earlier in the morning. The CNA indicated not being familiar with R1 but reported a light pink vaginal discharge in R1's brief to LPN 1 who told the CNA the finding was not off baseline since R1 had an active UTI with hematuria (blood in urine). On [DATE] at 10:42 AM, the physician assistant (PA) recalled receiving a phone call from LPN 1 on [DATE] regarding abnormal findings in the resident's renal ultrasound collected on [DATE]. According to the PA, R1's renal ultrasound indicated blood was found in the resident's bladder, but the PA did not order a hospital transfer since the resident's vital signs were stable and no significant vaginal bleeding was reported. The PA indicated not being familiar with R1 and deferred to the resident's attending physician. On [DATE] at 2: 28 PM, the attending physician indicated being familiar with R1's medical condition. The physician described R1 as advanced in age with multiple co-morbidities and had been on a steady versus rapid decline. The physician indicated laboratory and other diagnostic tests were being ordered, reviewed, and addressed with abnormal findings being treated as soon as they were identified. The physician indicated R1 was recently treated with intravenous (IV) fluids for dehydration and had been on oral antibiotics for UTI. The physician explained a renal/bladder ultrasound was ordered on [DATE] due to R1's hematuria (blood in urine) and results of which became available on [DATE]. According to the physician, R1's cystitis would have been treated with bladder irrigation but unfortunately the resident expired within hours of the diagnostic report being received. The physician verbalized staff reports of the resident being restless, refusing to eat and drink and vaginal discharge were not new symptoms and could be treated at the facility-level without ruling out a need for a hospital transfer in the event of a rapid decline or need for higher level of care. The physician indicated many factors may have played a role in the resident's demise which included an infection at old age, high potassium, and high blood urea nitrogen (BUN) due to poor renal function and volume depletion. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:35 PM, the physician verbalized R1 had a full code status and the LPN who walked into the resident's room and found R1 unresponsive without pulse or respirations should have initiated CPR because it was unknown how long the resident had been unresponsive. On [DATE] at 8:56 AM, the Executive Director (ED) and the DNS confirmed there were no providers, or anyone authorized to pronounce death in the building on [DATE]. The ED indicated the LPN should have confirmed R1's code status, initiated CPR, called a code blue which would have prompted other staff members to get involved by calling paramedics, getting the crash cart, and continuing with chest compressions until paramedics took over the scene. The ED verbalized the LPN had been employed at the facility since [DATE], was considered a seasoned nurse and was expected to have carried out the facility's code blue process properly prior to contacting the DNS. On [DATE] at 9:01 AM, the DNS recounted receiving a phone call from the LPN 1 in the late afternoon of [DATE]. The DNS recalled assuming the LPN had already done all the right steps prior to the phone call, namely, 1) confirming the resident's code status, 2) initiating CPR, 3) calling a code blue, 4) continued with chest compressions until paramedics arrived. The DNS acknowledged telling the LPN to call the Sheriff to pronounce death because the DNS assumed all proper steps had already been taken by LPN 1. On [DATE] at 11:27 AM, the CNA who was assigned to R1 on [DATE] indicated being familiar with the resident. According to the CNA, the resident had an Oxygen saturation reading in the 70's (normal range: 95% or higher) but after repositioning the nasal cannula, the reading went up to 96%. The CNA confirmed the resident had been eating and drinking less and had started to refuse care, but the decline had been a steady decline over a period of months. The CNA indicated it was difficult to determine whether the resident's demise was due to a delay or failure in care versus a natural occurrence because the resident's vital signs were normal on [DATE]. The CNA indicated reporting the resident's desaturation, and increased restlessness to the LPN but the CNA verbalized being uncertain if the LPN checked on the resident without the CNA knowing, since the CNA had become very busy throughout the shift. The facility policy on CPR required all nurses to be current with BLS. Review of LPN 1's training record revealed a current CPR card issued [DATE] and a renew date of ,d+[DATE]. The CPR policy updated [DATE], documented CPR would be initiated for residents who elected to have CPR initiated in their POLST. The Code Blue policy dated [DATE], documented when a resident was found without vital signs the first responder would call a code blue. Once the code status was established, CPR would be initiated for residents who elected CPR in their POLST. A code team leader is established, and necessary duties assigned. The emergency cart would be promptly brought to the scene, Oxygen management promptly initiated, and CPR would be continued until emergency personnel arrived and took over. Completion of the post event evaluation and code event minutes was done by a licensed nurse or support team during the code blue event. Following the [DATE] event related to failure to initiate CPR on a full code resident, the facility had taken the following corrective actions: - the LPN of concern was terminated on [DATE] (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- the board of nursing had provided written acknowledgment of the facility's complaint regarding the LPN's neglect on [DATE] - the inter-disciplinary team (IDT) reviewed the POLST of all residents - the nursing report sheets were updated to include residents' code status - in-services regarding change of condition, code status, CPR and code blue were provided to staff - the DNS audited basic life support (BLS) certifications of all direct care staff - a mock code drill was conducted on [DATE] with intent to conduct drills quarterly once per shift - the IDT discussed the incident and corrective actions post-incident at a quality assurance and improvement (QAPI) meeting on [DATE] Complaint #NV00070703 FRI #NV00070695

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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** 40131 Based on interviews, record review, and document review, the facility failed to complete or document the status of the orthopedic follow-up consultation for fractured bilateral feet for 1 of 4 sampled residents (Resident 2). This deficient practice had the potential to delay the necessary medical intervention and exacerbate the resident's pain and complications. Findings include: Resident 2 (R2) R2 was admitted on [DATE], with diagnoses including a closed fracture, a nondisplaced fracture of the lateral malleolus of the right fibula, a fifth metatarsal bone, a left foot, and weakness. A Physician order dated 01/30/2023, documented to follow up with an orthopedic surgeon in one week. A Care Plan dated 02/02/2023, documented R2 had an alteration in musculoskeletal status related to a fracture of bilateral feet. The interventions included the following for weight bearing status and to see physician orders. A Physician Progress Note dated 02/09/2023, documented the Chief Complaint / Nature of the Presenting Problem: skilled visit for a for a bilateral lateral malleolar fracture. After a fall, R2 presented with a bilateral malleolus fracture and a left second through 5th metatarsal base fracture. R2's fractures were non-operative, and was to follow up as an outpatient. On 04/04/2024 at 1:35 PM, a Registered Nurse (RN) assigned to R2 explained the process for outside consultations required a physician order. The RN indicated the staff member who received the order would relay it to the appointment scheduler. Staff could access the established schedule via the electronic calendar. The RN indicated the resident Care Manager who received the order at the time no longer worked at the facility. The RN verified R2's orthopedic appointment had not been scheduled or canceled in both the calendar and the progress notes. The facility Outpatient Consult Calendar from 01/30/2023 to 02/10/2023, lacked documented evidence R2's orthopedic consult had been scheduled. On 04/04/2024 at 1:53 PM, the Business Office Generalist (BOG) explained an outpatient consultation required an order. The BOG indicated responsibilities included scheduling appointments for residents, liaising with the physician's office for outpatient consultations, and organizing transportation for residents to and from appointments. The BOG explained if an appointment had been finalized, the date, time, and instructions would be placed in the electronic calendar. The BOG confirmed there was no indication R2's orthopedic appointment was set up, completed, or canceled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/04/2024 at 2:15 PM, the Director of Rehabilitation Services (DORS) emphasized the significance of orthopedic consultation for therapy. Therapists sought updates on the R2's weight bearing status and healing progress to enhance the resident's journey towards returning home. The DORS explained therapists could perform strengthening exercises, but optimal treatment hinged on the R2's weight-bearing status. The DORS further indicated the necessity of an orthopedic consultation, given the bipedal nature of human locomotion, to enhance R2's quality of life. On 04/04/2024 at 2:58 PM, the attending doctor could not recall the care of R2 for it had been more than a year. The attending physician indicated the staff were expected to follow and carry out R2's orthopedic consult. On 04/04/2024 at 3:15 PM, the Director of Nursing (DON) indicated if the schedule was finalized or had changes, nursing would be informed. The DON confirmed there was no documented evidence R2's orthopedic appointment was completed or canceled. On 04/09/2024 at 9:42 AM, the Divisional Director of Clinical Operations (DDCO) indicated there was not a specific policy for following physician's order but this was an expectation per [NAME] standard of practice and nursing overall. The DDCO provided the RN job description, which documented how RNs obtained and administered prescribed medications and treatments in accordance with approved nursing techniques and documented the same according to the facility's standards of practice. The DDCO indicated a physician's order for a consult or referral would fall under treatment services. Complaint #NV00068006

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview and document review, the facility failed to ensure 1) the emergency crash cart was free of expired supplies, 2) staff were trained on the suction equipment, oral airway device and automated external defibrillator (AED) and 3) mock code drills were conducted quarterly once per shift in accordance with facility policy. The deficient practice placed residents' safety at risk as a result of poor-quality response to an emergency such as aspiration, choking and cardiopulmonary arrest. Emergency Crash Cart On [DATE] at 9:23 AM, a Registered Nurse (RN) and the Resident Care Manager (RCM) were present for an inspection of the emergency crash cart located in the 500-Hall and 600-Hall nurse's station. The crash cart checklist for [DATE] and [DATE] reflected the emergency crash cart was checked daily with no missed entries. The RN and RCM indicated the night shift staff were assigned check the contents of the crash cart. The RCM confirmed the following observations: - six Amsino brand yankauer devices - expired [DATE] - three Medline brand yankauer devices - expired [DATE] - one bottle sterile water expired [DATE] - one compressor nebulizer - vendor maintenance due [DATE] - one suction swab expired [DATE] On [DATE] at 10:09 AM, the staff development coordinator (SDC) confirmed checking central supply and indicated there were no unexpired yankauer devices (an oral suctioning tool made of firm plastic) in the facility. Suction Device On [DATE] at 9:33 AM, the RCM confirmed there were no yankauer devices in the crash cart which were not expired. RCM indicated not being certain how the night shift staff checked the suction equipment and confirmed there was no practice yankauer attached to the suction device. The RCM indicated night shift staff were expected to physically plug in the suction equipment, turn the device on and test suction. The RCM was asked to demonstrate use of suction equipment. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:39 AM, the RCM connected the connector tubing to the gauge and the other end to the canister. The RCM and RN verbalized not knowing what the normal reading was for a well-functioning suction equipment. The RN and RCM indicated although they were not certain what the normal suction reading was, the RN and RCM verbalized suction strength should not be too weak nor too strong. The RN and RCM stated if the suction was too weak it would be ineffective in suctioning and if the suction strength was too strong it may hurt the patient. On [DATE] at 9:46 AM, the RN indicated according to the manufacturer's website, the suction device should have a reading between 10 millimeters (mm) of Mercury (Hg) (mmHg) to 15 mmHg. On [DATE] in the afternoon, the Executive Director (ED) confirmed staff had not been trained in the use of the suction equipment. AED device On [DATE] at 11:03 AM, two RNs were at the 300-Hall nurse's station where a yellow AED device was mounted on the wall box covered with a glass door. The RNs indicated the AED device was new and was delivered to the facility about a week prior. According to the RNs, the facility did not have an AED device prior to the arrival of this AED device. The RNs indicated receiving one-on-one informal training from the SDC for use of the AED device but did not receive any formal training and the RNs indicated being uncomfortable using the device. On [DATE] at 12:04 PM, the SDC indicated had received the AED device as a grant on [DATE] and nurses had not received formal training for the AED device. The SDC explained the function of the AED was to determine if there was cardiac activity and would prompt the user to deliver a shock if needed to re-establish cardiac activity. The SDC indicated the facility utilized American Red Cross or American Heart Association as the BLS standard of practice, but the SDC was uncertain if the AED was a required component. The facility's training for CPR was limited to compressions until paramedics arrived. On [DATE] in the afternoon, the Executive Director (ED) confirmed staff had not been trained in the use of the AED device. Oral Airway device On [DATE] at 9:51 AM, the crash cart had eight sizes of oral pharyngeal airway (OPA) devices distinguished from one another by color. The Registered Nurse (RN) indicated not being certain how to measure the OPA device appropriately to fit an individual. The RN indicated not being certain if the flange (flattened tip) was placed at the center of the mouth or the tip of the lip during measurement. The RN indicated knowing the correct size OPA must be used on patients because if the OPA was too big it could obstruct the airway and if it was too small it would not be able to keep the airway open. The RN could not recall when the last training was regarding OPA devices. On [DATE] at 10:00 AM, the SDC indicated being uncertain on how to properly measure an OPA device to an individual. Mock Code Drills (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:17 AM, an LPN indicated being employed for nine years but had not attended a mock code drill. The Mock Code Blue Drill policy dated [DATE], documented drills were held a minimum of once a quarter on each shift. Review of the facility's mock code drills lacked documented evidence a mock code drill was conducted in the first and fourth quarter of 2023. On [DATE] at 12:58 PM, the SDC confirmed the facility did not conduct mock code drills for the first quarter (Jan-March) 2023 and fourth quarter of 2023 (October-December). On [DATE] at 11:21 AM, the Executive Director (ED) and the Director of Nursing Services (DNS) indicated the facility assessment last reviewed on [DATE], documented resident care needs would include a proper response to emergencies such as cardiopulmonary arrests. According to the DNS, the facility assessment drove competency requirements. The DNS provided the general orientation checklist for new and existing hires which enumerated training topics which were refreshed annually and as needed. The General Orientation Checklist did not include orientation with the crash cart, operation and maintenance of the suction equipment and AED, use of an oral airway device or Code blue. On [DATE] at 11:28 AM, the DNS verbalized prior to the incident on [DATE] newly hired nurses and existing nurses were not trained on 1) checking all components of the crash cart, 2) oral pharyngeal airway use, 3) use and equipment check for suction machine and 4) use of AED device and 5) Code blue. The DNS acknowledged the above-mentioned topics should have been included in the training requirements for new and existing hires based on the needs of the resident care population of the facility.