STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024

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 0565

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to organize and participate in resident/family groups in the facility.

46265

Based on interviews and document review, the facility failed to ensure food concerns raised by the resident group were acted on, followed through and facility's actions (if any) were communicated back to the resident group. The deficient practice had the potential to have negative psycho-social outcomes to the residents.

Findings include:

On 10/09/2024 in the morning, Resident 51 (R51) was alert, oriented, and answered questions appropriately. R51 revealed being the President of the Resident Council. R51 explained the resident council meets on a regular basis every month to discuss any concerns to be brought to the attention of the facility staff. Discussions during the resident council were recorded by a staff member during the meeting. The Resident Council President indicated on the following dates the resident council discussed concerns regarding meals with no follow up or response from the facility:

- 06/06/2024

- 07/11/2024

- 08/2024

- 09/06/2024

- 10/04/2024

On 10/09/2024 at 11:03 AM, the Resident Council President indicated food has been discussed on a regular basis, but the facility has not provided a plan. Five out of five residents involved in the resident council agreed this remark was true.

On 10/09/2024 in the morning, Resident 8 (R8) indicated the grievances were not taken seriously and at times the former Executive Director had confronted the resident regarding the resident's concerns. The resident explained the former Executive Director was invalidating the resident's feelings.

On 10/09/24 at 11:06 AM, the Resident Council President indicated the former Social Worker was the grievance official and left in August and there was really no grievance official and therefore grievances were not being addressed.

(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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 11:27 AM, five residents indicated old business was not discussed in the subsequent meetings and facility action was not communicated to the resident group. The Resident Council President and R8 filed a grievance on food and received no response. If the grievance form documented a resolution to the resident's satisfaction, the resident verbalized disagreement this discussion took place. There was no one who got back to the residents and the documentation (if any) never took place. A grievance form dated 08/18/2024, documented Resident 55 (R55) filed a formal complaint regarding cold food, watery soup, food issue cannot get fixed because no one wants to help. The grievance form documented a kitchen staff member acted by in-servicing kitchen staff regarding food temperatures and palatability. The resident and kitchen manager signed the grievance on 08/18/2024. Page 2 of the grievance form documented, Resolution of Grievance must be completed within 2 days of grievance receipt. The document indicated the grievance was resolved due to staff being in-serviced and the resident was notified of the resolution on 08/20/2024. A grievance form dated 08/18/2024, documented Resident 51 (R51) filed a formal complaint regarding food not getting any better, late and cold and looks disgusting. The grievance form documented a kitchen staff member acted by in-servicing kitchen staff regarding food temperatures and palatability. The resident and kitchen manager signed the grievance on 08/18/2024. Page 2 of the grievance form documented Resolution of Grievance indicated the grievance was resolved due to staff being in-serviced and the resident was notified of the resolution on 08/20/2024. The document failed to include a physical signature from Residents 55 and 51 who were both alert and able to provide written signatures. On 10/09/24 at 2:09 PM, Residents 55 and 51reviewed their respective grievances dated 08/18/2024 and acknowledged the complaints regarding food were indeed verbalized by the residents. The residents reviewed the documents which revealed actions taken by the facility included in-services provided to kitchen staff regarding food temperatures and palatability which rendered the grievances resolved with results communicated and provided to the residents on 08/20/2024 was false. The residents indicated no one came to speak with the residents and the facility dismissed the grievances as resolved without resident approval. On 10/09/24 at 2:18 PM, the Activities Director, Director of Nursing, and Executive Director were made aware of the allegations from the residents. The three staff members agreed the facility policy for response to resident council concerns was not followed. The Executive Director acknowledged the Social Worker left employment in August and there was no full-time replacement as of the date of the investigation, the role was being filled between a part-time Social Worker and the Director of Nursing. The facility policy titled Resident Council (revised January 2017) documented residents have the right to gather and discuss thoughts, ideas, or issues related to the care and treatment. Concerns brought forth by the Council were resolved via the Center's grievance policy. Council members were encouraged to make suggestions and offer constructive criticism to staff advisors and or the Executive Director. The Center communicates a response and or decision to the Resident Council by the next meeting.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review, and document review, the facility failed to develop a baseline care plan for a resident who was admitted with a condom catheter for 1 of 19 sampled residents (Resident 140). The deficient practice had the potential to place the resident at risk for not receiving appropriate care related to the condom catheter which included perineal care and site monitoring. Findings include: Resident 140 (R140) R140 was admitted on [DATE], with diagnoses including chronic kidney disease stage 3 and atherosclerotic vascular disease. On 10/08/2024 at 10:43 AM, R140 laid flat in bed with eyes closed, a family member was at bedside. The family member indicated the resident was in the hospital for eight days following a fall at home and R140 had significantly declined in cognitive and physical abilities since the hospitalization . The family member explained R140 had only half a kidney left, was incontinent and had a urinary catheter which was placed in the hospital. The family member searched for the urinary catheter by lifting the blanket and looking underneath the bed and expressed confusion as to why R140 no longer had a urinary catheter, maybe they removed it. An admission note dated 01/04/2024, revealed R140 was incontinent of urine and had a condom catheter in place. The medical record lacked documented evidence a baseline care plan was developed to include interventions in managing R140's condom catheter such as site monitoring, and perineal care. On 10/09/2024 at 10:49 AM, the Certified Nursing Assistant (CNA) assigned to R140 indicated being in the room when the Resident Care Manager (RCM) removed R140's condom catheter the day before. The medical record lacked documented reason and circumstance on why R140's condom catheter was removed. On 10/09/2024 at 11:53 AM, the admitting Registered Nurse (RN) recounted R140 had a condom catheter when admitted on the evening of 10/04/2024. The RN indicated being a new nurse and was working with agency nurses at the time of R140's admission so the nurse did not know and could not ask anyone regarding how to proceed with R140's catheter. The RN acknowledged forgetting to mention R140's condom catheter to the day nurse during shift report. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/2024 at 12:00 PM, the RCM confirmed being assigned to R140 when the resident's condom catheter was starting to come off on the morning of 10/08/2024. The RCM obtained a removal order from the provider who was making rounds, but the RCM acknowledged forgetting to document the incident in R140's medical record. The RCM reviewed R140's medical record and confirmed care interventions related to the resident's condom catheter was not included in the resident's baseline care plan but should have been because it counted as an immediate care need. The RCM indicated care interventions included perineal care, replacing with correct size catheter and site assessment specifically the skin on which the condom catheter was attached. On 10/09/2024 at 3:39 PM, the Director of Nursing (DON) indicated the admitting nurse was responsible for entering care orders for R140's condom catheter which included monitoring site and urine, perineal care, and replacing with correct catheter size. The DON indicated the condom catheter was considered an immediate care need and should be included in the resident's baseline care plan. According to the DON, the condom catheter was not an invasive device and did not require a justification for continued use or an order to remove but appropriate care must be carried out for as long as the condom catheter was present. The Baseline Care Plan policy updated April 2024, documented the baseline care plan was developed within 48 hours of admission and included information regarding care and services sufficient to promote safe delivery of care. The baseline care plan consisted of physician orders, initial goals and goals triggered by the admission nursing evaluation.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51397 Based on observation, interview, record review, and document review, the facility failed to 1) monitor and report a decline in function for 1 of 19 residents (Resident 65) and 2) identify and report a resident's increase in pain related to worsening contractures for 1 of 19 unsampled residents (Resident 14). The deficient practice placed the residents at risk for diminished function and potentially an impact on the physical, mental and psychosocial well-being of the residents. Findings include: Resident 14 (R14) R14 was admitted on [DATE] with diagnoses including contractures of the right hand and foot. According to the Minimum Data Set, R14 scored a 03 which indicated the resident was not able to make needs well known. R14 was also diagnosed with aphasia (inability to articulate spoken words). Review of R14's care plan revised on 03/26/2024, identified: - Resident had limited physical mobility related to cerebral vascular accident (stroke). Goals included: - The resident will remain free of complications related to immobility, including contractures and skin breakdown. Interventions included the following: - Carrot orthotic (hand splint) in right hand, document refusal - Physical therapy, Occupational Therapy referrals as needed. - Right hand splint - Soft passive range of motion (ROM) to right hand. - Place rolled towel if unable to tolerate carrot orthotic (Hand splint) - Provide gentle range of motion as tolerated with daily care. - Physical therapy (PT), Occupational therapy (OT) referral as needed. -Review of the Physician's orders showed the following: - Place orthotic in right hand during the day, check placement, if resident refuses orthotic, perform passive range of motion (ROM). (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	- Soft ROM to right hand in the morning. Place rolled towel in between fingers and palm if orthotic is refused. - Monitor placement of right-hand splint by therapy and check skin for breakdown upon removal of splint. - Monitor skin to right hand contracture for skin breakdown every shift. Review of the Treatment Administration Record (TAR) reviewed from 10/01/2024 to 10/10/2024, ordered soft passive ROM to right hand daily in AM. Place rolled towel between fingers and palm if carrot is refused. The TAR showed R14 wore the orthotic four of those days and refused the orthotic six of those days Review of the progress notes dated 10/01/2024, documented R14 had severe expressive aphasia which made it difficult for the resident to verbalize needs and got easily frustrated. On 10/08/24 at 1:54 PM, R14 was observed with right hand contracture with no splinting. On 10/10/24 at 8:11 AM, therapy director stated R14 was discharged from OT 10/4/24. The director stated it was recommended for the resident to wear the carrot splint to prevent worsening contractures, as well as to protect the resident's skin. On 10/10/24 at 8:33 AM, observation of R14's right hand showed no splinting with fingers curled up in a tight fist. On 10/10/24 at 4:19 PM, observation of R14's right hand showed no splinting with fingers curled up in a tight fist. Hand splint was seen sitting on the bedside tray table. On 10/11/24 at 8:25 AM, observation of R14's right hand showed no splinting with fingers curled up in a tight fist. Hand splint was seen sitting on the bedside tray table. On 10/11/24 at 9:57 AM, observation of R14's right hand showed no splinting with fingers curled up in a tight fist. Hand splint was seen sitting on the bedside tray table. On 10/11/24 at 10:03 AM, the CNA who was taking care of R14 stated the restorative CNA was responsible for placing the orthotic. CNA stated the restorative CNA was pulled to work on the floor but would have more knowledge about the resident's required use of the orthotic. On 10/11/24 at 10:05 AM, restorative nursing assistant (RNA) was called to the resident's bedside. The RNA stated R14 was to have the carrot orthotic on but had a tendency to pull it out. The RNA was asked to place the carrot orthotic on the resident's right hand that was tightly contracted into a fist. The RNA lifted the resident's right-hand fingers to place the orthotic and the resident screamed out loud with facial grimacing and started to cry. R14 could not articulate the pain due to aphasia. After two attempts with the resident crying out in pain, the orthotic was successfully placed. R14 was then asked to remove the orthotic, tried several times and could not. The CNA stated R14 was having increasing pain related to wearing the orthotic. CNA stated they were required to report resident changes to the DON. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 10/11/24 at 10:15 AM, the resident care manager (RCM) stated R14's hand contracture pain was known, and the resident was getting pain medications. RCM stated the resident had the orthotic for a long time. When asked further questions about what was being done for the resident's pain, the RCM stated to speak to the DON who oversaw the restorative program On 10/11/24 at 10:41 AM, RNA stated there was no resident documentation specific to the resident refusing to wear the orthotic. RNA stated the nurses would document in detail the resident's pain regarding the orthotic and pain associated with wearing the orthotic. RNA stated R14 was never on a restorative program but had orders to wear the orthotic. On 10/11/24 at 12:49 PM, the Director of Nursing (DON) stated the CNAs should have reported the resident's issues regarding increasing pain associated with contractures. On 10/10/2024 at 1:50 PM, a change of condition policy was requested, DON stated a policy was not available. Resident 65 (R65) R65 was admitted on [DATE] with diagnoses including general weakness. Minimum Data Set (MDS) report indicated R65 scored a 15 on the Brief Interview for Mental Status (BIMS). This score indicated R65 was able to make needs well known. On 10/08/2024 at 10:12 AM, R65 was observed to have bilateral hand contractures. R65 was able to pick up a cup to drink but could not hold a toothbrush to brush upper and lower teeth. R65 stated the care staff provided no assistance with oral care and had not brushed teeth in a long time. R65 showed upper and lower teeth that were brown in color with heavy yellowish, brownish build up. On 10/09/2024 at 11:26 AM, R65 was observed to have bilateral hand contractures. R65 stated not having received oral care that day, was not able to hold toothbrush and was not getting any assistance with oral care On 10/09/2024 at 11:30 AM, the Certified Nursing Assistant (CNA) who took care of R65 was called to the resident's bedside. Upon observation, the CNA noted the resident's teeth were brownish, with heavy yellowish build up. The CNA stated based on the observation of R65's upper and lower teeth, the resident was not getting adequate oral hygiene. The CNA stated R65 was usually set up with a toothbrush, with toothpaste and was able to brush teeth without staff assistance. The CNA stated R65 was not set up to brush teeth that day and when asked why, CNA stated I don't know. The CNA was then asked to set up the resident to brush teeth as usual. The CNA placed toothpaste on the toothbrush and handed it to R65. After a few attempts, the CNA observed and stated R65 could not effectively hold the toothbrush and the resident brushed teeth by keeping the toothbrush still while turning their head side to side, instead of using circular hand motions to brush. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 10/09/2024 at 11:44 AM, the Resident Care Manager (RCM) was called to the resident's bedside. Upon observation, RCM noted the resident was not able to hold the toothbrush well enough and agreed R65 used their head by turning it side to side to brush. RCM stated the resident used to be able to brush their own teeth without assistance but was no longer able due to worsening hand contractures. The RCM did not state R65's worsening hand contractures and decline in function were documented or reported for further intervention. On 10/09/2024 at 11:50 PM, the Director of Nursing (DON) confirmed R65 was not on a restorative program and was not referred to Occupational Therapy (OT). On 10/10/2024 at 7:39 AM, the therapy director who oversaw the OT department, stated based on the documentation, the resident was discharged from OT on 02/02/2024. The director stated it was recommended for R65 to be enrolled into a restorative program for upper extremity functional maintenance. The director stated at the time of discharge from OT, R65 was able to grip and propel the wheelchair wheels using their hands independently. On 10/10/2024 at 1:00 PM, an Occupational Therapist was called to the resident's bedside and an assessment was done by OT, to determine R65's ability to brush teeth independently with set up. The therapist made the same observation and stated based on the resident's current ability and prior level of function, R65 would need to be back on OT due to a decline related to worsening hand contractures. During the assessment, the resident complained of pain in fingers while holding the toothbrush. After the assessment, visual observation of the resident's teeth showed no thick yellowish buildup and teeth no longer had the brownish color that was observed before. OT progress notes and evaluations documented R65 was assessed by OT on 10/30/2023. The note showed R65 had bilateral wrist contractures but did not have any functional limitations due to the contractures. The note also showed assistive hand devices (orthotics) were not needed upon discharge from OT. The note also showed R65's hand function was modified independent (able to perform tasks using an assistive device or with assistance). Following the bedside assessment made on 10/10/2024, an OT note documented R65 had developed functional limitations due to contractures. The note showed hand splints were recommended but R65 was not able to tolerate. Manual hand treatments were then recommended to eventually allow for the use of the hand splints. Review of R65's care plan revised on 05/10/2024, identified: - R65 had an activities of daily living (ADL) self-care deficit related limited mobility and range of motion (ROM). Goals included: -The resident will improve current level of function in upper and lower extremities. Resident will be able to perform tasks independently. - Staff to anticipate needs Interventions included the following: (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	- Encourage the resident to participate to the fullest extent possible with each interaction. - Physical Therapy (PT) /OT evaluation and treatment as per MD orders. The care plan lacked documentation to show goals and interventions for R65 decline in function related to worsening hand contractures. Review of the restorative, nursing progress notes from 06/2024 to 10/01/2024, documented R65 was on a restorative program from 02/2024 to 06/13/2024. Review of the progress notes from 06/13/2024 to 10/01/2024 lacked documentation to show R65's decline in hand function was reported to OT and R65's physician. Review of the daily oral hygiene flowsheets reviewed from 06/2024 to 10/2024, documented various days where R65 was setup, independent or partial/moderate assist for oral care. Review of the undated policy titled Activities of Daily Living, documented: - If the resident appears to be declining or needing more assistance, the nurse should be notified. Review of a facility document titled Change in condition, described when clinical staff should report to the medical provider. The document read: - Any symptom, sign or apparent discomfort that is: * A marked change in relation to usual symptom and signs or * Unrelieved by measures already prescribed The document further defined: - Non- immediate notification * New or worsening symptoms that do not meet above criteria On 10/10/2024 at 1:50 PM, requested Change of Condition policy and DON stated did not have one. On 10/11/2024 at 2:31 PM, the DON stated the RNA's should have reported the resident's decline in function in brushing teeth. DON stated education was needed for the CNA's/RNA's to report any change in condition such as decline in function related to worsening contractures. DON stated the RCM should have also communicated the resident's worsening hand contractures.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on interview, record review and document review, the facility failed to ensure 1) a physician's PRN order for an anti-anxiety medication had a stop date for 1 of 19 sampled residents (Resident 70) and 2) a gradual dose reduction was attempted for a psychotropic medication for 2 of 19 sampled residents (Residents 23 and 70). The deficient practice placed the residents at risk for receiving unnecessary medications. Findings include: The facility policy titled Psychotropic Drugs, documented psychotropic drugs were any drug which affects brain activities associated with mental processes and behavior. Residents taking psychotropic medications would undergo a gradual dose reduction unless contraindicated. As needed psychotropic medications were limited to 14 days unless a rationale was provided by the practitioner and documented in the medical record. Resident 70 (R70) R70 was admitted on [DATE] and readmitted on [DATE] with diagnoses including mood disorder and anxiety disorder. 1) An active physician order dated 03/31/2024 documented to give Alprazolam 0.5 mg by mouth every 6 hours as needed for restlessness. The medical record lacked documented evidence of an end date for as needed psychotropic medication. R70 had psychotropic consent form signed and active physician orders for the following additional psychotropic medications: - Olanzapine 10 milligram (mg) - Buspirone 15 mg - Depakote 500 mg - Zoloft 50 mg Resident 23 (R23) 2) R23 was admitted on [DATE] and readmitted on [DATE] with diagnoses including psychotic disorder with hallucinations and major depressive disorder. A physician order dated 07/23/2024 documented to give Sertraline 25 mg once daily for depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 09/19/2024 documented to give Quetiapine 25 mg two times a day for antipsychotic. A physician order dated 08/05/2024 documented to give Buspirone 15 mg three times a day for anxiety. The medical record lacked documented evidence R70 and R23 received a gradual dose reduction or rationale of why it was not performed for multiple psychotropic medications. On 10/10/2024 at 1:40 PM, the Consultant Pharmacist verbalized completing medication regimen review at least monthly for all residents of the facility. R70 or R23 did not have any recent recommendations from the Pharmacist. The Consultant Pharmacist confirmed all psychotropic medications with an as needed use should have a 14-day end date unless it was documented by the physician to continue. The Consultant Pharmacist indicated all psychotropic medications must undergo a gradual dose reduction conducted by a physician or physician extender. On 10/10/2024 at 1:49 PM, the Director of Nursing (DON) explained the primary physician at the facility did not feel comfortable completing the gradual dose reduction for psychotropic medications and the facility had recently switched to having the psychiatric physician or practitioner completing the gradual dose reduction. The DON indicated some residents have not received the gradual dose reduction due to switching to a different provider. The DON acknowledged and confirmed R70 had an active order for a psychotropic medication which was to be used as needed and there was no end date. The DON explained the resident had been in and out of the facility and it was an oversight during the latest admission.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, and document review, the facility failed to ensure outdated and expired vaccine vials were discarded in accordance with the facility's policy. Specifically, two opened vials of Influenza vaccine (formula Year ,d+[DATE]) were found inside the medication refrigerator. The deficient practice placed residents at risk for receiving outdated and expired Influenza vaccine during flu season , d+[DATE]. Findings include: On [DATE] at 9:12 AM, an inspection of the medication refrigerator in the 100-Hall storage room revealed two vials of Flucelvax Quadrivalent Influenza vaccine (formula ,d+[DATE]), Lot number AU313OB. Both vials were opened with contents, not labeled with open date, and had an expiration date of [DATE]. On [DATE] at 9:15 AM, the Resident Care Manager (RCM) confirmed the observation and explained RCMs were responsible for checking the medication rooms on a monthly basis to inspect for expired patient care medications and items. The RCM could not speak to why the Influenza vials for last year's flu season were still inside the medication refrigerator. On [DATE] at 9:22 AM, the Director of Nursing (DON) explained the RCMs, or any nurse were expected to inspect the medication rooms monthly to check for expired and outdated items for disposal. The DON was inside the medication room and confirmed the two vials of Influenza vaccine were opened with contents, undated, outdated and expired. The DON indicated last year's flu season ended in the beginning of [DATE] and there should have been no reason the vaccines had not been discarded until now. The DON verbalized the finding reflected routine inspections were not being done as expected. The Medication Storage policy dated 2007, documented outdated and discontinued medications are to be immediately removed from stock and disposed of according to procedures for medication disposal. Medication storage conditions were monitored on a regular basis as a random quality assurance check. When problems were identified, recommendations for corrective action must be taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51397 Based on observation, interview, and document review, the facility failed to ensure 1) kitchen staff were wearing appropriate facial coverings during food preparation and 2) molded strawberries were not being prepped for service. The deficient practice placed residents at risk for food related illnesses from ingesting contaminated food. Findings include: On 10/08/24 at 8:45 AM, the kitchen director and a cook were observed to have full beards and were not wearing beard nets during the initial tour of the kitchen. The kitchen director stated they should have been wearing beard nets. On 10/10/24 at 11:27 AM, observed another cook preparing multiple fruit salad plates, used strawberries that came from a container with a heavily molded strawberry. The cook was made aware of the molded strawberry, picked it up and attempted to throw it out of the container. The kitchen director who was watching the encounter told the cook to throw out the entire container of strawberries stating that the other strawberries were also contaminated. The kitchen director stated the staff member will need to be educated on infection control and food contamination. The kitchen director stated the staff member should have been more aware of the contaminated fruit. Facility policy tilted, Staff Attire, revised on 10/2023 stated the following: - All staff member will have hair off shoulders, confined to a hair net or cap with facial hair properly restrained. Facility policy for food and nutritional services titled, Personal Hygiene Standards, revised on 06/2021 documented: - employees with beards, should wear beard guards

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NAME OF PROVIDER OR SUPPLIER: Pahrump Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure 1) a hospice physician's order to get resident out of bed daily was followed and, 2) hospice aides reported a loosened pressure ulcer dressing to the facility nurse for 1 of 19 sampled residents (Resident 15). The deficient practice had the potential to negatively impact quality of life by depriving the resident of environmental stimulation and social interaction and placed the resident at risk for wound complications. Findings include: Resident 15 (R15) R15 was admitted on [DATE], with diagnoses including multiple sclerosis and hospice status. A hospice physician's order dated 07/12/2024, documented to get R15 out of bed to chair daily. The medical director for the skilled nursing facility (SNF) wrote an order dated 07/12/2024, to get R15 out of bed to chair daily during day shift. The quarterly minimum data set (MDS) dated [DATE], revealed R15 had a brief interview of mental status (BIMS) of 15 (intact cognition), was totally dependent on staff for activities of daily living (ADLs) and bed to chair transfers. R15 did not have rejection of care behaviors, was able to understand and could sometimes make self-understood using verbal and non-verbal expression. On 10/08/2024 at 10:50 AM, R15 laid flat in bed facing ceiling with eyes opened. R15 was able to respond to simple questions by moving head side to side to mean No and up and down to mean yes. R15's television (TV) was off, there was no music or any form of stimulation, and the window blinds were shut. R15 indicated being in hospice care and hospice staff came a couple of times a week to see the resident. On 10/09/2024 at 10:00 AM, R15 laid flat in bed facing ceiling with eyes opened. Television was off, no music or other stimulation, window blinds were shut. On 10/10/24 at 9:36 AM, R15 laid flat in bed facing ceiling with eyes opened. Television was off, no music or other stimulation, window blinds were shut. R15 nodded head from side to side when asked whether hospice staff had come to visit the resident since 10/08/2024. On 10/10/2024 at 10:56 AM, two hospice aides were outside R15's room. The aides indicated they came three times a week to provide R15 a shower, linen change, and other activities of daily living (ADLs) such as incontinence and oral care. One hospice aide indicated R15 had a stage three pressure ulcer with dressing coming off and the aide planned to communicate the loose dressing with R15's primary nurse. The two hospice aides indicated not being aware there was a physician's order to get R15 out of bed and it would not be a good time to get R15 out of bed now because the resident was watching favorite soap opera on TV. (continued on next page)

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/2024 at 11:05 AM, the aides entered R15's room with surveyor. R15 appeared clean, head of bed elevated approximately 30 to 40 degrees with TV on a soap channel. R15 had a big smile on face and nodded when asked if this was one of R15's favorite shows. The hospice aides were present when R15 indicated being interested in getting out of bed and going outside for fresh air, had not been offered by any staff to get out of bed and R15 would not refuse to get out of bed if offered. The hospice aides left R15's room verbalizing had another resident to see in the facility. On 10/10/2024 at 11:15 AM, the Registered Nurse (RN) indicated being assigned to R15 at least twice a week and was familiar with the resident. The RN indicated being aware R15 had an order to get out bed daily and assumed Certified Nursing Assistants (CNAs) had been offering the service to R15. The RN indicated expecting if R15 refused, the CNAs were to re-offer the service and report refusals to the RN who would speak with the resident, discuss, identify and address the resident's reason for refusal. The RN reviewed R15's medical record which revealed R15 was last gotten out of bed on 10/03/2024 during the flu shot clinic. The RN confirmed there was no documentation of offers, re-offers or resident refusals regarding the out of bed order for R15. The RN indicated the hospice aides had left for the day but did not communicate with the RN regarding R15's stage three wound dressing coming off. On 10/10/2024 at 11:28 AM, the CNA assigned to R15 indicated being assigned to R15 at least twice a week and was familiar with the resident. The CNA indicated not being aware there was an out of bed order for R15, so the CNA had not been offering the service when assigned to the resident. On 10/10/2024 at 12:02 PM, the hospice RN indicated the physician's order to get R15 out of bed was written by the hospice physician per the resident's own request in July 2024. The RN indicated not being aware staff were not offering the service to R15 on a daily basis per physician's order notwithstanding the resident had the right to refuse this service. On 10/10/2024 at 12:12 PM, the Director of Nursing (DON) reviewed R15's medical record and confirmed the last time R15 was gotten out of bed was on 10/03/2024, which was the date of the facility's flu clinic. The DON indicated R15 was bedfast, required total care and would benefit from getting out of bed for repositioning and social interaction among other things. The DON indicated expecting staff to offer R15 the service in accordance with the physician's order and to re-offer the service should the resident refuse the first attempt. According to the DON, resident refusals were to be communicated with the nurse who was expected to discuss, identify and address reasons for refusal and document the same in the resident's medical record. The DON indicated R15 currently had a stage three pressure ulcer for which the care was commonly shared between the hospice provider and facility staff. The Hospice Provision of Care policy updated September 2017, documented the hospice and facility communicated and agreed upon a coordinated plan of care based on an evaluation of the individual needs of the resident. Medications and services were provided as indicated by the agreement for coordination of services. The Hospice agreement dated 11/01/2020, documented hospice may use the facility's nursing personnel to assist in the administration of prescribed therapies.